LOS ANGELES COUNTY
COMMISSION ON HIV

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HIV PREVENTION PLANNING WORKGROUP
Virtual Meeting

Make A Difference in Your Community. Join Us to End HIV!

Agenda and meeting resources will be available prior to the meeting at http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

Wednesday, April 28, 2021

5:30PM-7:00PM (PST)

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/33vdtkea

JOIN VIA WEBEX ON YOUR PHONE:

1-415-655-0001 US Toll

Access code: 145 855 0926

*Link is for members of the public only. Commission members, please contact staff for specific log-in information if not already received.

Help prevent the spread of STDs and HIV. Let your voice be heard.

Your Input will inform the planning of prevention services in your community.

Be a part of the solution!

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LOS ANGELES COUNTY
COMMISSION ON HIV

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PREVENTION PLANNING WORKGROUP
Virtual Meeting Agenda

Wednesday, April 28, 2021 @ 5:30 – 7:00pm

To Register + Join by Computer: **https://tinyurl.com/33vdtkea**
To Join by Phone: +1-415-655-0001 | Access code: 145 855 0926

1. Welcome and Introductions 5:30pm – 5:40pm
2. Executive Director Comments 5:40pm – 5:45pm
3. Division of HIV and STD Programs (DHSP) Prevention Program Overview Including the following 5:45pm – 6:15pm
   a. Overview of Prevention Programs with Funding Amount(s)
      i. Funding amounts by source
      ii. Function,
      iii. Expenditures,
      iv. Program Year (PY) dates
      v. Funding restrictions
   b. Prevention Contracts Performance in Aggregate
      i. By Jurisdiction, District, Service Planning Area (SPA) and/or Zip Code
   c. Prevention Indicators
      i. Pre-Exposure Prophylaxis (PrEP) Cascade Data by Priority Populations
      ii. Data on Health Education/Risk Reduction (HERR) Program, Outreach and Linkage to Services
   d. HIV Testing
      i. Data by Priority Populations
      ii. By Jurisdiction, District, SPA and/or Zip Code
   e. Data on STD Express Clinics
4. Review Commission Approved Prevention Standards 6:15pm – 6:50pm
5. Steps and Agenda Development for Next Meeting 6:50pm – 6:58pm
6. Public Comment + Announcements 6:58pm – 7:00pm
7. Adjournment 7:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

VIRTUAL MEETING—CONSUMER CAUCUS
Monday, March 22, 2001 | 5:30-7:00PM
MEETING SUMMARY

Luckie Alexander (Co-Chair)	Miguel Martinez (Co-Chair)	Maribel Ulloa (Co-Chair)
Everardo Alvizo	Alice Castellanos	Kevin Donnelly
Ayana Elliott	Lawrence Fernandez	David Flores
Bridget Gordon	Michael Green (DHSP Staff)	Luis Herrera
Christopher Hucks-Ortiz	David Lee	Katja Nelson
Pamela Ogata, (DHSP Staff)	A Reina, (DMH Staff)	Terri Reynolds
Paul Sanchez	LaShonda Spencer, MD	Julie Tolentino (DHSP Staff)
Octavio Vallejo	Greg Wilson	Cheryl Barrit (COH Staff)
Carolyn Echols-Watson (COH Staff)	Abdul-Malik Ogunlade, (COH Intern)	

1. Welcome & Introductions

Miguel Martinez open the meeting with a welcome and introduction. Those in attendance introduced themselves and stated what they plan to achieve by attending the meeting.

Maribel Ulloa, Miguel Martinez, and Luckie Fuller, Co-Chairs of the Prevention Planning Workgroup (PPW) co- facilitated the meeting.

The meeting packet can be found on the Commission website at http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee.

2. Executive Director Comments

Cheryl Barrit, Executive Director reviewed the history of HIV prevention planning and the Commission. The Commission revised bylaws to integrate prevention planning in 2013. It was in 2013 the Prevention Planning Committee and the Commission merged as one integrated planning body. The workgroup has been charged with leading the community and Commission in improving and fully integrating prevention in planning priority setting and resource allocation process.

3. Overview Prevention Planning Activities

Luckie Fuller provided an overview of the PPW which was established by the Planning, Priorities and Allocations Committee in October 2020 to lead the prevention planning integration process. The workgroup is charged with leading, facilitating, and engaging

Commission and community members in the development process. This includes encouraging community voices not previously heard by the Commission. The group has set some activities which include a review of the Ending the HIV Epidemic (EHE) Plan; review pertinent prevention and care data; host community forums for input on prevention efforts with a special focus on highly impacted populations; review and reflect on information obtained ; and finally discuss steps toward a fully integrated planning process.

4. Ending the HIV Epidemic (EHE) Plan Overview

Julie Tolentino, Division of HIV and STD Programs (DHSP) provided a history and an overview of the EHE plan for Los Angeles County (LAC). Dr. Michael Green, DHSP, noted that prevention funding received and administered by DHSP comes from the following sources:

CDC Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments – Component A $17,950,094, which supports a variety of prevention services and surveillance. An additional $ 836,001 is from Component B to support quality improvement activities on PrEP coordination, education, and enrollment, and data collection on PrEP uptake.

The EHE plan has four pillars: 1) diagnose; 2) treat; 3 prevent; and 4) respond. The Prevention pillar has two areas of focus, Pre-exposure Prophylaxis (PrEP) and Syringe Services Programs (SSPs).

It was noted, the local EHE plan is a living document and intentional efforts are being made to seek input not previously or consistently included in HIV planning. EHE Plan execution has been impeded due to COVID 19. However, the following activities are in motion.

- Community engagement efforts will launch in April 2021. They include partnering with community agencies being responsive and able to make course correction as needed. Listening sessions and community-based projects with priority populations are planned. DHSP is working with the Department of Mental Health Task Force and Youth Community Advisory Boards as part of this effort.

- DHSP is developing a Memorandum of Understanding (MOU) with interesting partners to provide self-testing kits to providers for distribution.

- The Division is working with the City of Long Beach, Substance Abuse Prevention and Control (SAPC), City of Los Angeles, City of West Hollywood and Being Alive on a Syringe Exchange Program. Syringe exchange service providers in attendance

encouraged DHSP to include agencies with program experience. It was noted, the City of Los Angeles AIDS Coordinator's Office and SAPC are updating the syringe services listing. The providers noted the reduction in mobile testing units had a negative impact on services and home test kits are critical.

- A Contingency Management program using financial incentives to link and retain patients to care is being developed.

5. Division on HIV and STD Programs (DHSP) Prevention Programs Overview

Michael Green and Pamela Ogata DHSP staff shared examples DHSP efforts in providing prevention services. Dr. Green briefly touched on the following:

- Expenditure monitoring and year end projections of prevention services funding.
- Data points used to measure contract performance for prevention services.
- HIV testing and surveillance data is not available at the moment and they hope to provide more information at the next PPW meeting.
- PrEP education, outreach and linkage to services are funded by CDC. It was noted, universal data base does not exist, but DHSP has surveillance data through the PrEP Centers of Excellence.
- Health Education Risk Reduction (HERR) is being funded with reduced CDC funding.

6. Next Steps and Agenda Development for Next Meeting

The workgroup requested DHSP staff provide the following data for the next workgroup meeting.

- A more thorough overview of DHSP-funded prevention programs with funding amounts.
- Prevention fiscal information (i.e., funding amounts by source and/function, expenditures, PY dates, funding restrictions)
    - Are they on track to spend funding?
- Performance of prevention contracts as aggregate data (types of service, jurisdiction, district, SPA, zip code)
- Prevention indicators such as PrEP and any specific cascade data DHSP may have for priority populations.
- Data on health education/risk reduction (HERR), outreach, and linkage to services
- HIV testing data by priority populations (jurisdiction, district, SPA, zip code)
- Data on STD express clinics

Additional Issues of Interest to the Workgroup

- Review best practices through STD express clinics.
- Obtain additional standards for store front testing sites.
- Provide holistic approach to sexual health education. Include STDs in conversation.

- How will STD data be captured due to the temporary closing of Centers of Excellence due to COVID-19.
- Review Standards and Best Practices (SBP) approved by the Commission regarding Prevention Standards.
- The Workgroup agreed to meet the fourth Wednesday of the month. The next meeting is scheduled for April 28, 2021 from 5:30PM to 7:00PM

7. **Public Comment & Announcements** – No comments or announcements

8. **Adjournment** – Meeting adjourned

Grant	FY 2020 Award	Estimated FY 2020 Expenditures	FY 2021 Award
CDC EHE (PS 20-2010) (August 1 - July 31)	$ 3,360,658	$ 708,010	$ 3,360,658
CDC IHSPP (PS18-1802) Component A - Surveillance (January 1 - December 31)	$ 2,561,928	$ 1,526,287	$ 2,561,928
CDC IHSPP (PS18-1802) Component A - Prevention (January 1 - December 31)	$ 15,388,167	$ 13,795,454	$ 15,388,167
CDC STD PCHD (PS19-1901) (January 1 - December 31)	$ 3,266,404	$ 3,040,656	$ 3,324,265
CDC NHBS (January 1 - December 31)	$ 699,495	$ 459,476	$ 489,303
SAPC (Non-DMC) (July 1 - June 30)	$ 4,449,000	$ 3,254,011	$ 3,249,000
CA DPH STD Management and Collaboration Project (July 1 - June 30)	$ 497,400	$ 78,394	$ 497,400
CA DPH STD General Funds (July 1 - June 30)	$ 547,050	TBD	$ 547,050
HIV NCC (July 1 - June 30)	$ 18,340,000	TBD	TBD

Funding Restrictions
Cannot use funds for construction, purchase of needles or medication, research, advocacy and lobbying, and staff must be on budget for at least 50%
Cannot use funds for construction, purchase of needles or medication, research, or advocacy and lobbying
Cannot use funds for construction, purchase of needles or medication, research, or advocacy and lobbying
Cannot use funds for construction, advocacy or lobbying
Cannot use funds for construction, purchase of needles or medication, advocacy, or lobbying
Cannot be used for non-substance use/abuse related services, advocacy, or lobbying
Funds must be used to implement evidence-based public health activities with an emphasis on the prevention and control of infectious syphilis, congenital syphilis, gonorrhea, and chlamydia trachomatis infection
Funds must be used to implement public health activities to monitor, investigate, and prevent sexually transmitted diseases (STD). 50% of funds are required to be used to implement activities in conjunction with community based organizations (CBO).

HIV and or STD Prevention Activity	Approximate FY 2020 Funding	Funding Source(s)
HIV Counseling, Testing, and Referral Services	$9,377,000	CDC Integrated HIV Surveillance and Prevention Program (IHSPP) Component A, HIV NCC
Storefront, healthcare settings, social and sexual networks, and HIV testing with syphilis screening		
STD Testing and Screening Services (Category 1 and 2)	$6,590,000	CA DPH STD Management and Collaboration Project, CDC Strengthening STD Prevention and Control for Health Departments (STD PCHD), Tobacco Settlement Funds, Infectious Disease Funds
STD testing and screening and sexual health express clinics		
Home HIV Self-test Kits	$888,000	CDC Ending the HIV Epidemic
HIV test kits provided through DHSP pilot program targeted to substance use treatment and resource centers, PrEP sites, and partner services. At-home HIV test kits provided through the National Association of State and Territorial AIDS Directors (NASTAD) "Take Me Home" at-home testing program.		
Health Education/Risk Reduction Services	$3,500,000	CDC IHSPP, HIV NCC
Outreach encounters that assist in providing client-centered linked referrals to HIV and STD testing services and PrEP and individual or group-level education services		
Vulnerable Populations	$5,700,000	CDC IHSPP, CDC STD PCHD, HIV NCC, STD NCC
HIV and STD prevention services to African American and Latino YMSM and transgender individuals in the central and south areas of Los Angeles County		
HIV Biomedical Prevention	$2,400,000	Non Drug Medical (Non DMC), HIV NCC
Biomedical HIV Prevention Navigation Services aimed at recruiting, linking and retaining in care those at highest risk for contracting and/or transmitting HIV.		
Comprehensive HIV and STD Testing in the City of Long Beach	$1,200,000	STD NCC, CDC IHSPP Component A

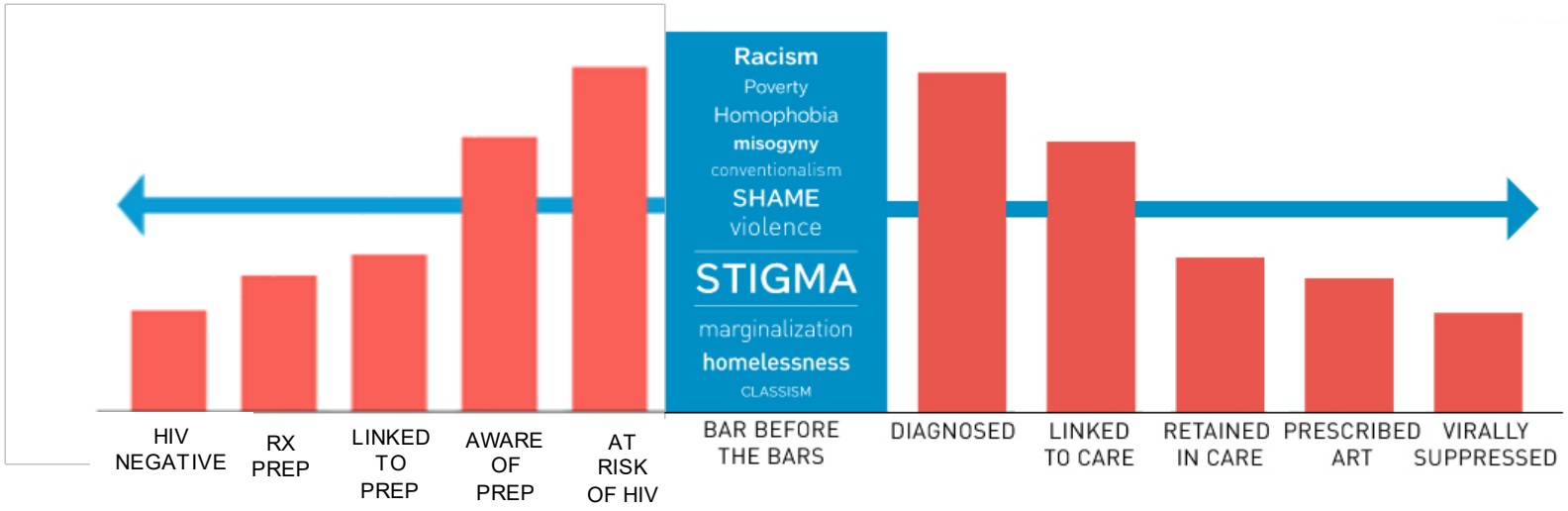
Comprehensive HIV and STD testing and STD treatment services in Long Beach to reduce HIV and STD transmission. Funding amount only represents one FY 2020 contract.		
National HIV Behavioral Survey (NHBS)	$490,000	CDC NHBS
Los Angeles County's participation in this four-cycle national survey (MSM, IDU, Heterosexuals, and TG). Survey findings are used for the program development, resource allocation, and ending the HIV epidemic planning		
Community-based Sexual Health Programs	$4,900,000	STD PCHD, CA DPH STD Management and Collaboration Project, STD NCC
STD testing, screening, diagnosis, treatment, and prevention services		
Social Marketing	$75,000	CA DPH STD Management and Collaboration Project
HIV/STD prevention social marketing campaign targeted for those at highest risk for HIV/STDs through the expansion of LAC's condom distribution program		
CT/GC Medication	$92,000	CA DPH STD General Funds
Patient delivered partner therapy medication distribution		
Rapid Syphilis Test Kits	$97,028	CA DPH STD Management and Collaboration Project
Point-of-care testing of persons at risk for syphilis in settings where routine clinical follow up of laboratory testing may not be possible		

Overview of Contracted HIV Prevention and Testing Services in Los Angeles County

Division of HIV and STD Programs
April 28, 2021

COH Prevention Workgroup
April 28, 2021

Status Neutral Continuum



Adapted from: https://www.nastad.org/domestic/hiv-prevention-health-equity

Biomedical Prevention Services

Prevention Data Sources

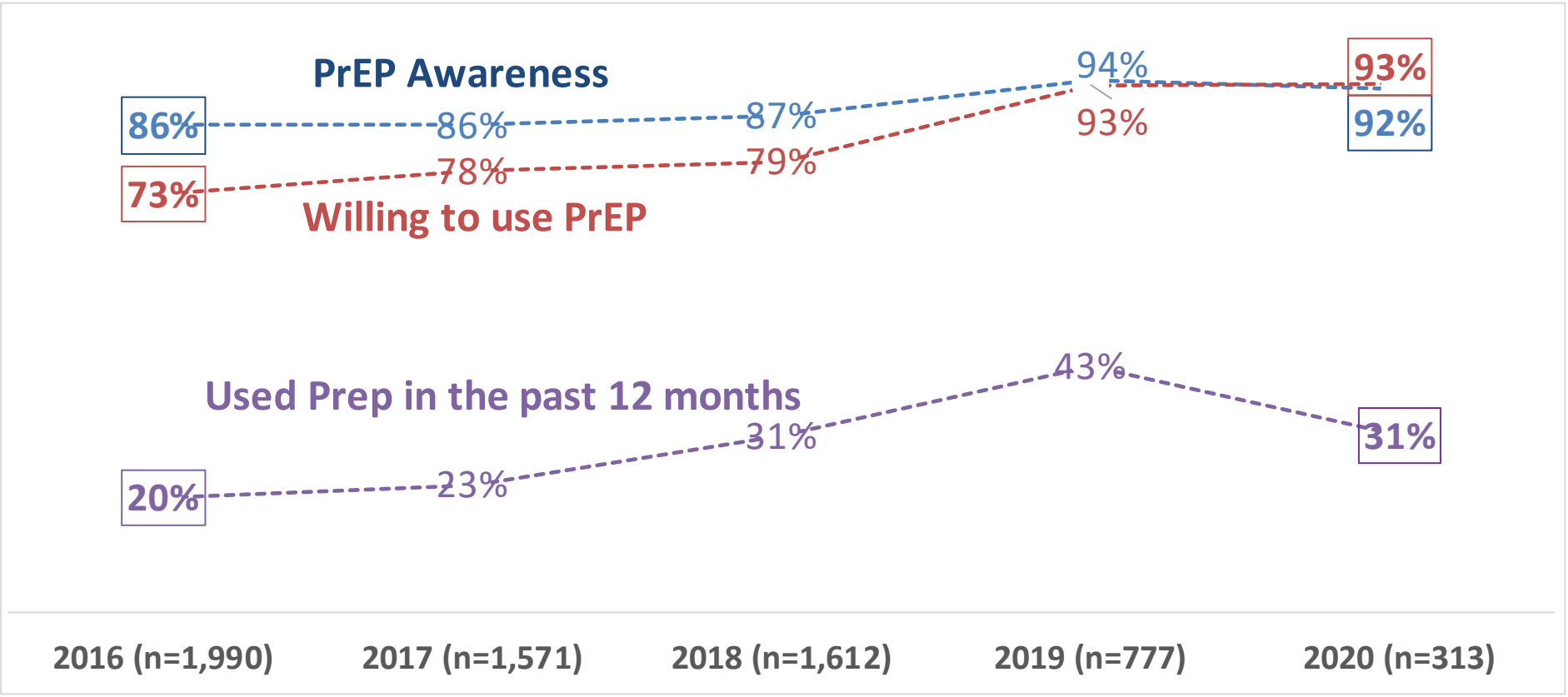
- HIV/STD Testing Services
- National HIV Behavioral Surveillance Project
- **LAC Apps-Based Survey**
- **Contacted Biomedical Services**
- Contracted HIV Education and Risk Reduction (HERR) Services
- Contracted Vulnerable Populations Services

Online PrEP Monitoring PrEP

- Purpose: To monitor PrEP knowledge, attitudes and behaviors among priority populations for the CDC PrIDE initiative.
- Sample of Black and Latino MSM and Transgender Persons (TGP) recruited through dating apps
- Conducted annually since 2016
- Key indicators:
  - **PrEP Awareness:** Before today, had you ever heard of PrEP?
  - **Willingness to use PrEP:** If it was available to you, would you be willing to take PrEP daily?
  - **PrEP Use:** In the past 12 months, have you taken PrEP daily for a period of at least one month?

Have Core PrEP Outcomes Changed in LAC?

PrEP awareness, willingness to use PrEP and PrEP use in past 12-months significantly increased from 2016 to 2019*

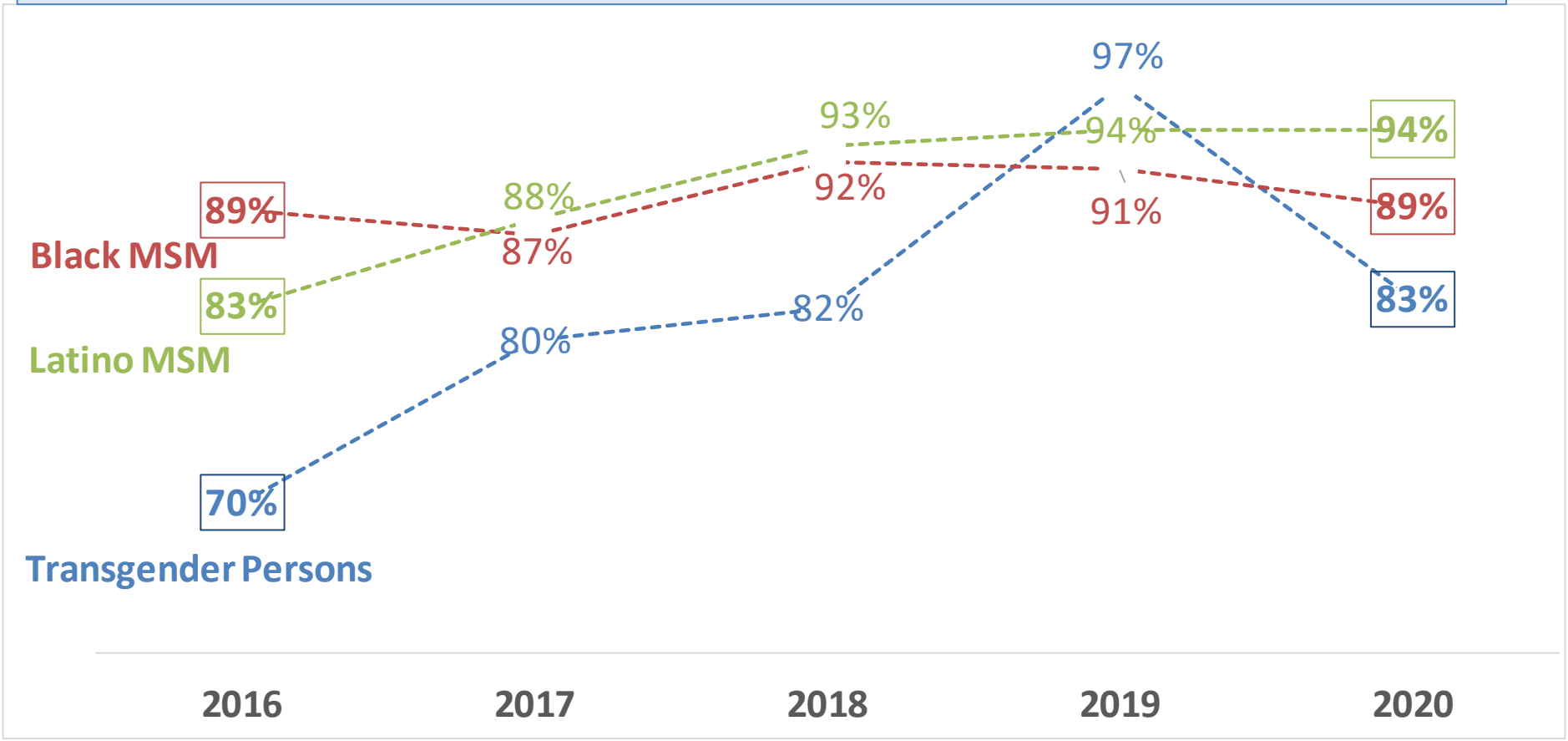


*p<0.001

[1]Collected at baseline in April 2016 and in all follow up surveys (October 2016, February 2017, August 2017, February 2018, July 2018, December 2019, December 2020); MSM recruited via app TGP all sources

Which Priority Groups Saw Increased PrEP Awareness?

PrEP awareness significantly increased Latino MSM and TGP through 2020 but remained relatively unchanged among Black MSM

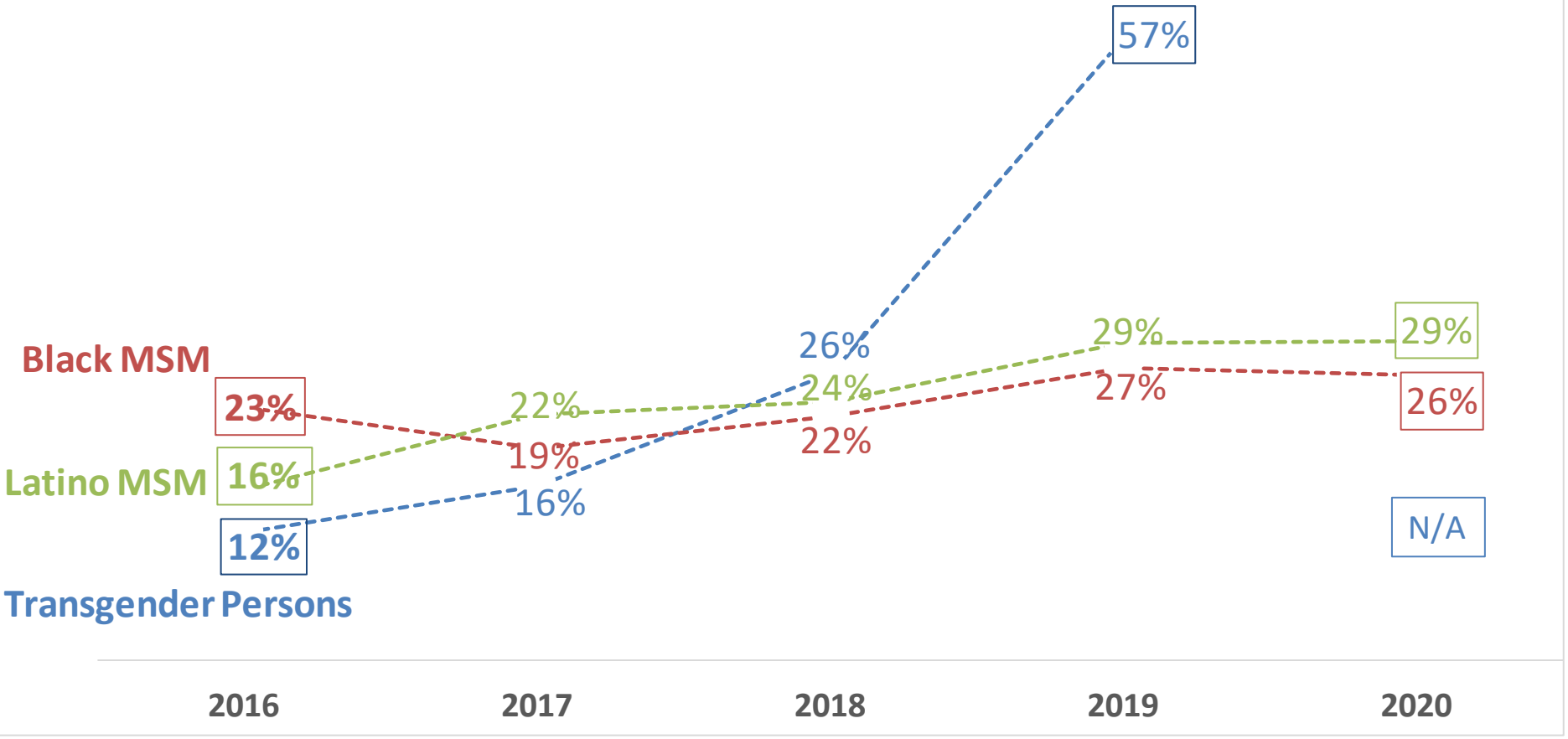


*LMSM and TGP p<0.001

[1]Collected at baseline in April 2016 and in all follow up surveys (October 2016, February 2017, August 2017, February 2018, July 2018, December 2019, December 2020); MSM recruited via app TGP all sources

Which Priority Groups Saw Increased PrEP Use?

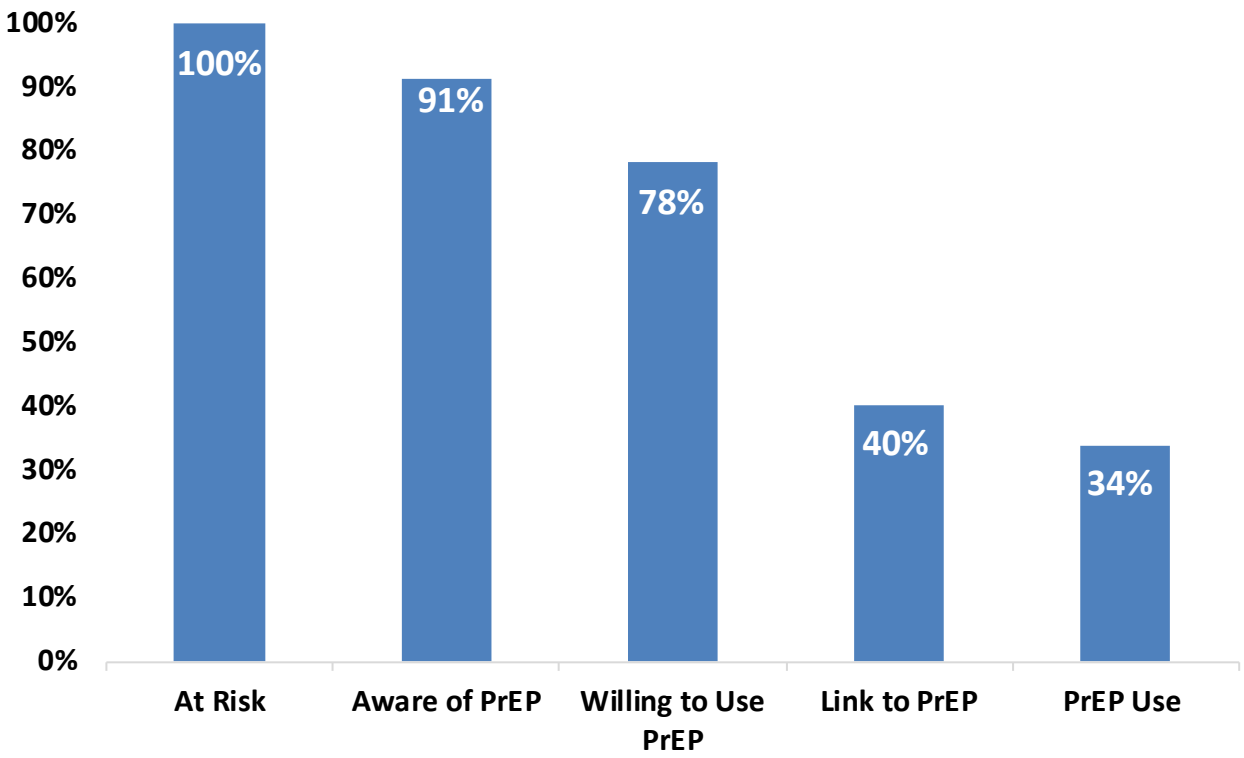
PrEP use within the past 12-month significantly increased across all groups since 2016*



*p<0.001

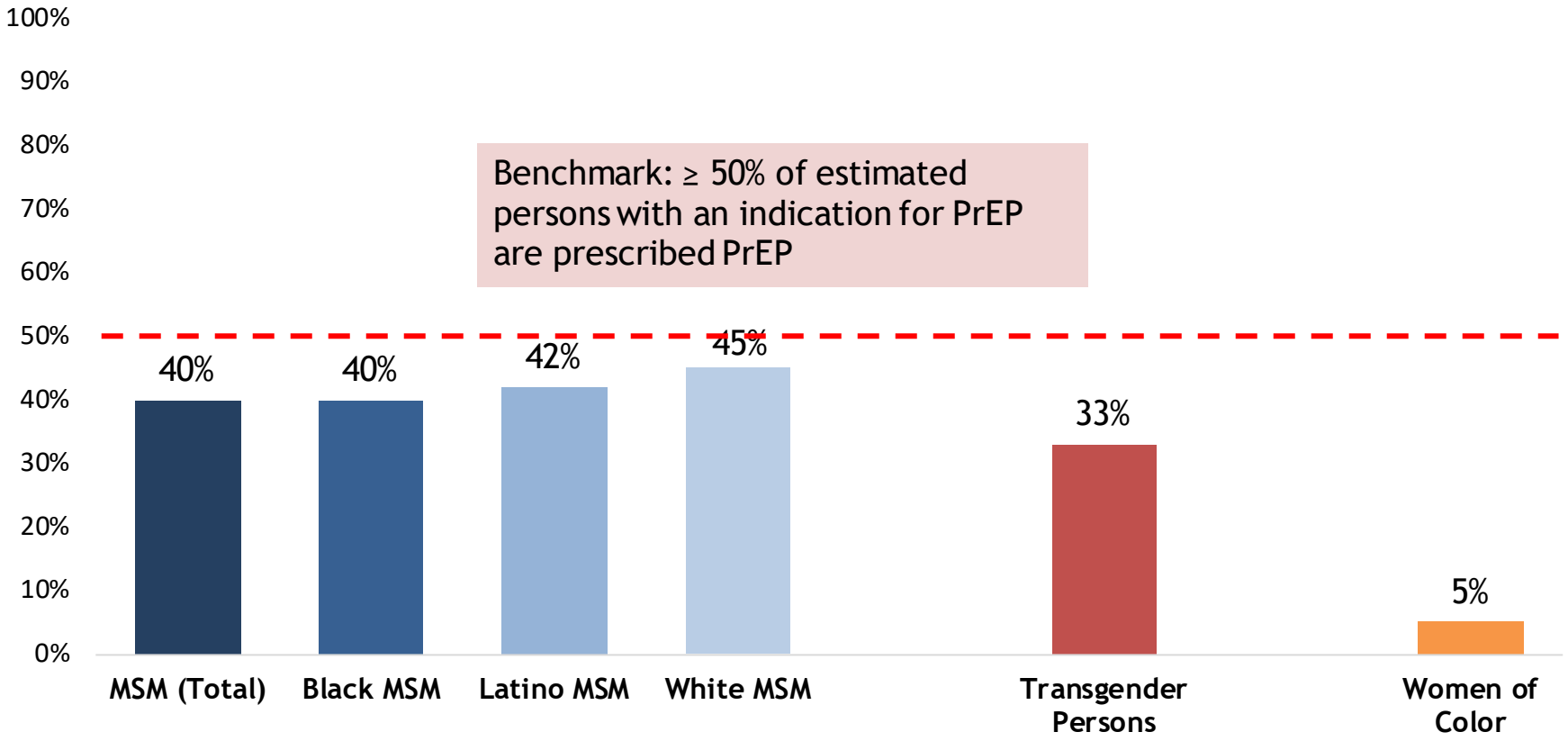
[1]Collected at baseline in April 2016 and in all follow up surveys (October 2016, February 2017, August 2017, February 2018, July 2018, December 2019, December 2020); MSM recruited via app TGP all source; TGP data for 2020 not presented due to low sample size

Los Angeles County PrEP Continuum of Care for MSM, 2018-2019



- At risk was estimated using the CDC's PrEP indicator estimation calculator, which employs a multiplier method to local data (2017 LAC surveillance data on proportions of HIV diagnoses by race/ethnicity and risk group and LAC Health Survey estimates of risk group sizes) to derive estimated numbers of adults with indications by risk group.
- Aware of PrEP, willing to take PrEP, linkage to PrEP and use of PrEP in past 12 months based on MSM response to online PrEP survey collected in 2018 and 2019 (90%, 87%, 46% and 39% respectively (Los Angeles County Division of HIV and STD programs internal data).

2018 estimates suggest that none of the priority populations in LAC met the EHE PrEP benchmark of at least 50% coverage

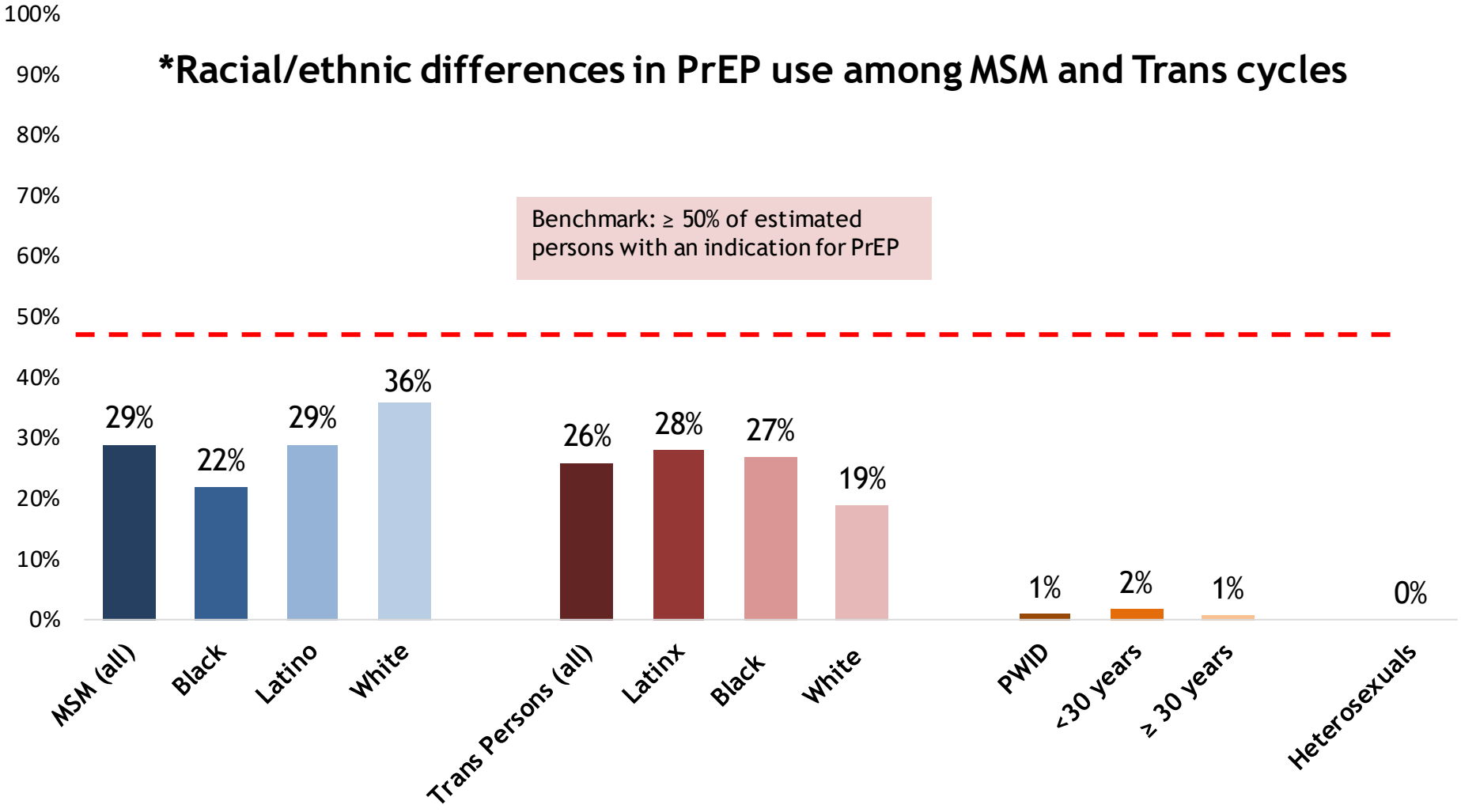


Main Sources: LAC Health Survey 2018 (MSM), NHBS (MSM, WoC), CDC PrEP Indication Calculator, DPH STD Clinics (WoC), DHSP PrEP Survey (MSM, TGP), and DHSP Partner Services (MSM, TGP, WoC)

*Current PrEP use reported by NHBS populations is below EHE benchmark

*PrEP lowest among PWID and HET cycles

*Racial/ethnic differences in PrEP use among MSM and Trans cycles



Data Source: LAC NHBS: MSM cycle, 2017; PWID cycle, 2018; Transgender and At-risk Heterosexual cycles, 2019.

PrEP Centers of Excellence (COEs)

- Includes 13 clinics across LAC to promote access to and uptake of biomedical prevention services (PrEP and PEP)

- Since inception in 2016, a total of 8,290 clients have been screened for all biomedical prevention services

6,025 unduplicated clients prescribed PrEP

- **92% cisgender male**, 5% transgender, 3% cisgender female
- **45% Latinx**, 35% White, 11% Black, 9% Asian/PI, and ≤ 1% Native American
- **Average age= 33 years** (range 14-74 years)

2,420 unduplicated clients prescribed PEP

- **87% cisgender male**, 3% transgender, 10% cisgender female
- **44% Latinx**, 34% White, 12% Black, 9% Asian/PI, and ≤ 1% Native American
- **Average age=31 years** (range 14-73 years)

Little change seen in PEP prescriptions overall and by priority populations at COEs

PEP clients were mainly MSM, with about 1 in 3 PEP clients being Latino

Population	2016*	2017	2018	2019
TOTAL CLIENTS	**259**	**752**	**717**	**613**
MSM	**237 (92%)**	**655 (87%)**	**605 (84%)**	**513 (84%)**
Black	28 (11%)	67 (10%)	66 (11%)	61 (12%)
Latino	106 (45%)	285 (44%)	268 (44%)	220 (43%)
Transgender Persons	**6 (2%)**	**20 (3%)**	**22 (3%)**	**20 (3%)**
Black	1	1	1	4
Latinx	5	15	19	12
Women of Color	**9 (3%)**	**35 (5%)**	**40 (6%)**	**31 (5%)**
Black	1	7	17	9
Latina	8	28	23	22

*Biomedical Contracts began in August 2016

Top Indicators for PrEP by Priority Population at PrEP Centers of Excellence (COEs)

	MSM	TGP	Cis Gender Women
1	Multiple Partners with unknown HIV Status	Multiple Partners with unknown HIV Status	Partner is Living with HIV
2	Condomless Receptive Sex	Condomless Receptive Sex	Multiple Partners
3	Anogenital STD or Syphilis	Transactional Sex	Partner is MSM

Clients served from August 2016-September 2018

Little change seen in PrEP prescriptions overall and by priority populations at COEs

PrEP clients were mainly MSM, with about 1 in 10 PrEP clients being Latino

Priority Population	2016	2017	2018	2019
TOTAL CLIENTS	**282**	**2,003**	**2,449**	**2,068**
MSM	**264 (94%)**	**1,824 (91%)**	**2,183 (89%)**	**1,876 (91%)**
Black	23 (9%)	172 (9%)	221 (10%)	208 (11%)
Latino	111 (42%)	771 (42%)	988 (45%)	825 (44%)
Transgender Persons	**11 (4%)**	**106 (5%)**	**159 (6%)**	**86 (4%)**
Black	2	13 (12%)	20 (13%)	7 (8%)
Latinx	6	75 (71%)	103 (65%)	58 (67%)
Women of Color	**2 (<1%)**	**37 (2%)**	**45 (2%)**	**38 (2%)**
Black	0	7	10	11
Latina	2	30	35	27

*Biomedical Contracts began in August 2016

Contracted HIV and STD Testing and Screening Services

HIV Testing Data Sources

- HIV Surveillance
  - New diagnoses in all of LAC
- National HIV Behavioral Surveillance Project
  - HIV prevalence and testing behaviors among MSM, TGP, HET and PWID
- **Contracted HIV Testing Services**
  - Testing volume
  - Testing positivity
  - New and previously identified HIV diagnoses
  - Linkage to care

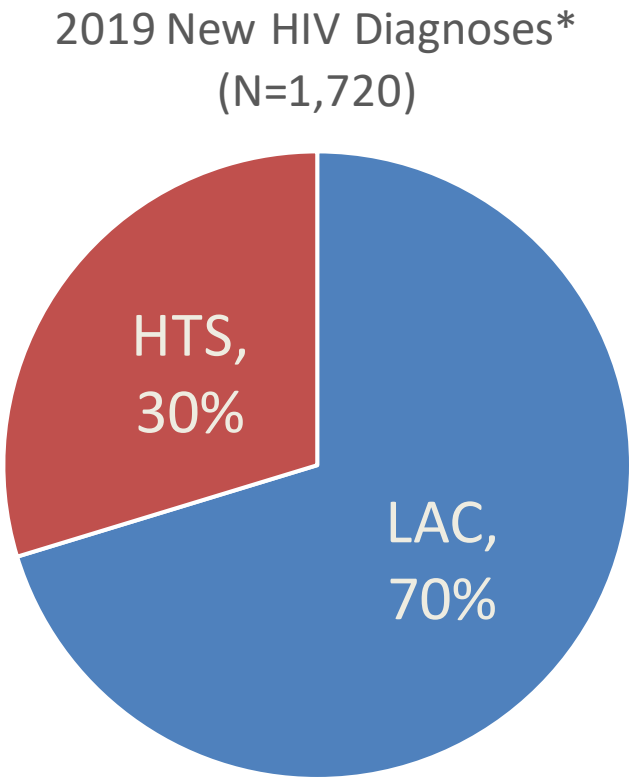
2019 HTS Measures

- **Testing volume** is the **total number of HIV tests performed** within the observation period
- **Positivity** is the **total number clients with a positive test result out of all of the tests performed** within the observation period
- **New positivity** is the number **clients with a positive test result not previously reported** in the HIV surveillance system
- **Linkage to care** is the **percent of diagnosed clients with evidence of a medical visit within 30 days** of their HIV diagnosis.

Data source: HIV Testing Services (HTS) database as of 03/13/2020; may only include data processed as of 03/12/2020.

Scope of Contracted HIV Testing Services

- New HIV diagnoses identified through contracted HTS providers in 2019 represent approximately 1 in 3 new HIV diagnoses in LAC



*Data sources: Division of HIV and STD Programs, eHARS data as of March 25, 2021 and HIV Testing Services as of March 13, 2020 and are subject to change

Contracted HIV Testing Services, 2019

TOTAL HIV TESTS CONDUCTED	128,003	NEWLY DIAGNOSED HIV POSITIVITY	0.4%

980	511	469
Total HIV tests with a positive test result	were **newly diagnosed** with HIV (52%)	were **previously diagnosed** with HIV (48%)

61% of persons newly diagnosed with HIV were **linked to medical care within 7 days**	**82%** of persons newly diagnosed with HIV were **linked to medical care within 30 days**	**90%** of persons newly diagnosed with HIV were **linked to medical care within 90 days**	**75%** of persons newly diagnosed with HIV were **referred to partner services**

2019 HIV Testing Modalities by Setting

Healthcare	Non-Healthcare
• 4 Community Clinics • 2 Jails (Men's Central Jail/K6G, Century Regional Detention Facility)* • 12 Public Health STD Clinics • 1 Community-based STD Clinic	• 17 Storefronts • 6 Mobile Testing Units • 2 Multiple Morbidity Testing Units* • 11 Commercial Sex Venues* • 2 Courts/Drug Expansion (DREX) program • 1 Social Network Testing • HIV Testing Events

DHSP also supports 5 Community Wellness Centers* and 10 PrEP Centers of Excellence*

HIV and STD Testing provided at settings designated with an ""*

Contracted HIV Testing Services Settings

- Of the 128,003 HIV tests conducted in 2019, half (50%) were in health care settings (50%), 28% were in mobile testing and 22% were non-healthcare settings

New positivity in health care settings: 0.5%	New positivity in non-healthcare settings: 0.4%	New positivity in in mobile testing settings: 0.2%

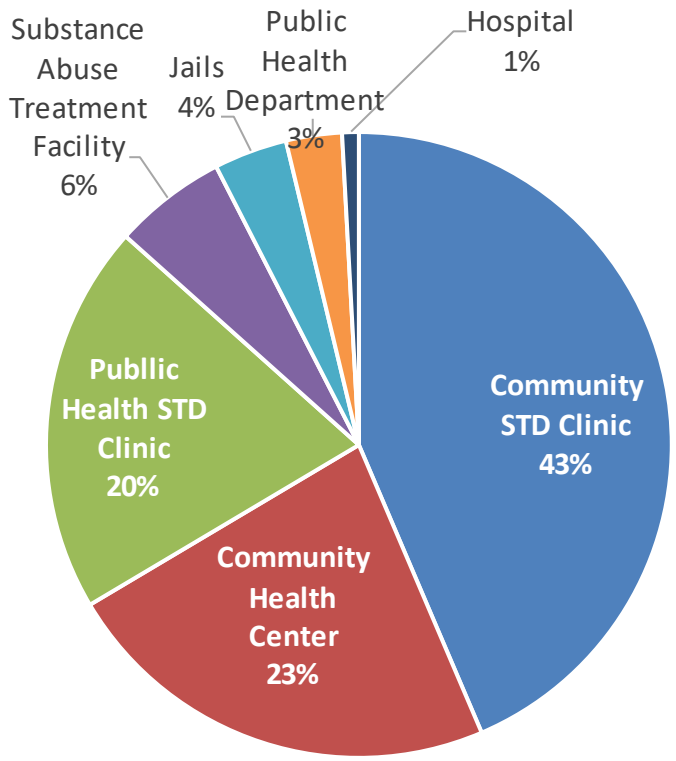
- Despite having the lowest testing volume, new positivity was highest in non-healthcare setting

Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Testing volume was more than double in health care compared to non-health care settings

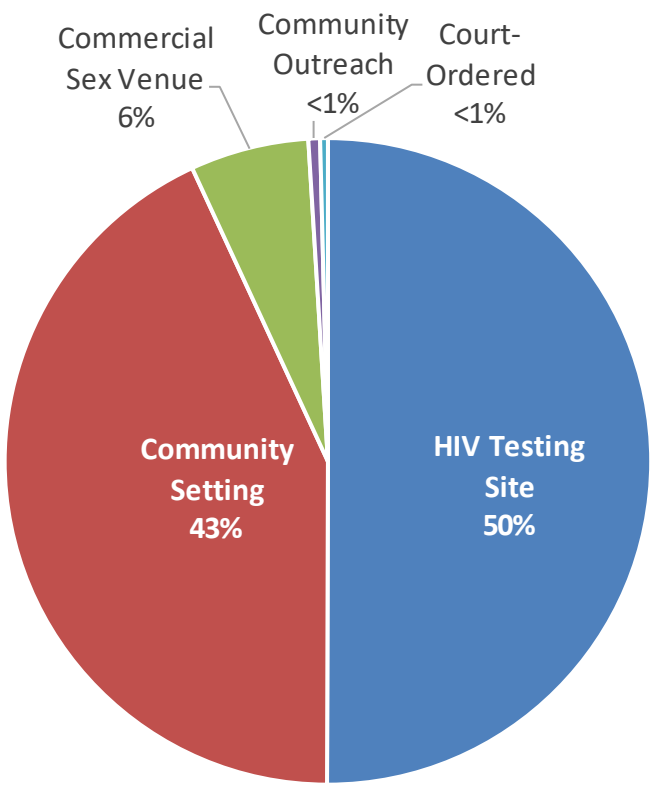
Health care settings=64,484 tests

2 in 3 tests were performed in community STD clinics and health centers



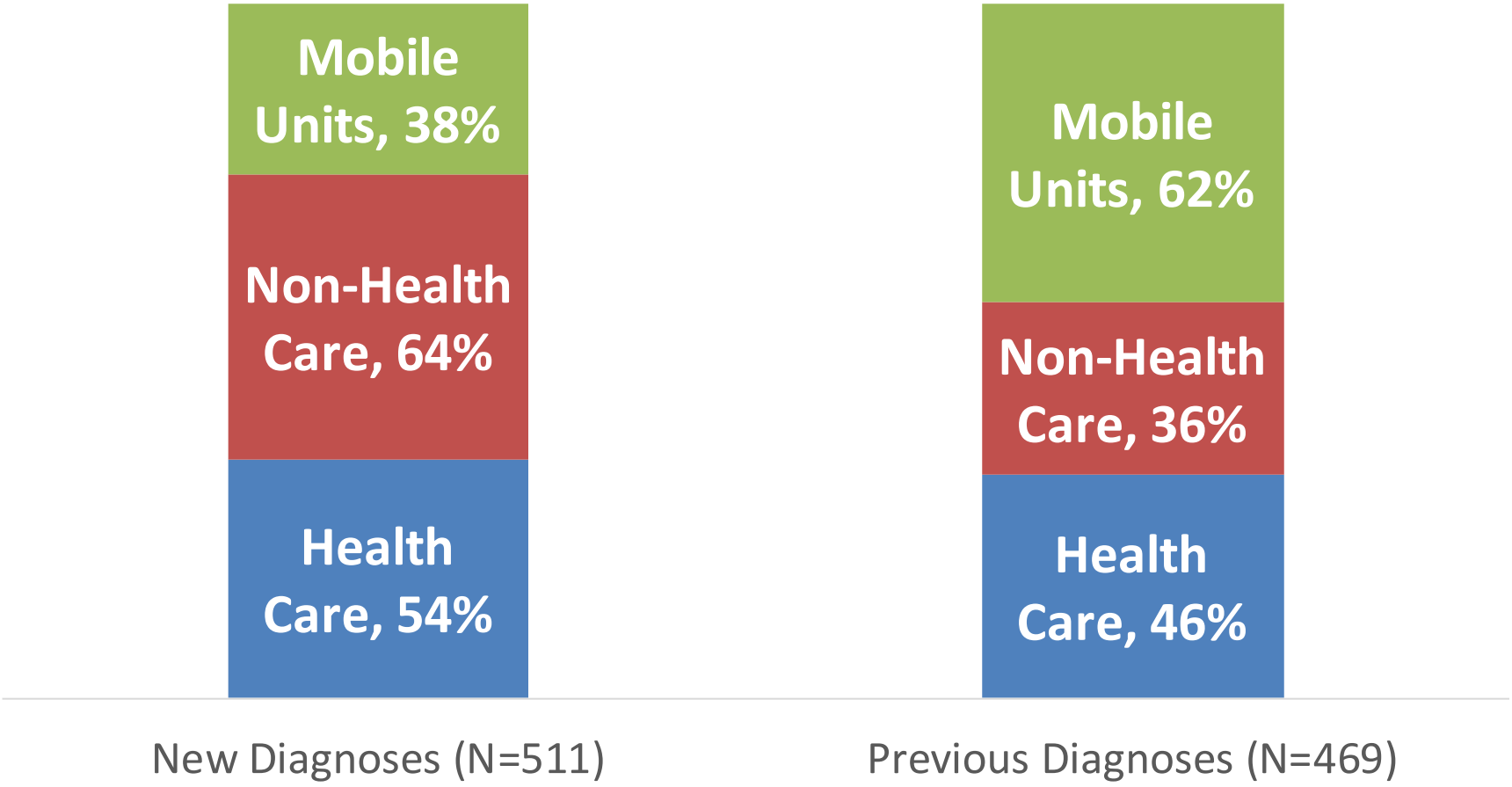
Non-healthcare settings=27,931 tests

3 in 4 tests were performed in HIV testing sites and community settings



Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

- **2 out of 3 new diagnoses were identified in non-health care settings**
  - **Majority of previous diagnoses in the mobile unit setting**



Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Linkage to Care in Contracted HTS Settings

- Of the 511 HIV diagnoses in 2019, the highest linkage to care(LTC) rates were among those identified in health care settings

30-day LTC in health care settings: 88%	30-day LTC in non-healthcare settings: 82%	30-day LTC in mobile testing settings: 59%

- Only HIV testing providers in the health care setting exceeded the EHE LTC benchmark of 85% or more

Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Contracted HIV Testing Outcomes by Race/Ethnicity, 2019

- Testing volume was highest among Latinx clients
- While the number of new diagnoses was highest among Latinx, new positivity was highest among Other racial/ethnic groups
- The EHE LTC benchmark was only achieved for Latinx and NH/PI clients

Racial/Ethnic Group	# Tests	# New Diagnoses	New Positivity	LTC ≤ 30 days
Latinx	47,665	200	0.4%	85%
White	29,540	100	0.3%	84%
Black	26,951	97	0.4%	76%
Other group	14,805	84	0.6%	82%
Asian	7,385	23	0.3%	70%
American Indian/Alaska Native	1,917	5	0.4%	80%
Native Hawaiian/Pacific Islander	399	2	0.5%	100%
TOTAL	**128,003**	**511**	**0.4%**	**82%**

Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Contracted HIV Testing Outcomes by Gender Identity, 2019

- Testing volume was highest among cisgender male clients
- New positivity among transgender women was nearly 10 times higher compared to cisgender women and twice that for cisgender men
-
- The EHE LTC benchmark was only met among clients without a reported gender identity

Gender Identity	# Tests	# New Diagnoses	New Positivity	LTC ≤ 30 days
Cisgender males	89,963	447	0.5%	82%
Cisgender females	35,621	39	0.1%	74%
Transgender women	1,637	16	1.0%	81%
Transgender men	468	1	0.2%	0%
Gender not reported	311	8	2.6%	100%
Transgender not specified	3	0	--	--
TOTAL	**128,003**	**511**	**0.4%**	**82%**

Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Contracted HIV Testing Outcomes by Age, 2019

- Testing volume and new positivity was highest among clients aged 18-29
- No age groups met the EHE LTC benchmarks however was lowest among the youngest and oldest clients

Age in Years	# Tests	# New Diagnoses	New Positivity	LTC ≤ 30 days
Under 18 years	1264	2	0.2%	50%
18-29 years	52,142	239	0.5%	83%
30-39 years	36,942	162	0.4%	83%
40-49 years	18,065	69	0.4%	80%
50-59 years	13,050	32	0.3%	81%
60 and older	6,423	7	0.1%	43%
Not reported	117	0	--	--
TOTAL	**128,003**	**511**	**0.4%**	**82%**

Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Contracted HIV Testing Outcomes by HIV Risk, 2019

- Testing volume and new positivity was highest among clients with other or missing HIV risk category reported
- While new positivity was highest among MSM/ID, the number of new diagnoses was the lowest
- The EHE LTC benchmark was only met among clients with other or missing HIV risk category reported

Risk Category	# Tests	# New Diagnoses	New Positivity	LTC ≤ 30 days
Other/missing	69,273	308	0.4%	86%
Heterosexual	31,380	36	0.1%	69%
MSM	21,813	144	0.7%	79%
IDU	4,853	14	0.3%	86%
MSM/IDU	684	9	1.3%	44%
TOTAL	**128,003**	**511**	**0.4%**	**82%**

Data Source: Division of HIV and STD Programs, HIV Testing Services as of March 13, 2020

Comparison of HTS Pay-for-Performance Indicators, 2019-20

- Overall testing volume severely impacted by COVID-19
- Positivity rate increased despite lower testing volume
- Little improvement in LTC from 14 to 90 days in 2020

	2019	2020
Testing volume (#)	78,516	22,251
New Positivity rate	0.86%	1.1%
Linked to care ≤14 days	N/A	59%
Linked to care ≤90 days	64%	61%

**Positivity calculated as: # new positives by self report/testing volume X 100.*
Data Source: Division of HIV and STD Programs, HIV Testing Services as of 02/19/2020 and 03/17/2021 for 2019 and 2020 years, respectively; data is provisional and limited to only PFP service modalities (Storefront, Social Network Testing and Long Beach contracts).

Summary

- While PrEP awareness, willingness to use PrEP and PrEP use among priority populations in LAC has increased since 2016, there has been little change in utilization of PrEP at COEs
- Similarly, there has been little change in utilization of PEP at COEs since 2016
- Testing volume, positivity and linkage to varies by setting and client population
- Incomplete reporting of race/ethnicity and gender identity data may misrepresent HIV test positivity within these categories

Next Steps

- Advancing data reporting along neutral continuum with 2021 HTS forms
  - Track re-screening rates
  - Provision of biomedical and behavioral prevention services
- EHE Initiatives
  - Promotion of routine opt-out testing
  - Rapid Linkage to ART
  - TelePrEP
  - Expanded access to HIV testing through self testing kits
  - Increasing access to and capacity of syringe services programs

Questions?

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Acknowledgments: DHSP staff Shoshanna Nakelsky, Ekow Sey and Andrea Soriano

Additional Resources on DHSP Website

- 2019 Annual HIV Surveillance Report

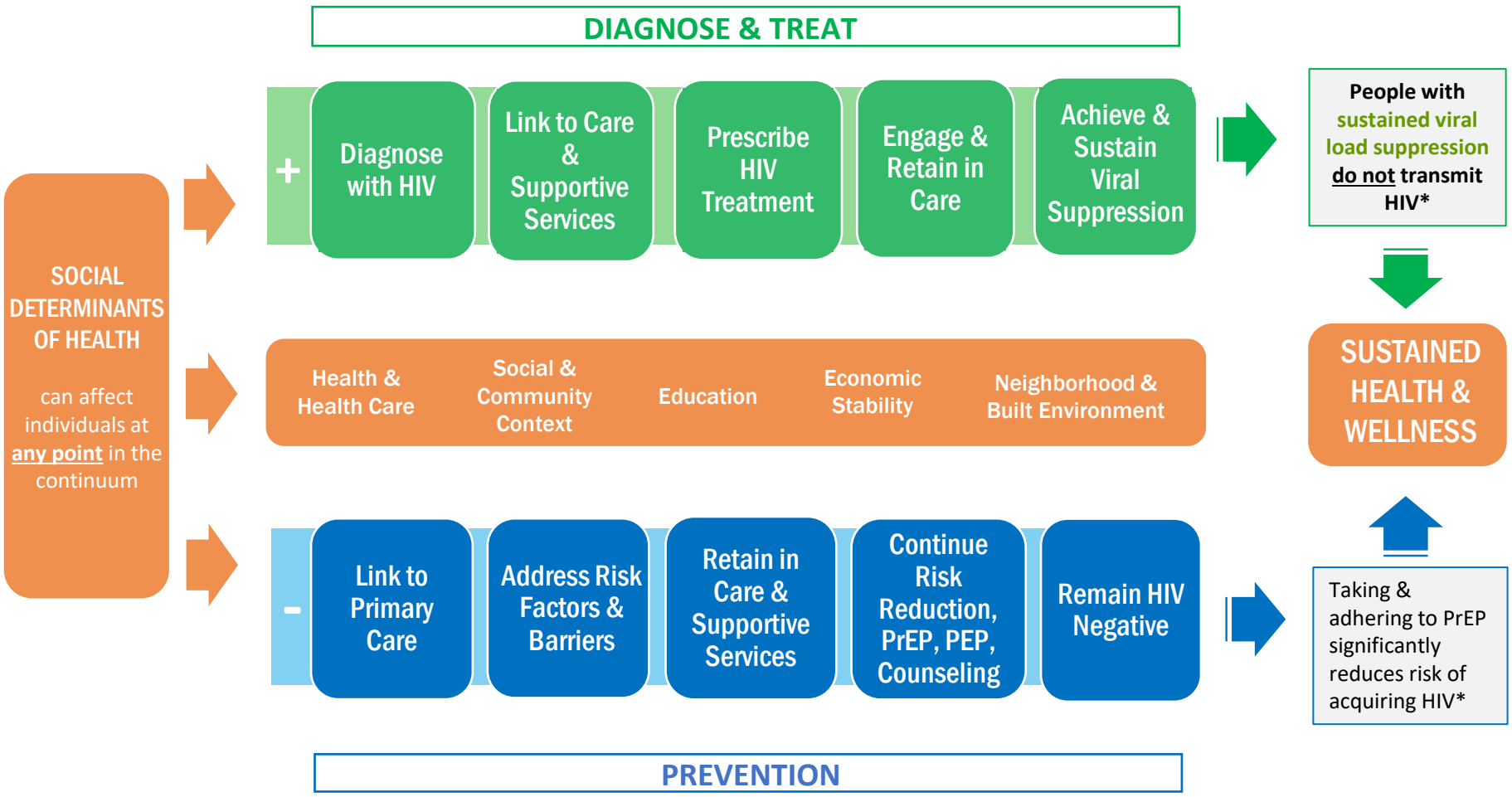
http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/2019Annual_HIV_Surveillance_Report_08202020_Final_revised_Sept2020.pdf

- Impact of COVID-19 on Contracted HIV and STD Services, LAC
  - http://www.publichealth.lacounty.gov/dhsp/COVID-19/Impact_of_COVID-19_on_Contracted_HIV_and_STD_Services_in_LA_County_May2020.pdf
- Biomedical Services: Dashboards for PrEP COEs
  - http://www.publichealth.lacounty.gov/dhsp/Reports/PrEPandPEP_Dashboards_Year_1-3.pdf
  - http://www.publichealth.lacounty.gov/dhsp/Reports/Biomedical_HIV_Prevention_Contracts_Year%204_REV11-19.pdf
- NHBS Factsheets
  - PWID:http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/NHBS_IDU5_Report_08222019.pdf
  - MSM: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/NHBS_MSM5_Report_7-22-19.pdf
  - HET: http://www.publichealth.lacounty.gov/dhsp/Reports/HIV/NHBS_HET4_Report_%207-22-19.pdf

LOS ANGELES COUNTY
COMMISSION ON HIV

Comprehensive HIV Continuum Framework

The HIV Continuum is a framework for people to stay healthy, have improved quality of life, and live longer. The Commission on HIV adapted the Continuum to demonstrate HIV, sexual health, and overall health are influenced by individual, social, and structural determinants of health. Individuals can enter and exit at any point in the Continuum. The Continuum guides the Commission on community planning and standards of care development.



Revised 9/10/19; 11/17/20
Commission approved 9/12/19

*For more information visit https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html

Los Angeles County HIV Prevention Standards

Los Angeles County Commission on HIV

June 8, 2017

Division of HIV and STD Programs

LOS ANGELES COUNTY COMMISSION ON HIV

Purpose of HIV Prevention Service Standards

- SBP Committee is charged with developing standards for the organization and delivery of HIV care, treatment and prevention services.
- Used in monitoring contractors and in determining service quality.
- Minimum standards intended to help agencies meet the needs of clients. Providers may exceed standards.

LOS ANGELES COUNTY
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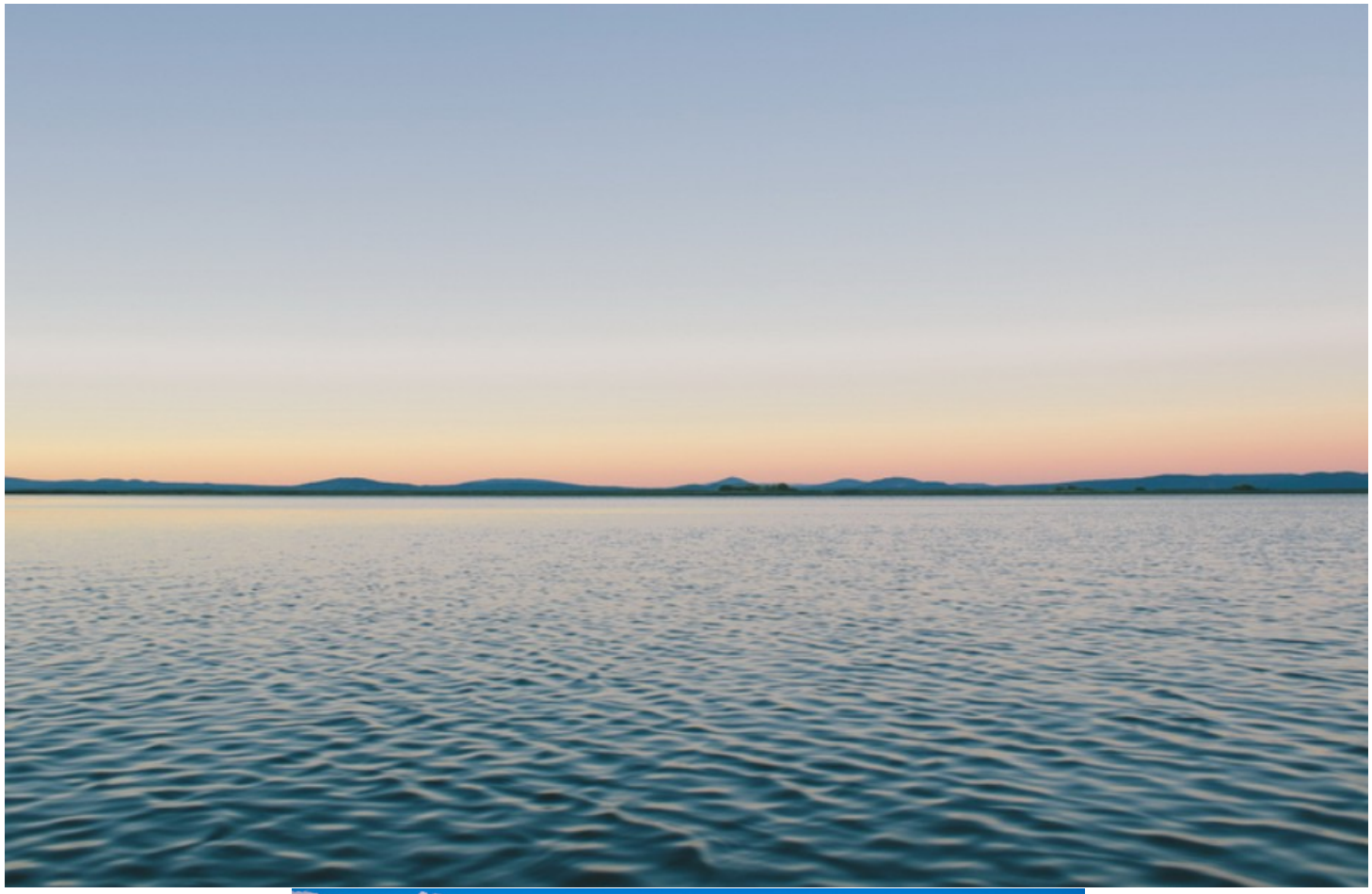
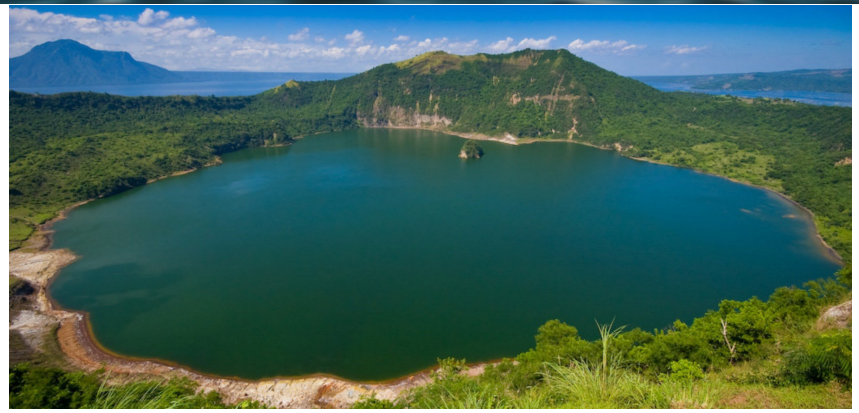
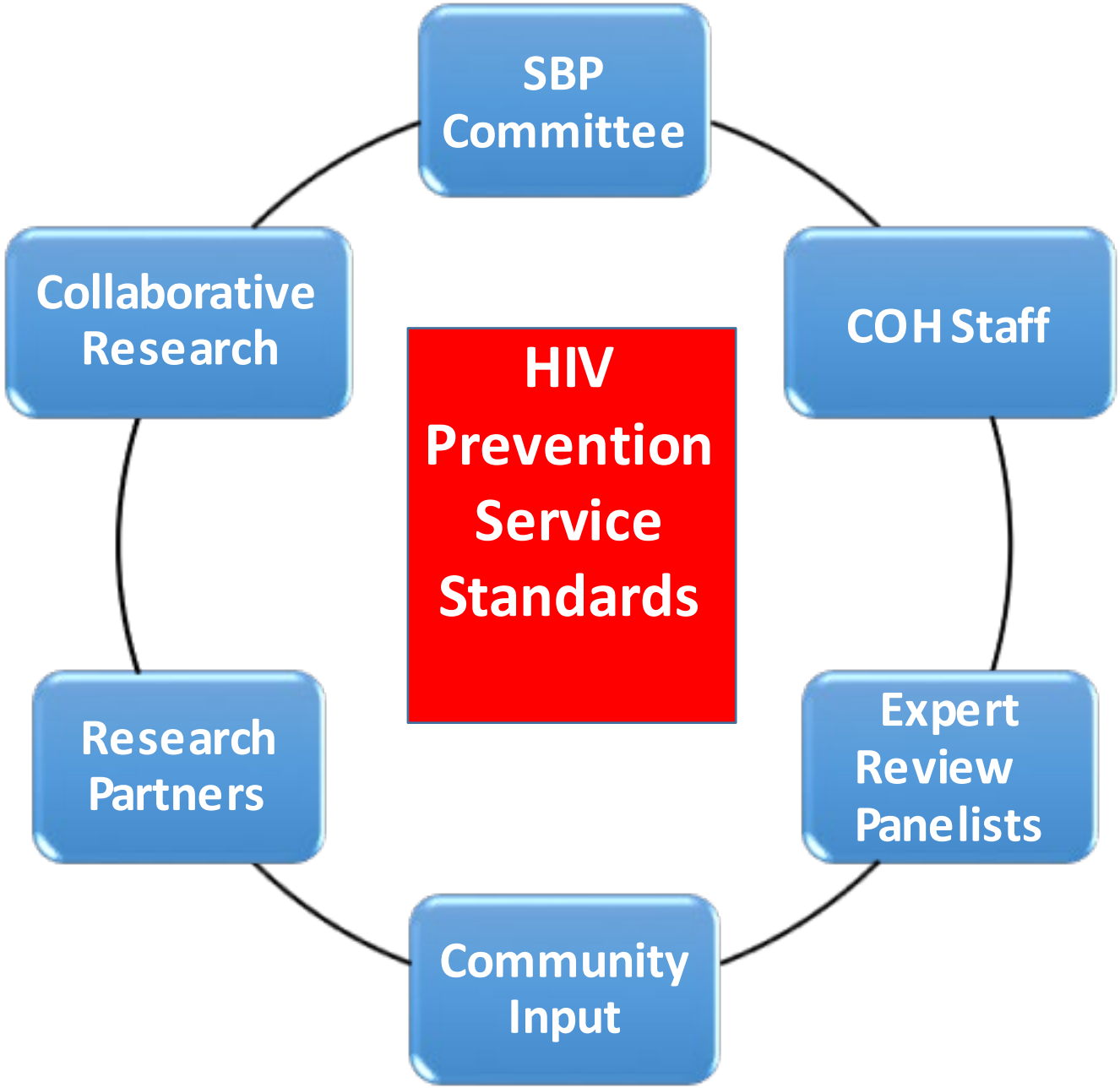




Project Team and Knowledge Partners

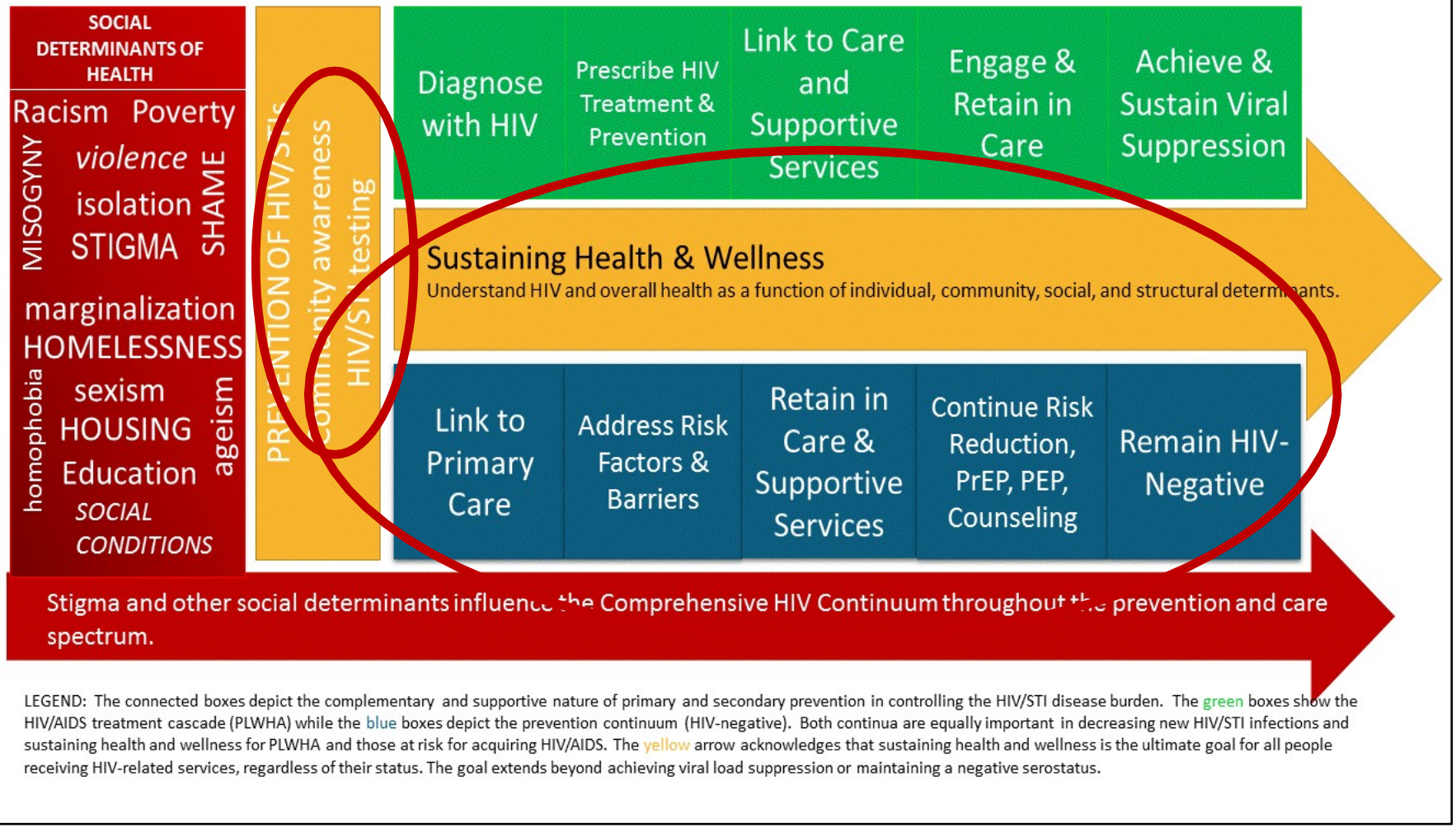


HIV Prevention Standards Development Process

1. Reviewed key documents
2. Drafted Prevention Service Standards
3. Draft Standards reviewed by 4 Expert Review Panels
4. Drafted next version based on feedback
5. Held Community Review Meetings
6. Updated document for public comment period

LOS ANGELES COUNTY
COMMISSION ON HIV

The Los Angeles County Commission on HIV
Comprehensive HIV Continuum Framework



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

HIV Prevention
Universal Service Standards

HIV prevention services in Los Angeles County must be:

1. Holistic
2. Responsive to the needs and strengths of the populations served
3. Designed to address or mitigate social determinants of health
4. Strength-based
5. Sex-positive
6. Culturally responsive

HIV Prevention Service Standards

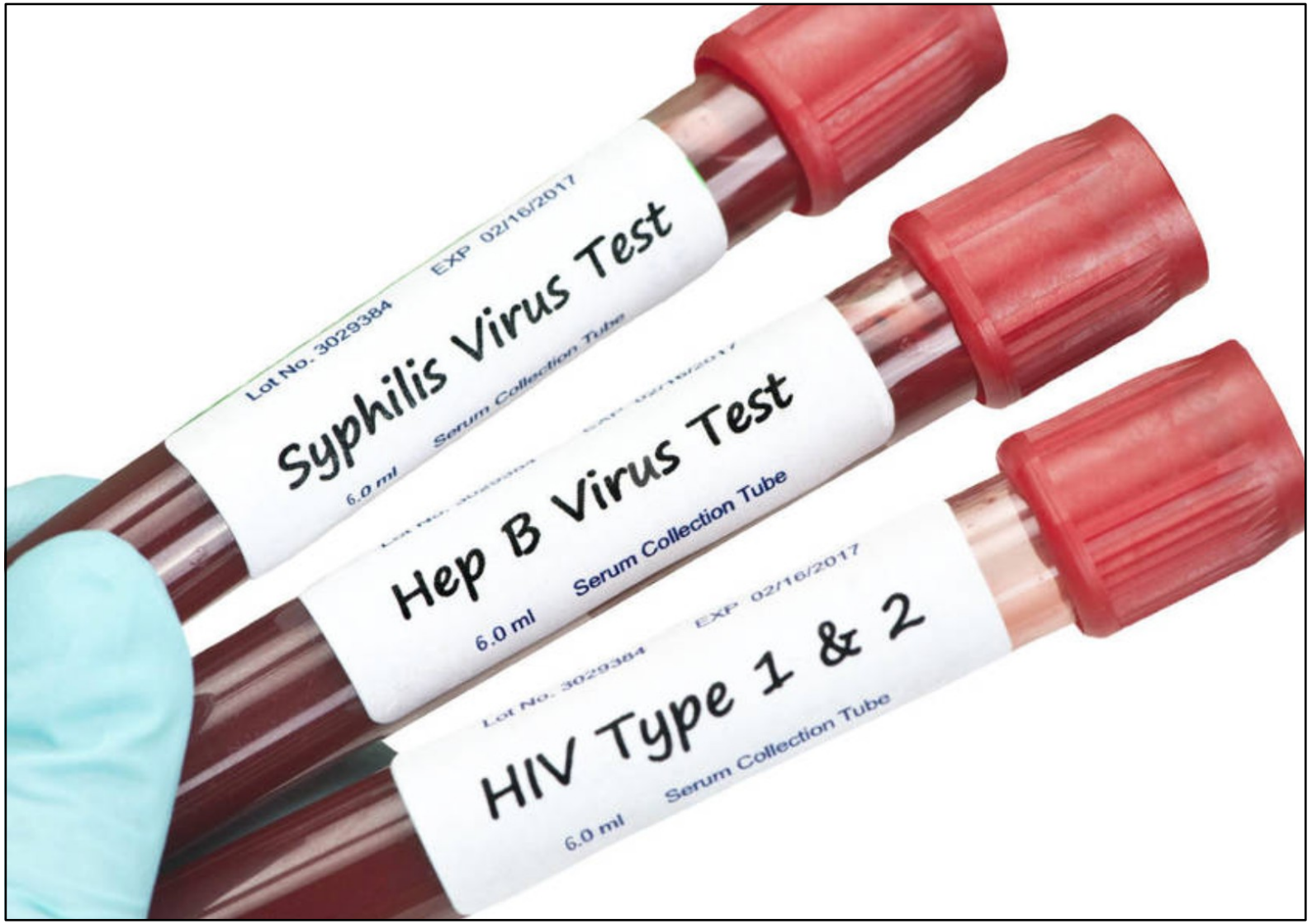
1. Assessment
2. HIV and STD Testing
3. Linkage to Biomedical Prevention Services
4. Referral and Linkage to Non-Biomedical Prevention Services
5. Retention and Adherence to Prevention Services

Assessment

Assessment: Key Components

- Assessments should align with the client's reason(s) for accessing services and point of entry.
- Whenever possible, collect demographic information in a manner that is affirming of various identities.
- Specific topics or areas should be assessed only if the provider is prepared to manage the possible responses, and only if the provider can offer resources, referrals, and/or services in response.
- The assessment process should utilize a health promotion approach.
- The assessment process should include assessing for medical and social factors.

HIV & STD Testing

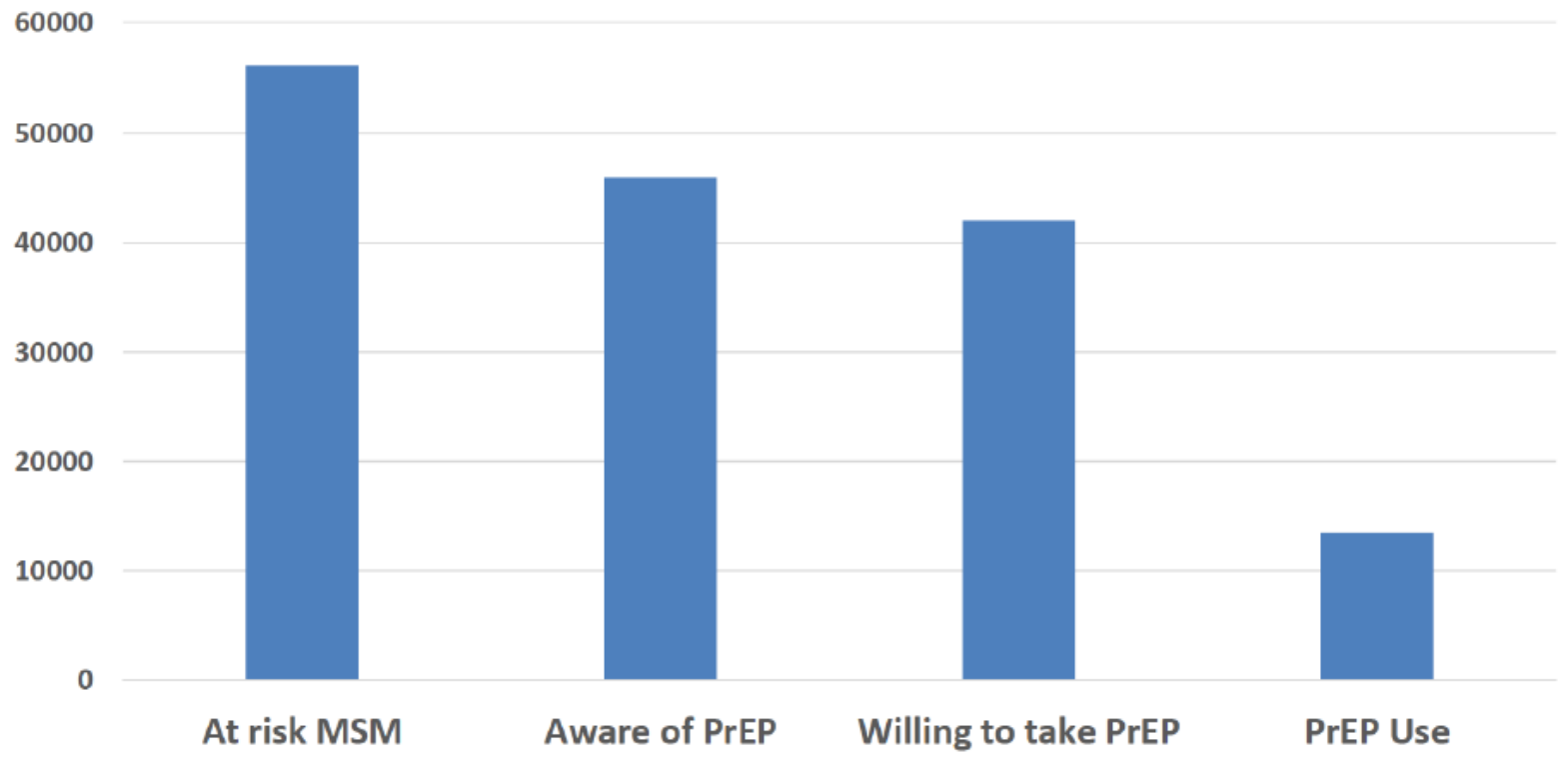


HIV and STD Testing: Key Components

- Individuals at high risk for HIV should get tested every 1-3 months.
- HIV testing must be voluntary and free from coercion.
- Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings.
- HIV testing should be simple, accessible, and straightforward.
- Testing sites should employ strategic targeting and recruitment efforts.
- HIV and STD Testing services must follow the most current guidelines from the CDC.

Linkage to Biomedical HIV Prevention Services

Los Angeles County PrEP Continuum of Care for MSM, May 2016



At risk LAC MSM population established by determining the number of virally unsuppressed HIV positive MSM and multiplying by the average number of annual unique HIV –ve sex partners of HIV positive MSM, 3* (NHBS, 2014). Aware of PrEP, willing to take PrEP, and use of PrEP in past 12 months based on MSM response to meet-up app based survey, May 2016, of 82%, 75%, and 24% respectively (Los Angeles County Division of HIV and STD programs internal data).

Linkage to Biomedical Prevention Services: Key Components

- The goal of linkage and referral activities is to connect clients to those services that address their needs in the most expeditious manner possible.
- Linkage to biomedical interventions (i.e. PrEP and PEP) is often a priority.
- Linkage standards are based on the Los Angeles County PrEP Continuum: increase awareness, willingness, and uptake.
- If your agency doesn't provide PrEP, develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
- Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours.

Referral and Linkage to Non-Biomedical Prevention Services

Referral & Linkage to Non-Biomedical Prevention Services: Key Components

- Not all non-biomedical services that a client may need are easily accessible, therefore hard to ensure *linkage*.
- Emphasis on *active referrals*: address barriers to accessing services by helping the client make contact with a service provider or agency.
- Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services.
- Assisting clients with enrolling in health insurance.
- Actively referring clients who are not accessing regular care to a medical home or primary care provider.
- Assessing possible facilitators and barriers to accessing services.

LOS ANGELES COUNTY
COMMISSION ON HIV

Retention and Adherence to Prevention Services

Retention and Adherence to Prevention Services: Key Components

Retention:

- Assist clients with scheduling follow-up visits
- Provide reminders for all visits
- Offer or refer to navigation assistance, when possible
- Reinforce the benefits of prevention services
- Regularly assess facilitators and barriers to retention, and support clients to overcome identified barriers
- Regularly assess clients' need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*

Retention and Adherence to Prevention Services: Key Components

Adherence:

- Inform clients about the benefits of sustained adherence to PrEP and PEP
- Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
- Work with client to develop a plan for stopping PrEP, when appropriate, and transitioning to other prevention options
- Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

Approved the Commission on HIV 06/14/18

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BACKGROUND

PURPOSE: HIV Prevention Service Standards outline the essential elements of service delivery a provider agency must adhere to when implementing HIV prevention services. The purpose of the service standards is to ensure consistent high-quality service delivery throughout Los Angeles County. Service standards establish the minimal level of service delivery. Providers are encouraged to exceed this minimal level if able to, given their capacity and scope.

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV infection. Therefore, a multitude of strategies (e.g. housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent the acquisition of HIV. Because it is not feasible to create standards for every potential prevention service, the HIV Prevention Service Standards described in this document focus on ensuring that every individual at risk of acquiring or transmitting HIV infection is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time.

Additionally, because there are many different types of organizations that may provide prevention services, it should be understood that not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV/STD testing only, will not necessarily be expected to provide adherence services for clients who are accessing PrEP.

A NEW ERA OF HIV PREVENTION: The overall approach to HIV prevention has shifted drastically in recent years, due largely to major improvements in HIV medication, or antiretroviral therapy (ART). According to the Centers for Disease Control and Prevention, "people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV-negative partner. When ART results in viral suppression, defined as less than 200 copies/ml or undetectable levels, it prevents sexual HIV transmission."[1]

Treatment advancements have also ushered in a new era of HIV prophylaxis for HIV-negative individuals, specifically HIV pre-exposure prophylaxis (PrEP), and HIV post-exposure prophylaxis (PEP). PrEP is a daily pill taken by individuals who are HIV-negative before they are potentially exposed to HIV. PrEP, when taken consistently, is a highly effective prevention intervention. PEP is a 28-day course of an antiretroviral regimen taken within 72 hours of a high risk HIV exposure to prevent HIV seroconversion.

Given these scientific breakthroughs, the central tenets of today's HIV prevention efforts focus on biomedical prevention interventions, including the viral suppression of HIV-positive individuals and widespread access to PrEP, particularly for populations that are

[1] https://www.cdc.gov/hiv/library/dcl/dcl/092717.html

disproportionately impacted by HIV disease (i.e., Black and Latinx gay/bisexual/same-gender loving men, and transgender women of color).

DEFINITION OF HIV PREVENTION SERVICES: HIV Prevention Services are those services used alone or in combination to prevent the transmission of HIV. *Biomedical* HIV prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission by reducing the viral load of people living with HIV (PLWH) and/or by reducing the susceptibility of HIV infection among HIV-negative individuals (via PrEP and PEP).

GOALS OF HIV PREVENTION EFFORTS IN LOS ANGELES COUNTY: Aligned with the Los Angeles County Comprehensive HIV Plan (2017-2021)[2] and the National HIV/AIDS Strategy (NHAS)[3], the overarching goals of HIV prevention efforts in Los Angeles County are to:

1. Reduce new HIV infections, and
2. Reduce HIV-related disparities and health inequities.

Furthermore, these service standards support the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond goals:

1. Reduce annual HIV infections to 500 by 2020
2. Increase the proportion of persons living with HIV who are diagnosed to at least 90% by 2022
3. Increase the proportion of diagnosed people living with HIV who are virally suppressed to 90% by 2022

METHOD/HIGH IMPACT PREVENTION: In order to achieve our goals, we must implement a *High-Impact Prevention*[4] approach that utilizes combinations of scientifically proven, cost-effective, and scalable interventions targeted to the populations most disproportionately impacted by HIV in Los Angeles County, as indicated by those populations with the highest HIV incidence rates and the lowest rates of viral suppression. The Los Angeles County Comprehensive HIV Plan (2017-2021), based on the most recent surveillance data, identifies the following populations that experience the highest HIV incidence rates in Los Angeles County:

- Men who have Sex with Men (MSM)
- Black/African American MSM, Transwomen, and Cisgender Women
- Transwomen
- Young Men (18-29) who have Sex with Men (YMSM)
- Persons living in the Metro, South, and South Bay Service Planning Areas (SPAs)

[2] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016.
[3] The National HIV/AIDS Strategy for the United States: Updated to 2020. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf
[4] High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. https://www.cdc.gov/hiv/policies/hip/hip.html

Among people living with HIV, the following populations have the lowest rates of viral suppression in Los Angeles County:

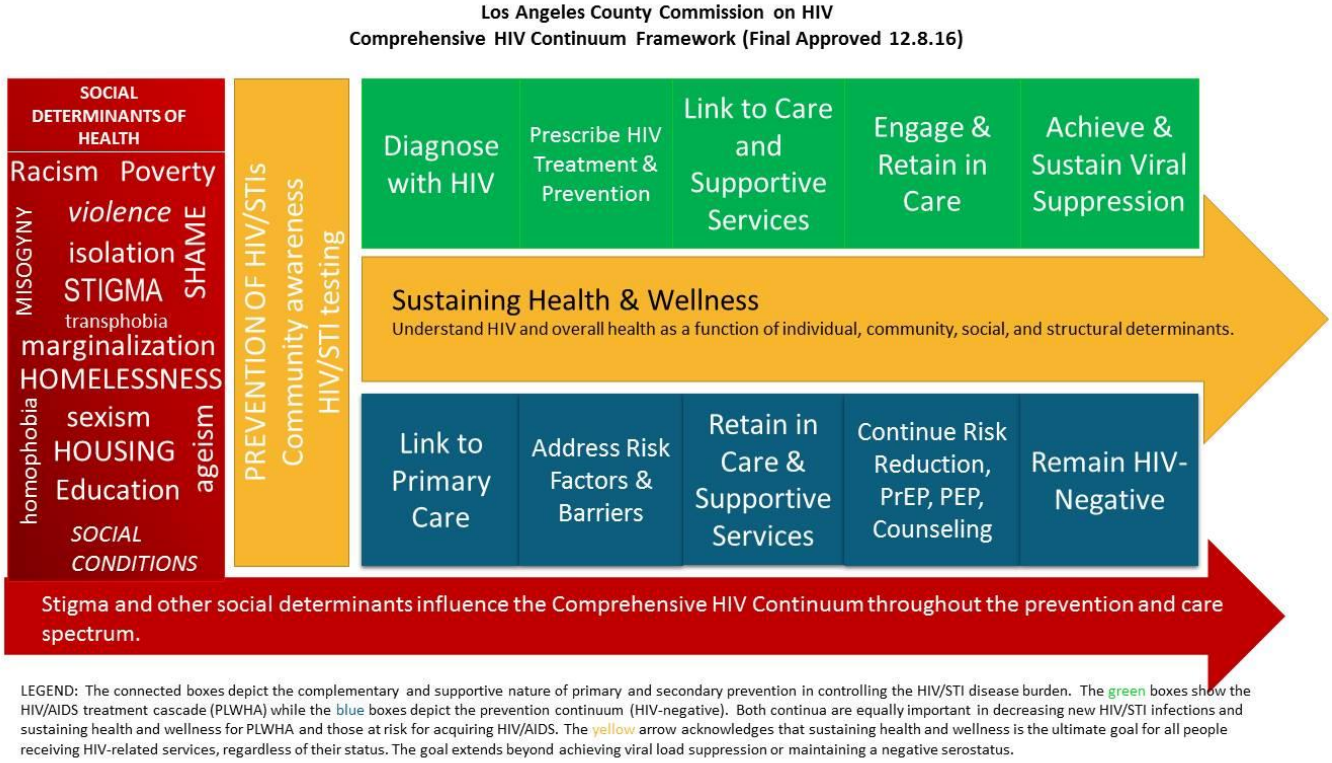
- Persons who inject drugs (PWID)
- Youth (18-29 years)
- Cisgender women
- Transgender persons
- Blacks/African Americans
- American Indians/Alaska Natives

In addition, there are many other populations and sub-populations highly impacted by HIV, including, but not limited to:

- Latino MSM
- Asian/Pacific Islander MSM
- Latina Cisgender women
- People between the ages of 13-17
- People over the age of 50
- Incarcerated populations
- Stimulant users
- Commercial Sex Workers
- Sex and needle-sharing partners of individuals who are HIV-positive

FOUNDATION FOR DEVELOPMENT OF STANDARDS: The Los Angeles County Commission on HIV's *Comprehensive HIV Continuum Framework,* depicted in Figure 1, below, was used to guide the development of the HIV Prevention Service Standards. The *Comprehensive HIV Continuum* is an aspirational framework that builds upon the social ecological model to underscore the importance of addressing HIV care and prevention across several dimensions. The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STD disease burden. The green boxes depict the HIV Care Continuum (focused on people living with HIV), while the blue boxes depict the HIV Prevention Continuum (focused on HIV-negative individuals).

Figure 1: The Los Angeles County Commission on HIV *Comprehensive HIV Continuum Framework*



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

Standards Development Process: The development of the HIV Prevention Service Standards included the input and feedback of service providers, consumers, members of the Standards and Best Practices Committee (SBP), and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. In addition, four Expert Review Panels (ERPs) composed of subject matter experts were convened to provide extensive critique on proposed standards. Moreover, two community meetings were convened to further vet the proposed standards. All comments were thoroughly reviewed by the SBP Committee resulting in recommended revisions.

In order to guide the development of the HIV Prevention Service Standards, SBP Committee members, ERPs, and community stakeholders considered the following questions:

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD[5] prevention services?

[5] For the purposes of this document, we chose to use the term STD (Sexually Transmitted Disease), rather than STI (Sexually Transmitted Infection). Factors that we weighted in making this decision included: perceived stigma; literal meaning of *disease* versus *infection*; and alignment with county, state, and national departmental names.

2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs?
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

See Dr. H. Hunter Handsfield's article, "Sexually Transmitted Diseases, Infections, and Disorders: What's in a Name?" (http://www.ncsddc.org/blog/sexually-transmitted-diseases-infections-and-disorders-what's-name).

UNIVERSAL STANDARDS

UNIVERSAL HIV PREVENTION SERVICE STANDARDS: In order to achieve the goals of reducing new HIV infections and HIV-related disparities, HIV prevention services in Los Angeles County must include the following universal standards:

Whole Person Care: Preventing HIV is typically one priority among many in the lives of people accessing our services. Therefore, HIV prevention services are most effective when they are delivered with the *whole person* in mind. Whenever possible, programs and services should attend to clients' overall physical health, mental health, and spiritual health, as guided by each individual client.

Address the social determinants of health: Social determinants of health are the economic and social conditions that influence the health of individuals and communities.[6] Social determinants shape the contexts that either increases or decreases an individual's risk of exposure to HIV. Because HIV disparities are inextricably linked to social determinants, interventions or services that focus on social determinants (e.g. racism, homophobia, transphobia, housing, education, employment, healthcare, etc.) are necessary to reduce these disparities. The implementation of such structural interventions typically requires a great deal of time and effort on behalf of multiple stakeholders, given that social determinants are deeply entrenched and institutionalized in our society. For this reason, many HIV prevention agencies may not have the capacity to implement structural or social level interventions. However, HIV prevention services should minimally reflect an understanding of the role of social determinants in their design (e.g. consider a client's competing priorities related to housing and employment). HIV prevention agencies, no matter how small, should strive to complement traditional HIV prevention services), with services that help to address social determinants (e.g. resume writing workshops).

Strength-Based: A strength-based approach to service design and provision seeks to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life. Services that focus solely on individuals' deficits, needs, problems, or pathologies tend to focus only on what a client needs to "fix" about themselves, thus emphasizing negative behaviors rather than emphasizing resiliency and protective factors. Furthermore, when we emphasize what a client is lacking, a dependency is created on the provider and a process of disempowerment occurs. A strength-based approach focuses on individuals' strengths, resources and the ability to recover from adversity; allowing a client to focus on opportunities and solutions rather than problems and hopelessness. A strength-based approach results in different questions being asked (see Assessment section below) and facilitates an openness and exploration on behalf of the provider-client relationship.

[6] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health

Sex-Positive: When services are delivered from a "sex-positive" framework or attitude, they are free from judgment about clients' sexual behaviors, including the behavior itself (as long as it is consensual); the number and type of sexual partners; and the frequency of sexual behaviors (Center for Positive Sexuality). A sex-positive attitude also serves to destigmatize sex, and may also serve to reduce other forms of stigma experienced by clients related to being gay, being transgender, living with, or being at risk for HIV, etc. Being sex-positive does not mean that you ignore behaviors or circumstances that may increase someone's risk of acquiring HIV or STDs. On the contrary, when clients know that they will not be shamed or judged for the behaviors they engage in, they then will be more likely to disclose important facts and likely will be receptive to information from providers that helps them reduce their risk and/or build upon protective factors.

Cultural humility: All HIV prevention organizations should strive to deliver culturally responsive services. Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities.[7] Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: structural, community, organizational, and individual. Culturally-responsive services acknowledge that power imbalances exist between groups of people and cultures based on historical and institutional oppression and privilege; that we are not simply "different" from one another. Culturally responsive agencies also create a physical environment that is welcoming, warm, and that communicates a sense of safety for clients.

Cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities (Tervalon & Murray-Garcia, 1998). This critical consciousness is more than just self-awareness, but requires one to step back to understand one's own assumptions, biases and values (Kumagai & Lypson, 2009). Individuals must look at one's own background and social environment and how it has shaped experience. Cultural humility cannot be collapsed into a class or education offering; rather it's viewed as an ongoing process. Tervalon and Murray-Garcia (1998) state that cultural humility is "best defined not as a discrete end point but as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves" (p. 118). This process recognizes the dynamic nature of culture since cultural influences change over time and vary depending on location. Throughout the day, many of us move between several cultures, often without thinking about it. For example, our home/ family culture often differs from our workplace culture, school culture, social group culture, or religious organization culture. The overall purpose of the process is to be aware of our own values and beliefs that come from a combination of cultures in order to increase understanding of others. One cannot

[7] Adapted from: Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014). *Protocol for culturally responsive organizations.* Portland, OR: Center to Advance Racial Equity, Portland State University.

understand the makeup and context of others' lives without being aware and reflective of his/her own background and situation.

To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Whereas cultural *competency* implies that one can function with a thorough knowledge of the mores and beliefs of another culture, cultural *humility* acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own. What you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their culture.[8] Tenets of cultural humility include:

1) Lifelong learning & critical self-reflection
2) Recognizing and challenging power imbalances for respectful partnerships, and
3) Institutional accountability

Data driven and outcome-based: Data-driven and outcome-based program planning ensures that programs and services address specific needs in the community and lead to specific outcomes in mind, and including an evaluation component which enables you to capture data (Ryan et al, 2014). More specifically, data-driven and outcome-based programs and services:

- are designed based on quality data and with specific HIV-related outcomes in mind
- are responsive and relevant to the communities we serve
- are developed in response to specific drivers or causes of HIV-related problems in our communities
- are aligned with local and national HIV prevention goals
- require the collection and utilization of process and outcome data in order to continuously improve
- show meaningful results that demonstrate the value of our services
- contribute to the body of knowledge in the HIV field

Elicit community feedback: Responsive services are services that are designed and/or delivered with continuous feedback from the populations served. Feedback should help to ensure that the services are culturally appropriate, effective in preventing HIV, respectful of clients, strength-based, sex-positive and destigmatizing, and easily accessed. Feedback methods may include client satisfaction surveys, focus groups, secret shoppers, and other means to continuously assess quality of services.

[8] Cultural humility: Essential foundation for clinical researchers, Katherine A. Yeager, PhD, RN and Susan Bauer-Wu, PhD, RN, FAAN

CORE PREVENTION COMPONENTS

Summary of Core Prevention Service Components: The HIV Prevention Service Standards detailed in this document seek to ensure the provision of a core set of integrated HIV prevention services aimed at preventing the acquisition and transmission of HIV and STDs. The Core Prevention Service Components are: Assessment, HIV/STD Testing and Retesting, Linkage to HIV Medical Care and Biomedical Prevention Services, Referral and Linkage to Non-Biomedical Prevention Services, and Retention and Adherence to HIV Medical Care and Prevention Services. These categories, in addition to their corresponding data indicators, documentation needs, and population-based outcomes, are outlined in Table 1.

Table 1: Summary of Core Prevention Service Components

Core Prevention Service Components	Data Indicators	Documentation Needs	Population-Based Outcomes
1. Assessment	• Number of clients/patients who complete assessments • Number of participants screened for: connection to a medical home; primary care engagement; insurance coverage; HIV status; STDs; immunizations; pregnancy; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual and needle-sharing behaviors that may increase their risk of HIV acquisition or transmission	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections • Decrease the number of STDs • Increase the number of persons with known HIV status • Increase the number of persons treated for STDs • Increase the number of newly diagnosed clients that have their first HIV medical visit within 72 hours of their diagnosis.
2. HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before	• Documentation of HIV/STD testing in client files and data management system • Documentation of type and frequency of outreach and recruitment	

	• Number of persons who test positive for an STD who are treated or referred to treatment • Percentage of high-risk[9] negative clients having documentation of HIV/STD testing every 3 months • Type and number of outreach and recruitment methods	methods • Documentation of clients treated for STDs or referred to treatment	• All service provides should strive towards linking newly-diagnosed PLWHA to anti-retroviral therapy within 72 hours of diagnosis.
Core Prevention Service Components	**Data Indicators**	**Documentation Needs**	**Population-Based Outcomes**
3. Linkage to HIV Medical Care and Biomedical Prevention Services	**HIV-positive individuals:** • Number of HIV-positive clients linked to HIV medical care within 72 hours of receiving a HIV-positive test result. • Number of HIV-positive clients lost to care who re-engage in HIV medical care within 30 days of interaction with provider **HIV-negative individuals:** • Number of high-risk HIV-negative clients receiving education on	• Documentation of linkage to HIV medical care • Documentation of re-engagement in HIV medical care • Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?") • Documentation of linkage to a PrEP services(may be	• Increase the number of out-of-care previously diagnosed clients that are re-engaged in HIV medical care within 30 days of their identification. • Increase the number of HIV positive clients that have at least 2 medical visits per year at least 3 months apart. • Increase the

[9] "High risk" is defined as someone who has an HIV positive sex partner; a history of bacterial STD diagnosed in the past 12 months; a history of multiple sex partners of unknown HIV status; or other risk factors that increase HIV risk, including transactional sex (such as sex for money, drugs, housing); or someone who reports sharing injection equipment such as those used to inject drugs or hormones.

	PrEP • Number of high-risk[10] HIV-negative clients who are interested in PrEP • Number of high-risk HIV-negative clients interested in PrEP that are linked to a PrEP Navigator. • Number of high-risk HIV-negative clients who received a PrEP prescription • Number of high-risk HIV-negative clients receiving education on PEP • Number of high-risk HIV-negative clients who received PEP within 72 hours of exposure	internal or external linkage)	number of HIV-positive persons that are virally suppressed (<200 copies/ml)
	• Number of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP	• If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services	• Increase the number of HIV negative clients that are given accurate PrEP and PEP information • Increase the number of high-risk HIV negative individuals accessing HIV pre-exposure prophylaxis (PrEP) and HIV post-

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			exposure prophylaxis (PEP), as needed
Core Prevention Service Components	**Data Indicators**	**Documentation Needs**	**Population-Based Outcomes**

4. Referral and Linkage to Non-Biomedical Prevention Services	• Number of high-risk HIV-negative and HIV-positive clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	
	• Number of high-risk
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability or distribution
			Same as above

	HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[11] • Number of external and internal[12] condoms distributed free of charge		
Core Prevention Service Components	**Data Indicators**	**Documentation Needs**	**Population-Based Outcomes (from CHP)**
5. Retention and Adherence to HIV Medical Care, ART, and Other Prevention Services	• Number of HIV-positive clients who receive HIV medical care at least 2 times per year, at least 3 months apart • Number of HIV-positive clients who adhere to their HIV medications • Number of HIV-positive clients who remained engaged in prevention service as needed • Number of PrEP and PEP clients referred to medication adherence interventions or support services. • Number of PrEP and PEP clients who access medication	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to ART, PrEP or PEP medication (optimal adherence for PrEP is 90% and 95% for ART of prescribed doses) • Documentation of PrEP and PEP clients who access medication adherence services	Same as above

[11] Assuming that primary care is available to the client, which may not always be the case (i.e. for undocumented individuals, individuals who speak a language other than English, transgender individuals, etc., affordable and accessible primary care may not always be available).

[12] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

	adherence interventions or support services. • Number of HIV-negative clients who remained engaged in prevention service as needed • Number of PrEP clients who adhere to PrEP medication per adherence plan determined with PrEP provider • Number of PEP clients who adhere to PEP for 28-day course		

ASSESSMENT

Client assessments are often the first in-depth interaction a client has with a provider agency, and thus can foster a lasting positive relationship built on trust and respect, if conducted correctly. Conversely, an assessment that a client perceives to be judgmental or disrespectful in any way can impede the client's willingness or ability to secure necessary prevention services.

Standards for Assessment:

Assessments should be conducted by trained personnel.
The training should include basic client-centered counseling techniques (e.g. how to communicate in a non-judgmental manner, the use of appropriate body language, etc.), and should also include elements that are specific/relevant to the type of assessment(s) conducted. For example, providers should be trained in how to utilize specific mental health and/or substance abuse screening tools (e.g. Patient Health Questionnaire (PHQ-2)), if the assessment utilizes such tools.

The assessment process should include the following activities and or elements (not necessarily in this order):

1. Explain the purpose of the assessment and obtain verbal consent to continue
2. Conduct the assessment in private, with no other clients, and preferably no other staff members able to hear the conversation
3. Gather relevant information to determine the client's needs, risks, and strengths, when appropriate
4. Inform the client of the services available (internally and externally) and what the client can expect if they were to enroll
5. Establish the client's eligibility for services, including HIV status, if relevant, and other criteria
6. Inform the client of any documentation requirements for the assessment (e.g. income verification for insurance purposes)
7. Collect required county, state, federal client data for reporting purposes
8. Collect basic client information to facilitate client identification and client follow-up
9. Begin to establish a trusting client relationship.

Assessments should be a cooperative and interactive endeavor between the staff and the client, and should be conducted in a strength-based manner.

The assessment should highlight clients' skills, competencies and resilience in addition to their

challenges and needs. Included below are some examples of strength-based questions[13] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

1. What is working well (either in general, or with respect to a certain subject, e.g. adherence, overall health, etc.)?
2. Can you think of things you have done in the past that have helped with ___?
3. What small thing could you do that would make ____ better?
4. Tell me about what a good day looks like for you? What makes it a good day?
5. On a scale of 1 to 10 how would you say ___ is? What might make that score a little better?
6. What are you most proud of in your life?
7. What inspires you?
8. What do you like doing? What makes this enjoyable?
9. What do you find comes easily to you?
10. What do you want to achieve in your life?
11. When things are going well in your life – tell me what is happening?
12. What are the things in your life that help you keep strong?
13. What do you value about yourself?
14. What would other people who know you say you are good at doing?
15. You are resilient. What do you think helps you bounce back?
16. What is one thing you could do to have better health, and feeling of wellbeing?
17. How have you faced/overcome the challenges you have had?
18. How have people around you helped you overcome challenges?
19. What are three things that have helped you overcome obstacles?
20. If you had the opportunity, what would you like to teach others?
21. Without being modest, what do you value about yourself, what are your greatest strengths?
22. How could/do your strengths help you to be a part of your community?
23. Who is in your life?
24. Who is important in your life?
25. How would you describe the strengths, skills, and resources you have in your life?
26. What could you ask others to do, that would help create a better situation for you?
27. What are the positive factors in your life at present?
28. What are three (or five or ten) things that are going well in your life right now?
29. What gives you energy?
30. What is the most rewarding part of your life?
31. Tell me about a time when you responded to a challenge in a way that made you feel really on top of things?
32. How have you been able to develop your skills?
33. How have you been able to meet your needs?

[13] Adapted from "50 First Strength-Based Questions" (http://www.changedlivesnewjourneys.com/50-first-strength-based-questions).

34. What kind of supports have you used that have been helpful to you? How did the supports improve things for you?
35. Tell me about any creative, different solutions you have tried. How did this work out?

Clients should be the primary source of information during an assessment.
However, if appropriate and with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information.

Assessments should be conducted in a client-centered manner that accommodates clients who are unable or otherwise hesitant to attend the appointment at the provider agency.

Diverse methods of interaction (e.g., text-based, via social apps, in-person) should be supported, given that confidentiality policies are adhered to.

Assessments that are conducted should align with the client's reason(s) for accessing services and point of entry. For example, a client who is interested in accessing HIV/STD testing, PEP, or PrEP should not have to endure a lengthy assessment before accessing these services. Clients should be able to access services as expeditiously as possible. However, in some situations, or at a different point in time, a longer assessment may be appropriate.

Whenever possible, collect demographic information in a manner that is affirming of various identities and of intersecting identities.

For example, allow clients to identify their race or ethnicity using whatever categories best fit for them. When asking questions related to gender identify, consider using the two-step question that captures a transgender person's current gender identity as well as their assigned sex at birth: 1. What is your current gender identity? 2. What sex were you assigned at birth (on your original birth certificate)? Also, ask all clients what pronoun(s) to use to address them (he, she, they) (Center of Excellence for Transgender Health).

If appropriate, assess for barriers to accessing services and remaining engaged in services.

If barriers are identified, assist the client in identifying potential solutions.

Specific topics or areas should be assessed only if the provider can offer support, resources, referrals, and/or services in response.

For example, if questions are asked pertaining to a client's history of trauma, the provider should be prepared to handle a client's potential range of emotions. Given that providers/agencies have resources, referrals, and/or services at hand, consider including the following topics in client assessments:

- Connection to spirituality
- Intimate partner violence
- Trauma
- Sex-trafficking

The assessment process should utilize a health promotion approach.
This includes using information collected during the assessment/ screening to identify appropriate messages that promote health-seeking behavior and minimize risk-behaviors or circumstances. The intention is to offer information, and suggest services and interventions that are tailored to the specific person (and their partners, if relevant) and to highlight current health promoting behaviors and overall strengths of the client. Health promotion includes provision of information or resources related to:

- overall health (may include overall physical health, nutrition, oral health, spiritual health, and emotional health)
- behavioral interventions (e.g., brief or intensive risk reduction strategies that encourage safer sex and use of sterile drug-injection equipment, substance use treatment)
- biomedical interventions (e.g., PrEP, STD services, special reproductive and pregnancy services)
- clarifying concepts and misinformation about HIV transmission, acquisition, or prevention methods
- specialized counseling and support to members of HIV-serodiscordant relationships
- a variety of condoms (e.g. external, internal[14], non-latex, etc.) and lubrication options
- new, sterile syringes through syringe services programs, pharmacists, physicians, or other legal methods to persons who lack consistent access to sterile drug-injection equipment

The assessment process should include assessing for medical and social factors that impact HIV acquisition and transmission.
Individuals at high risk for HIV acquisition or transmission can experience significant personal, social, and structural challenges, such as poverty, mental illness, substance use, unstable housing, and lack of regular medical care. Assessments should include questions pertaining to these medical and social factors that influence HIV acquisition or transmission.

[14] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

HIV/STD TESTING AND RETESTING

HIV and STD testing often serve as the first point of entry in the HIV Care and Prevention Continua and for many, the key opportunity to facilitate linkage to a comprehensive array of services. Individuals at high risk for HIV should be tested every 3-6 months, regularly assessed for risks and needs, and linked or re-linked to other HIV prevention services, depending on their needs.

Agencies should implement a streamlined model of HIV testing that includes delivering key information, conducting the HIV test, completing brief risk screening, providing test results, providing referrals and/or ensuring linkages to services tailored to the client's status and specific needs.

Standards that apply to HIV/STD testing include[15]:

- HIV/STD testing must be voluntary and free from coercion. Patients/clients must not be tested without their knowledge/written consent.
- Opt-out HIV screening (notifying the patient/client that an HIV test will be performed, unless the patient/client declines) is recommended in all settings.
- Use of antigen and antibody (Ag/Ab) combination tests is encouraged unless persons are unlikely to receive their HIV test results. However, providers should be alert to the possibility of acute HIV infection and perform an (Ag/Ab) immunoassay or HIV RNA in conjunction with an antibody test. Persons suspected of recently acquired HIV infection should be referred immediately to an HIV clinical-care provider.
- Preliminary positive screening tests for HIV infection must be followed by additional testing to definitively establish the diagnosis.
- Agencies should adhere to local and state public health policies and laws to ensure they deliver high-quality HIV testing services that are culturally competent and linguistically appropriate.
- HIV testing should be simple, accessible, and straightforward. Minimize client barriers and focus on delivering HIV test results and on supporting clients to access follow-up HIV care, treatment, and prevention services as indicated.
- To reach populations at high risk for HIV infection, sites should employ strategic targeting and recruitment efforts, establish program goals and monitor service delivery to ensure targeted testing is achieving program goals.
- To provide the most accurate results to clients, sites should use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their agency. Establishing relationships with facilities offering laboratory-based HIV testing is important for referring clients who may have acute HIV infection.

[15] Adapted from *Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers*. https://www.cdc.gov/hiv/pdf/testing/cdc_hiv_implementing_hiv_testing_in_nonclinical_settings.pdf

- Sites should consider offering HIV testing services for couples or partnered relationships to (a) attract high-risk clients who are not otherwise testing and (b) identify HIV-discordant couples and previously undiagnosed HIV-positive clients.
- Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings while also preserving the client's option to decline HIV testing and ensuring a provider-client relationship conducive to optimal clinical and preventive care.
- Inform clients at high-risk for HIV/STDs about 1) methods to reduce the risk of HIV/STD acquisition; 2) STDs that can facilitate HIV acquisition; 3) the benefits of screening for STDs (that are often asymptomatic) and STD treatment
- Assess these risk factors for HIV/STD transmission:
    - Sexual, alcohol, and drug-use triggers (boredom, depression, incarceration, sexual violence, sex work, abuse) and behaviors that may lead to HIV/STD transmission
    - Recent sex and/or needle-sharing partners who were treated for HIV/STDs, and/or other behaviors they may have that contribute to possible HIV acquisition
    - Past and recent HIV/STD diagnosis, screening, and symptoms
    - Survival sex work
    - Sense of self-worth
- Lack of basic health information and/or information pertaining to HIV/STD risk
- Offer external and internal condoms, and lubrication options
- Personnel from every HIV and STD testing site should be knowledgeable about the HIV and STD burden in their health district. Report cases of HIV/STDs according to jurisdiction requirements and inform clients diagnosed with HIV and/or STDs that case reporting may prompt the health department to offer voluntary, confidential partner services

STD Testing services must follow these guidelines, adapted from the CDC:[16]

1. All adults and adolescents ages 13 and older should be tested at least once for HIV.
2. Annual chlamydia screening of all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection
3. Annual gonorrhea screening for all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection.
4. Syphilis, HIV, hepatitis B, chlamydia and gonorrhea screening for all pregnant women, starting early in pregnancy, with repeat testing as needed, to protect the health of mothers and their infants.
5. Screening at least once a year for syphilis, chlamydia, gonorrhea, and hepatitis C for all sexually active gay, bisexual, and other men who have sex with men (MSM), as

[16] Access this link for more information:
http://publichealth.lacounty.gov/dhsp/Providers/LAC_ONLY_STDScreeningRecs-5-2017.pdf

well as sexual active transgender women who have sex with men. MSM or transgender women who have sex with men, who have unprotected sex should be screened more frequently for STDs (e.g., at 3-to-6 month intervals).

6. Sexually active gay and bisexual men and sexually active transgender women who have sex with men may benefit from more frequent HIV testing (i.e., every 3 to 6 months).
7. Anyone who has unprotected sex or shares injection drug equipment should get tested for HIV at least once a year.

In populations for whom no recommendations exist, screening should be based on risk factors, local epidemiology and prevalence of specific STDs in the service area. The Los Angeles County Department of Public Health, Division of HIV and STD Programs' (DHSP) mapping project[17] depicts STD and HIV burden by health district throughout Los Angeles County. This project ranks geographical areas (health districts) in order of highest to lowest HIV and STD burden by analyzing several important driving factors including number of infections, number of people infected, the population size, geographic size, and results from hot spot analyses.

[17] http://publichealth.lacounty.gov/dhsp/Mapping.htm

LINKAGE TO HIV MEDICAL CARE AND BIOMEDICAL PREVENTION SERVICES

Once HIV status is determined and the needs of clients are identified via the assessment and/or screening process, they should be connected to appropriate services to address those needs in the most expeditious manner possible.

For both recently diagnosed and previously diagnosed HIV-positive clients, linkage to/re-engagement in HIV medical care is a critical component of the HIV Care Continuum. Likewise, for high-risk HIV-negative individuals who have recently been tested for HIV and STDs, linkage to biomedical interventions (i.e. PrEP and PEP) is a priority.

Linkage to Care Definition: Linkage to care is the first time a newly-diagnosed person living with HIV (PLWH) attends an appointment with an HIV medical service provider following their HIV diagnosis.

Linkage to Care Standard (Service Expectation): Newly-diagnosed PLWH receives ART within 72 hours of diagnosis.

*It is recognized that service providers that provide the full array of HIV prevention and treatment services must be supported and trained to build their capacity in order to reach this standard.

Standards for linking newly-diagnosed persons to HIV medical care and re-engaging previously diagnosed HIV-positive persons who have fallen out of care to HIV medical care include:

- Develop written protocols to ensure linkage to HIV care within 72 hours after diagnosis or re-engagement in care within 30 days after identification (for those out of care)
- Inform persons about the benefits of starting HIV care and antiretroviral treatment (ART) early (even when feeling well)
- Assess possible facilitators and barriers to linkage and retention and provide or make referrals for other medical and social services that may improve linkage and retention
- Help persons enroll in health insurance or medical assistance programs that provide HIV care or cover costs of care
- Collaborate with other health care providers, case managers, navigation assistants, nonclinical community-based organizations, and health department personnel to provide services that promote prompt linkage to and retention in care, disclosure and partner services
- Track outcomes of linkage and retention services and provide follow-up assistance to persons who have not started HIV medical care within 72 hours after diagnosis or within 30 days for those out of care

- Train staff to comply with laws, policies, and procedures to protect patient confidentiality when exchanging personal, health, or financial information used for linkage and reengagement services
- Provide staff training and tools to increase competence in serving patients with differing health literacy levels
- Train clinical providers about the most recent U.S. Department of Health and Human Services guidelines that advise offering ART to all persons (regardless of CD4 cell count) for health benefits and preventing HIV transmission.
- Help schedule the first HIV medical visit, seeking same-day or priority appointments when possible, especially for newly diagnosed persons
- Provide transportation assistance to the first visit, when possible
- Verify attendance at first visit by contacting the patient or the HIV health care provider
- If the first visit was not completed, provide additional linkage assistance until visit is completed or no longer required
- If providing HIV medical care, offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)

Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:

- Co-locating HIV testing and HIV medical care services
- Multiple case management sessions
- Motivational counseling
- Reminders for follow-up visits
- Help enrolling in health insurance or medical assistance programs
- Assist clients in securing documentation necessary to access medical services
- Transportation services to the health care facility
- Providing or linking to other medical or social services (e.g., substance abuse treatment, mental/behavioral health services, child care)
- Maintaining relationship between patient and a consistent care team

Standards for linking HIV-negative persons to biomedical prevention interventions include:

- If agencies do not provide PrEP services, they must develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
- Inform clients about the benefits of biomedical interventions to prevent the acquisition of HIV
- Ask all high-risk HIV-negative clients if they are interested in learning more about PrEP or PEP
- Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours (or 2 business days)
- Provide immediate, active, and, if necessary, repeated, linkage services to clients with an expressed interest in PrEP, and the immediate need for PEP
- Counsel and refer individuals exposed to HIV within a 72 hour time range for evaluation to a PEP program or Emergency Department as appropriate.

- Provide follow-up assistance to clients who are not able to link to a PrEP Navigator
- If an agency provides PrEP, assess the client's readiness to engage in PrEP services and barriers and facilitators to starting services
- Help schedule appointments to see a PrEP Navigator or PrEP provider (in-house or external)
- Offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
- Maintain a client-friendly environment that welcomes and respects new clients
- Provide reminder (and accompaniment, if possible) for first appointment, using the client's preferred contact method(s)
- Offer support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
- Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - Co-locating HIV testing and biomedical interventions
    - Client accompaniment to access services
    - Multiple case management sessions
    - Motivational counseling
    - Providing trauma-informed care
    - Providing crisis intervention counseling
    - PrEP navigation
- Offer guidance and assistance on how to obtain financial assistance for PrEP through private- or public-sector sources
- Assist with health insurance and other benefits, including linkage to health insurance navigators, case management and client navigation, and intervention-specific programs (e.g. PrEP medication and co-pay assistance programs)

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES

Although numerous HIV prevention related services exist throughout Los Angeles County, clients in need of services may not be willing or able to access them. For example, an undocumented transgender woman may want to access regular primary care, but may not feel comfortable doing so if she fears transphobia or legal implications. For this reason, while the ultimate goal is *linkage* to a needed service, oftentimes *referrals* are all an agency can be held accountable for.

Standards related to referring clients to non-biomedical services focus on *active referrals* rather than *passive referrals*. The latter defined as telling a client about a service and or giving them a phone number and leaving it up to them to initiate contact. Conversely, active referrals address barriers to accessing services by helping the client make contact with a service provider or agency. This may include scheduling the appointment with the client and/or accompanying them to their first appointment.

Based on information obtained via the assessment process, clients may be in need of any number of prevention services; specialty services that address medical needs (e.g. primary care); and/or social needs (e.g. needs related to housing, employment etc.). Whenever possible, agencies should strive to provide specialty services onsite. If this is not feasible, providers need to ensure that clients are referred to external specialty services. How these services are prioritized depends upon the need of each particular client.

The standards for actively referring clients to non-biomedical prevention services include:

- Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services
- Assisting clients with enrolling in health insurance by referring them to a benefits counselor
- Actively referring clients who are not accessing regular care to a medical home or primary care provider
- Assessing possible facilitators and barriers to accessing services
- Tracking outcomes of referral services (i.e. track linkages) and providing follow-up assistance to clients who have not been linked to prevention services
- Helping schedule the first prevention-related service appointment
- Linking all newly diagnosed individuals with HIV, syphilis or gonorrhea to the LAC DHSP Partner Counseling and Referral Services.
- Actively referring to mental/behavioral health services, substance use services, behavioral interventions and other psychosocial and ancillary services (e.g. housing, employment, nutritional and social support)
- Providing transportation assistance to the first visit, when possible
- Offering convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)

- Maintaining a client-friendly environment that welcomes and respects new clients
- Providing reminders for first appointment, using the client's preferred contact method
- Offering support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
- Identifying and utilizing specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - Co-locating HIV testing and prevention services
    - Multiple case management sessions
    - Motivational counseling
    - Trauma-informed care
    - Crisis intervention counseling
    - Navigation assistance
- Maintaining a relationship with a consistent prevention team
- Offering assistance with health insurance and other benefits, including active referrals to health insurance navigators
- Make available online directories of providers, agencies, telemedicine agencies, and professional advice hotlines that offer specialty services. Ensure that these resources are gay- and trans-affirming and otherwise culturally appropriate.
- Develop and participate in provider networks that offer specialty services for persons with HIV, especially persons who are uninsured or underinsured or who live in underserved areas
- Develop written protocols, memoranda of understanding, contracts, or other agreements that define financial arrangements, staff and agency responsibilities for providing linkages, making referrals, and the tracking of referral completion and satisfaction
- Establish policies and procedures to safeguard the confidentiality of personal and health information exchanged during the linkage/referral process
- Train staff and any specialty service providers in the following topics:
- Staff roles and responsibilities within the agency
- Issues such as sex trafficking, substance use, etc. that can provide a better understanding of their clients' needs
- Identifying specialty service providers who serve the community
- Tailoring of services to personal characteristics (e.g., language, location, and insurance status)
- Inter- and intra-agency referral procedures
- Maintaining confidentiality of collected personal information
- Advocating for persons who need specialty services
- Minor consent for HIV/STD testing (consent from youth aged 13 and older)
- Engage case managers, navigation assistants, or other staff to provide service coordination for persons living with or at risk for HIV who have complex needs
- Routinely provide print or audiovisual materials that describe specialty services provided onsite or through referrals
- Monitor the quality of referrals for specialty services to inform quality improvement

strategies (e.g., proportion of referred persons who obtained specialty services), client satisfaction, and barriers and facilitators

- Routinely assess agency staff regarding knowledge and comfort to offer the prevention services the agency is providing
- Include services related to economic empowerment and job-readiness
- Empower immigrant communities to access available services

RETENTION AND ADHERENCE TO HIV MEDICAL CARE, ART, AND HIV PREVENTION SERVICES

Retention to HIV medical care is described as at least 2 medical care visits per year, at least 3 months apart. Adherence to ART is described as the extent to which a person takes ART according to the medication instructions. An adherence to ART of 95% is required as an appropriate level to achieve maximal viral suppression and lower the rate of opportunistic infections (Patterson DL et al). Sustained high adherence is essential to suppress viral load in HIV positive individuals and, in turn, improve health outcomes and prevent HIV transmission. Adherence to ART is also critical to maximize the benefit of PrEP and PEP among HIV-negative individuals. Additionally, a key component of the Comprehensive HIV Continuum is retention and adherence to prevention services to facilitate ongoing access to the full array of services, including behavioral interventions, psycho-social services, etc.

Standards related to retention and adherence to HIV medical care and ART include:

- Develop protocols to update patient contact information at each visit (e.g., residence, phone number(s), payment method)
- Develop procedures to routinely assess factors that enable or hinder attending visits
- Establish procedures to identify patients at risk for lapses in care and services that support their continued care
- Establish methods to monitor timing and completion of each patient's scheduled medical visits
- Schedule follow-up HIV medical care visits
- Provide reminders for all visits, using the person's preferred method of contact
- Reinforce the benefits of regular HIV care for improving health and preventing HIV transmission to others during in-person encounters or outreach by phone, email, or other methods
- Periodically assess facilitators and barriers to retention and motivate the person to overcome the barriers
- Verify if the person attended follow-up visits, even when the patient was seen in another clinical setting
- Participate in multidisciplinary teams with health educators, service linkage facilitators, community health workers, case managers, nurses, pharmacists, and physicians to assess and support adherence to antiretroviral treatment
- Provide adherence support tailored to each person's regimen and characteristics, according to provider role, authority, and setting
- Provide or refer to medication adherence interventions
- Offer advice on how to obtain sustained coverage or subsidies for ART through private- or public-sector sources

Standards related to retention and adherence to prevention services, including biomedical prevention services, include:

- Inform clients about the benefits of sustained adherence to PrEP and PEP. Optimal PrEP adherence is 90% of prescribed doses.

- Reinforce the benefits of prevention services
- Regularly assess facilitators and barriers to retention, and supporting clients to overcome identified barriers
- Regularly assess clients' need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*
- Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
- Work with client to develop a plan for stopping PrEP, when appropriate (e.g. temporarily, long-term, or quitting use) and transitioning to other prevention options, including addressing relationship issues and health issues that increase HIV/STD risk
- Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)
- Offer advice on how to maintain financial assistance for PrEP through private- or public-sector sources
- Advise clients to take PrEP medications as prescribed; provide information about the regimen, and check for understanding in the following areas:
    - Details of the regimen, including dosing method and schedule, dietary restrictions, and what to do when drinking alcohol or when missing doses
    - Consequences of missing doses
    - Potential side effects
    - Potential interactions with other prescription, nonprescription, and recreational drugs, alcohol, and dietary supplements that may impair PrEP medication effectiveness or cause toxicity that could impair adherence
    - Advising the client that PrEP does not protect them from other STDs and pregnancy
- Routinely assess the client's questions, concerns, or challenges regarding PrEP use to identify potential problems
- Assess self-reported adherence at each visit using a nonjudgmental manner
- Assess and manage side effects at each visit
- Consider assessing PrEP prescription refills or pill counts, if feasible, when needed to supplement routine assessment of self-reported adherence
- Address misinformation, misconceptions, negative beliefs, or other concerns about PrEP regimen or adherence
- Acknowledge the challenges of maintaining high adherence over a time and offer long-term adherence support, especially when health coverage, insurance, or other life circumstances change
- Promote disclosure of challenges to adherence, and when disclosures occur, address them in a nonjudgmental manner
- Apply motivational interviewing techniques during routine adherence assessments. These include:
    - asking about the methods clients have successfully used or could use to increase adherence
    - asking about recent challenges to adherence and how they could be overcome

- Offer advice, tools, and training tailored to individual strengths, challenges, and circumstances to support adherence. Examples of advice include:
    - linking taking PrEP to daily events, such as meals or brushing teeth
    - using pill boxes, dose-reminder alarms, or diaries as reminders
    - carrying extra pills when away from home
    - actions to take if pill supply is depleted or nearly depleted
    - avoiding treatment interruptions when changing routines (e.g., travel, erratic housing, or legal detention)
- Encourage persons to seek adherence support from family members, partners, or friends, if appropriate
- Provide or refer to medication adherence interventions

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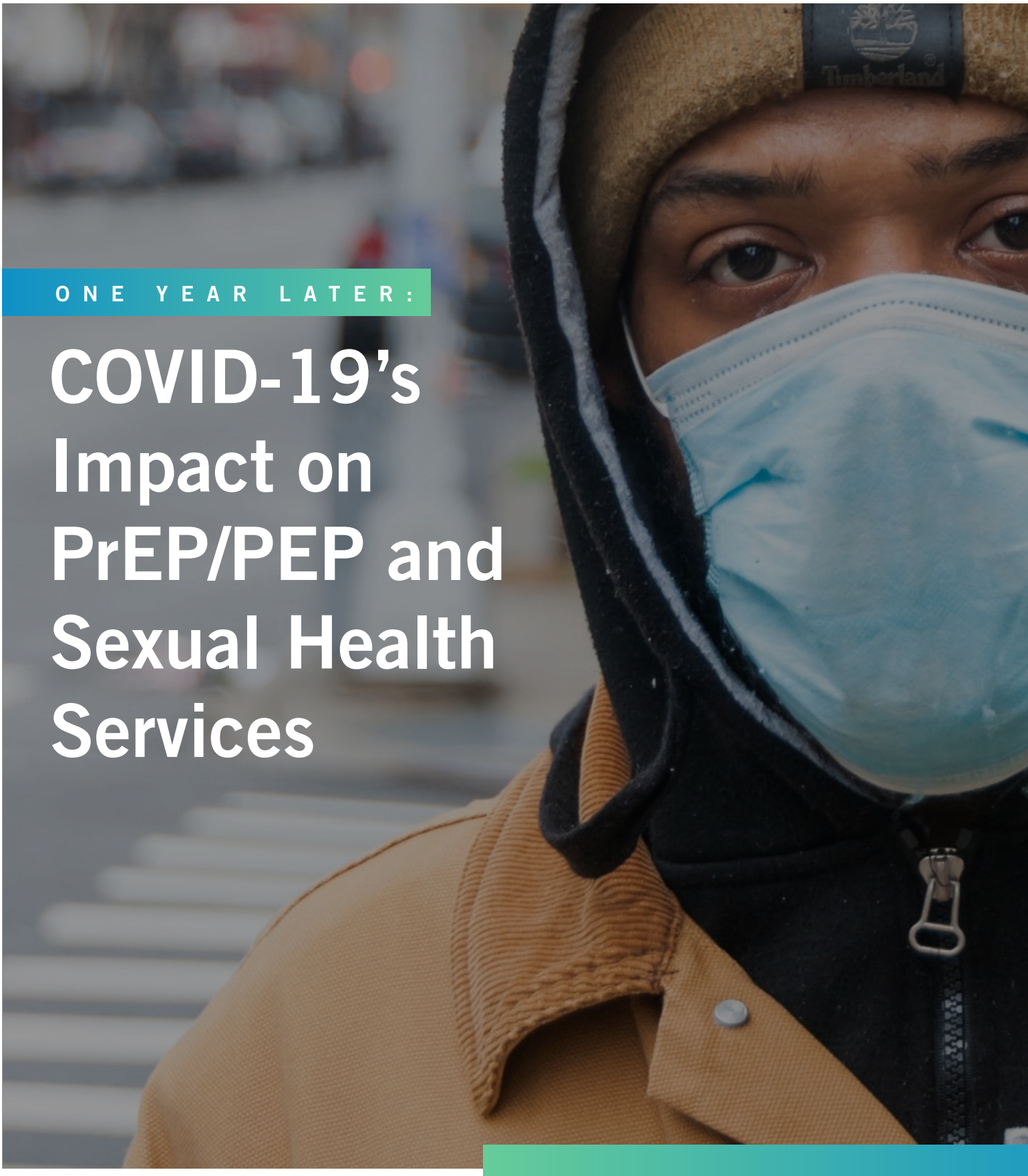
National Coalition of STD Directors

NASTAD



ONE YEAR LATER:

COVID-19's Impact on PrEP/PEP and Sexual Health Services

EXECUTIVE SUMMARY

The United States has been in a state of emergency concerning the COVID-19 global pandemic since March 2020. With the country responding to the pandemic for over a year, the National Coalition of STD Directors (NCSD), in collaboration with NASTAD, examines the impact COVID-19 has had on PrEP/PEP and sexual health services, particularly in the South.

Throughout the nation's response to the pandemic, sexual health programs were uniquely impacted.

- Much of the sexual health workforce was pulled into COVID-19 detail, causing significant service disruptions.
- Sexual health programs implemented harm reduction practices to mitigate COVID-19 risks when serving clients.
- PrEP and PEP programs were impacted across the care continuum, from awareness to adherence. Jurisdictions are tasked with ending an epidemic during a pandemic. Ending the HIV Epidemic: A Plan for America (EHE) goals may be affected due to the challenges COVID-19 has had on the health care system.

As jurisdictions continue addressing both the HIV epidemic and the COVID-19 pandemic, the following recommendations can improve PrEP/ PEP access during this time.

- TelePrEP programs can significantly increase PrEP access during COVID-19 and beyond. Many jurisdictions are working to implement telePrEP programs to assist with client's PrEP maintenance, and initiation to PrEP.
- HIV/ STD self-testing programs can help individuals complete their routine PrEP screenings, reducing barriers for clients.

INTRODUCTION

COVID-19 cases have totaled more than 26 million with over half a million deaths occurring in the United States[1]. While the entire country has been impacted by COVID-19, the southern United States has significantly, making up about a third of new cases in January 2021. With a significant number of new cases being reported in the South, its healthcare systems experienced considerable strain. Structurally, the South leads in having the nation's lowest physician per patient rate. For instance, Mississippi has a 191.3 active physicians per 100,000 population, as opposed to Massachusetts's 449.5 active physicians per 100,000 population.[2] Dually, southern hospital systems in states such as Georgia reported that their hospitals were at maximum capacity for COVID-19 patients. Many southern states experienced daily case counts surpassing the previous average daily counts from summer 2020.[3] In further consideration, the South is also known to have populations with higher morbidities from chronic disease than other Americans not living in the South, such as diabetes, cancer, and hypertension which are risk factors of COVID-19.[4] These higher incidences of morbidity also extend to HIV and other STDs. The South, before COVID-19, had the highest HIV diagnosis and death rates as well as ranking in the top five highest number of STDs cases such as primary and secondary syphilis, congenital syphilis, chlamydia, and gonorrhea.[5] Furthermore, the rate of pre-exposure prophylaxis (PrEP) usage in the South is lower than any other region in the country, with a PrEP to Need ratio (PnR) of 3.0.[6] This score indicates fewer PrEP users in the South relative to the need for PrEP in this region.

of the United States' population lives in the South

of new HIV cases each year occur in the South

There are many contributing factors for these health outcomes. The South has the highest poverty rate in the nation and leads in the number of Americans without health insurance. For instance, eight of the 16 southern states have not expanded Medicaid, creating barriers to accessing health care even greater.[7] The history of racism and poverty in the South stems from chattel slavery to Jim Crow. It has led to some of the reasons why southerners disproportionately experience worse health outcomes.

Along with having higher disease rates, the South incarcerates more of its population than elsewhere in the United States.[8] Incarceration has been identified as a risk factor for COVID-19 and having COVID-19 related complications. Those who are incarcerated do not typically have access to adequate hygiene and protective measures against COVID-19 such as masks, social distancing, and frequent hand washing. As southern prisons, such as those in Louisiana, experience spikes in COVID-19 cases weekly[9], there are no policies in place to better protect those imprisoned through measures such as decarceration. According to UNAIDS, reducing overcrowding in prisons can help to prevent the spread of COVID-19. This can help to reduce the amount of people at risk for becoming infected with COVID-19 and require the provision of continuing HIV care for patients that are still incarcerated and those that are released during the COVID-19 pandemic. This continuation of HIV care recommended by UNAIDS, also encourages "close collaboration with public health authorities, to allow people to continue their treatments without interruption at all stages of detention and upon release. They also recommend for jurisdictions to take a health systems approach, where prisons are not separated from the continuity-of-care HIV pathway but integrated with community health services."[10]

Since the beginning of the pandemic, COVID-19 has greatly impacted the delivery of sexual health services throughout the United States. The intersection of COVID-19 and the impact on sexual health includes: Interruptions of STD/HIV services, sexual health clinic closures/patient visit frequency, PrEP/PEP implementation and retention, as well as the ability for public health jurisdictions to plan and achieve their Ending the HIV Epidemic goals.

To further explore the impact COVID-19 has had on the provision of sexual health and HIV prevention services, the National Coalition of STD Directors (NCSD), in collaboration with NASTAD, developed this paper to detail the many challenges, and opportunities, COVID-19 has brought to the HIV/STD prevention field, particularly in the southern United States.

COVID-19'S IMPACT ON SEXUAL HEALTH

COVID-19 has greatly impacted the sexual health workforce and caused significant service disruptions.

When COVID-19 was declared a national emergency in March 2020, sexual health clinics' doors were closed off from the public to comply with the nationwide shutdowns. NCSD sought to collect data from STD programs, sexual health clinics, and Disease Intervention Specialists (DIS) to assess the impact of COVID-19 response on the STD field through three "COVID-19 & The State of STD Field" surveys.

NCSD used these surveys and targeted weekly calls to identify challenges experienced by our membership secondary to COVID-19. Information sharing calls for the Clinic and DIS communities occurred from March to August 2020.

In the spring of 2020,

- **83%** of STD programs were deferring STD services or field visits
- **62%** of STD programs could not maintain their HIV and syphilis caseloads
- **66%** of clinics reported a decrease in sexual health screening and testing
- **60%** of clinics experienced reduced capacity to treat STDs
- **22** clinics reported that their capacity was reduced by more than half

Similarly, NASTAD conducted a request for information (RFI) with its' members to assess the impact COVID-19 was having on HIV and hepatitis programs, one in May 2020 and a second in August 2020. Of the 49 respondents from May's RFI, 13 were from the South. Findings from NASTAD's August RFI show that 90% of jurisdictions report staff being detailed to COVID-19, a significant increase from May's RFI results. Additionally, respondents shared that due to social distancing and local restrictions, HIV prevention programs had a "decreased ability to continue outreach and engagement activities" and are working on innovative ways to continue outreach for prevention activities. Because of service disruptions related to COVID-19, surveillance data still does not and likely will not match actual STD rates. As of January 2021, CDC estimates that 1 in 5 individuals in the US has a sexually transmitted infection.[11] Summer is a popular time for testing outreach events at pride festivals and community-based outreach which were largely cancelled due to COVID-19.

The public health emergency response to COVID-19 caused mass scale disruptions to the sexual health field including screening, diagnoses, and treatment. While STD clinic staff were eager to lend their expertise to the COVID-19 response, the work's enormous scope and taxing nature made it challenging for sexual health clinics to sustain their response without additional resources. With STDs at an all-time high, redeployment due to COVID-19 threatened an already over-burdened and under-resourced STD prevention network. A southern state whose STD staff has been mostly redeployed to COVID-19 emergency response shared:

> ***"STD and DIS staff are working 7 days a week and are doing their very best to help save lives like they always have. But this effort is not sustainable; staff are burned out, tired, overwhelmed and scared."*** [12]

NCSD's January 2021 survey report found that the proportion of STD clinic staff redeployed on COVID-19 response decreased from 78% in March 2020 to 37% in January 2021. Moreover, 90% of respondents report their jurisdiction is conducting COVID-19 contact tracing and 87% of these programs are leading, staffing, assisting or supporting their jurisdiction's COVID-19 contact tracing efforts. However, COVID-19 redeployments are continuing to interfere with STD programs' ability to provide DIS services including a 28% decrease in chlamydia services, 23% decrease in syphilis services and an 18% decrease in gonorrhea services as of January 2021. Of the 39 respondents from that survey, there was representation from six jurisdictions in the South. Additionally, 29% of jurisdictions are utilizing DIS in COVID-19 vaccine distribution including Tennessee and Fulton County, Georgia. Another 8.7% are not currently utilizing DIS in vaccine distribution response but plan to soon, which further detracts from their ability to provide sexual health contact tracing services.[13]

SEXUAL HEALTH CLINICS

Sexual health clinics quickly pivoted to provide services, yet many challenges persisted.

66% of sexual health clinics reported decreased sexual health screening and testing, and added restrictions on patients' eligibility for appointments, such as: Patients must be symptomatic, need treatment, or be a current PrEP patient. Clinics were performing telehealth appointments only and limiting the number of patients to maintain social distancing. STD treatment capacity was also impacted, with 22% of clinics reporting that their clinical capacity to provide STD treatment reduced by half. Challenges to treatment included: Limited pharmacy capacity and drug availability, identifying alternative oral regimens for

chlamydia and gonorrhea, to reduce in-person visits, and identifying ways to treat syphilis cases, usually requiring injectable treatment. In April of 2020, CDC issued updated treatment guidance in response to COVID-19 clinic closures outlining therapeutic options for symptomatic patients and their partners when in-person clinical evaluation is not feasible.[14] In December 2020, CDC released updated treatment recommendations for gonococcal infection.[15]

Many clinics closed at the start of the pandemic. Those that remained open struggled with acquiring personal protective equipment (PPE), modifying clinic flows and layouts, and limiting the number of patients to ensure appropriate social distancing.

To mitigate COVID-19 risks, many sexual health clinics implemented preventive measures, including: Taking a patient's temperature, referring symptomatic patients to a local testing site, performing pre-appointment phone interviews to screen for household COVID-19 symptoms, offering services by appointment only, and eliminating walk-in hours and availability of sexual health services in their community.

As mentioned, in addition to affecting screenings, treatment was impacted as well. Beginning in the spring 2020, the availability of various medications used to treat STDs was unpredictable. These medication shortages were not due to inadequate production by manufacturers but rather fragilities within the supply chain and problems with logistics and distribution.

When COVID-19 hit the US in early March 2020, STD test manufacturing companies quickly shifted production to multi-test swabs. In addition to STD testing, they were the primary collection device for COVID-19 assays. This decreased production capacity for unisex and urine collection tubes was not a challenge initially as sexual health clinics decreased testing capacity. However, this contributed to test kit shortages across the country as STD testing picked up. These companies have resumed urine/unisex kits production, with new production lines coming online over the next several months, but shortages persist across the country. Sexual health clinics also faced a surplus of expiring test kits in the Summer of 2020 as sexual health services began to resume across the country. A bulk of their test kits were left unused due to service interruptions caused by COVID-19. Virtual elimination of asymptomatic, routine screening can have devastating consequences, reducing routine HIV screening of individuals seeking STD testing/ treatment, potentially leading to increased HIV rates.[16] Some jurisdictions have received reports of a severe form of gonorrhea, called disseminated gonococcal infection, which is an uncommon but significant complication of untreated gonorrhea.

COVID-19'S IMPACT ON PREP/PEP IMPLEMENTATION

COVID-19 has greatly impacted PrEP and PEP services across the care continuum[17], from awareness to adherence.

As sexual health clinics reported clinic closures, reduced clinic hours and services, STD testing kit shortages, and diminished laboratory capacity, the initiation and retention of PrEP patients as well as access to PEP was disrupted throughout this past year. In May 2020, the CDC released a "Dear

Colleague" letter to provide guidance on PrEP provision during clinic disruptions. Their guidance included the recommendation of home specimen collection kits for HIV and STDs, or an at-home HIV self-test.[18]

It was also recommended to extend 30-day prescriptions of PrEP to 90-days, to ensure patients had access to their medication. As of this writing, NCSD has reported an increase in seroconversions, during the intermittent COVID-19 lockdowns, of patients on PrEP before the COVID-19 pandemic. To address the barrier COVID-19 has on delivering in-clinic PrEP services, some clinics have employed telehealth visits for PrEP.

Another challenge impacting PrEP/PEP uptake and provision is COVID-19's impact on unemployment, triggering a loss in health insurance and an added barrier for paying for PrEP/PEP services and prescriptions. In April 2020, the unemployment rate reached its highest point (14.8%) at an unprecedented level, not seen since data collection started in 1948, before declining to a still-elevated level in December (6.7%).[19]

To address this unemployment disparity, sexual health clinics have continued to encourage and assist PrEP patients to apply for PrEP Assistance programs that are not employer-based, such as Ready, Set, PrEP and other medication assistance programs.

As mentioned above, sexual health services have been greatly impacted, resulting in decreased testing for HIV and STDs. As PrEP is recommended for individuals who have been diagnosed with an STD within the past six months, decreases in screenings not only reduces the number of people aware of their status but also reduces those that have been identified as eligible for PrEP.[20] While this is an example of challenges to PrEP initiation, PrEP has been impacted across the continuum, from awareness to adherence.

- Research presented during the 2020 International AIDS Conference (IAC) in July showed a one third decrease in PrEP usage during the COVID-19 shut down.[21] Many of the study participants reside in the Northeast and the West coast regions, however, southern states were represented in this study. Of the 394 survey respondents, approximately 89% stopped PrEP as they felt they would "no longer engage in risky behaviors", eight percent shared they could no longer access the medication due to either losing their insurance, couldn't receive a prescription or refill, or couldn't complete the necessary labs. While a majority of the PrEP users surveyed stopped voluntarily, additional barriers posed by COVID-19 did impact PrEP usage among users. This raises the question, how many individuals not surveyed have experienced similar challenges?

- Another finding presented at the 2020 IAC was a study conducted by Fenway Health in Massachusetts.[22] During the study period of January 2020 to April 2020, findings identified lapses in PrEP refills "surged" by 191 percent, while new PrEP patients decreased by approximately 72 percent. While this study did not survey individuals from the South, it can be inferred that some of the challenges experienced by the PrEP cohort in Boston may have been compounded by additional barriers to PrEP experienced in the South. These challenges and more have led individuals to wonder how COVID-19 is overall impacting the EHE initiative.

- Lastly, in a national virtual cohort study of gender minority adolescents and young adults released February 2021, 3445 participants aged 13-34 years, mostly from the mid-west and southern regions were surveyed to asses COVID-19's impact on participant's emotional and financial well-being, and access to routine HIV/STD testing and PrEP. The survey results showed that a "significant minority of PrEP users (42.3%) reported changing or stopping PrEP during the pandemic, due to disrupted PrEP follow-up care (43.8%), while 20% reported difficulty accessing HIV/STD testing during the pandemic." These three studies all demonstrate the impact COVID-19 has had on PrEP uptake and utilization, directly affecting the goals to end the HIV epidemic.

These three studies all demonstrate the impact COVID-19 has had on PrEP uptake and utilization, directly affecting the goals to end the HIV epidemic.[23]

IMPACT ON ENDING THE HIV EPIDEMIC

COVID-19 is impacting jurisdiction's work on ending the HIV epidemic plans and reaching program goals.

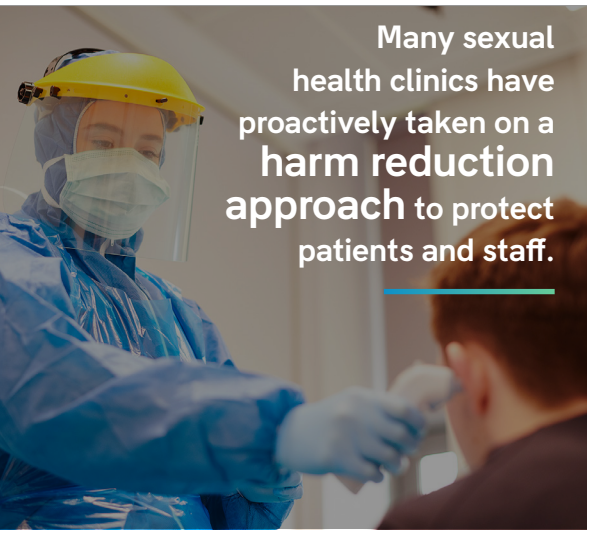
While the United States focuses on the COVID-19 global pandemic, work towards the Ending the HIV Epidemic: A Plan for America (EHE) continues. Announced by the federal government in 2019, the EHE plan focuses on four key strategies (also known as the four pillars): Diagnose, Treat, Prevent, and Respond to reduce new HIV transmissions by 75 percent in 2025, and 90 percent by 2030. The first phase of the EHE plan includes 57 high incidence jurisdictions, approximately half of which are in the South. The jurisdictions included in the EHE plan are also high prevalence areas for the COVID-19 pandemic. The prevent pillar includes proven interventions to prevent HIV transmission, including: PrEP, PEP, and syringe service programs. For this paper, PrEP and PEP will be the main focus when discussing this pillar. While COVID-19 has impacted each pillar of the EHE plan, the prevent pillar has been particularly impacted.

In a southern specific workshop held by NASTAD in November 2020, participants were asked to share some challenges they've experienced in ending the HIV epidemic during COVID-19. Participants shared that the staff bandwidth has decreased due to COVID-19 response, HIV and STD testing has decreased (due to less testing and appointment availability), and individuals shared challenges conducting community engagement due to social distancing. As community engagement was a significant component to developing EHE plans, jurisdictions had to get creative to receive necessary plan feedback in time to be submitted by December 31, 2020, the deadline for the final plans (an extension from the original due date). All EHE plans were submitted to the CDC and can be viewed on this map.

HOW CLINICS MAINTAINED ACCESS

Clinics implemented various harm reduction strategies to provide sexual health services safely.

Some of the best practices that have evolved during the pandemic are limiting routine screening, instituting appointment only policies for visits at clinics, advising patients with symptoms of COVID-19 to avoid coming in, and prioritizing higher risk patients with symptoms for treatment. For example, suppose a patient demonstrates COVID-19 symptoms and they require STD services. In that case, they are seen in a dedicated exam room by providers attired in full PPE. Some clinics have prioritized treatment for syphilis and resistant gonorrhea and have halted pharyngeal chlamydia and gonorrhea tests to reduce risk. The CDC has advised that safety measures and harm reduction practices need to be tailored for each context. Staff and provider safety should be the foremost priority.[24] Measures that do not require or minimize physical contact, such as phone calls, video chats, or texting are recommended.



Many sexual health clinics have proactively taken on a harm reduction approach to protect patients and staff. Sexual health clinics have also adopted practices such as asking patients to wait in the parking lot until their appointment, measuring temperatures at the entrance of facilities, limiting visit durations, requiring face masks, spacing out seating in waiting rooms to enable social distancing, and implementing enhanced cleaning procedures. Others have made staffing changes such as having only essential staff come into work, rotating staff workdays to limit exposure, and asking staff such as insurance navigators, PrEP coordinators, and DIS to work remotely.[25]

Some sexual health clinics decided early on to stay open to relieve the pressure on emergency departments and urgent care centers who were overwhelmed with COVID-19. Others have devised creative solutions to cope with PPE shortages. In addition to taking harm reduction measures, sexual health clinic providers and staff have demonstrated incredible courage by reporting to work despite serious concerns about their health or the health of vulnerable family members. Staff burnout has become a major concern for clinics around the country and many have implemented self-care programs. In light of the unprecedented challenges posed by the pandemic, many sexual health clinics have made contingency plans to provide services. Many have taken steps to ensure that groups that are already vulnerable and at higher risk - such as those without health insurance, older people, racial minorities, and sexual and gender minorities can access critical services.

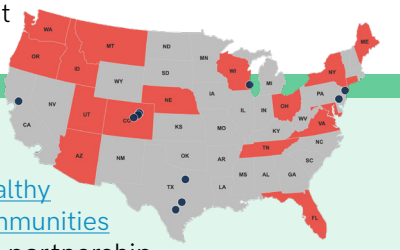
Sexual health clinics have played a crucial role in mitigating the COVID-19 pandemic by using their specialized resources and infrastructure such as DIS and contact tracers. However, there are concerns that COVID-19 will lead to the shutting down of sexual health clinics and interruption of services due to staff and resources diversion. There are also concerns about the long-term implications of reduced sexual health services, such as new and repeat infections not being identified and treated, likely overwhelming the public health infrastructure once widespread sexual health testing resumes. NCSD also identified significant leadership challenges, such as providing support to new contact tracing supervisors, and ensuring the health and overall wellbeing of clinic staff facing chronic trauma exposure and immeasurable amounts of stress.

INNOVATIVE PRACTICES: TELEHEALTH AND SELF-TESTING

Jurisdictions increased telehealth and HIV/STD self-testing services and started implementing new programs to meet client's needs.

As clinics continued to provide services, remote sexual health services, including PrEP uptake, became a major area of service expansion during the ongoing pandemic. Sexual health clinics around the country have implemented telehealth programs to conduct STD screenings, diagnose, and provide treatment by prescribing oral medications. To further promote telehealth during COVID-19, the federal government changed policies to assist with the provision of telehealth services across the country.[26] Under the COVID-19 public health emergency declaration, providers were given more HIPAA flexibility for telehealth technology, allowing providers to conduct virtual visits over "everyday technology", such as Zoom or Skype.[27] COVID-19 waivers and regulatory changes made it easier for providers to deliver telehealth services to Medicare and Medicaid patients by reimbursing providers for telehealth visits, expanding the list of services provided by telehealth, and allowing providers to deliver telehealth across state lines.[28]

Self-collection by mail or non-clinic-based testing has also emerged as a viable alternative to in-person HIV/STD testing. Supporting HIV/STD screening by relying on self-collection by mail testing presents many opportunities. However, there are challenges such as higher costs, accuracy issues, and regulatory barriers. Sexual health clinics around the country have established or expanded self-collect testing by mail services and many are utilizing EHE funding to support these efforts. However, we estimate fewer than 15% of jurisdictions are currently implementing such programs.



Building Healthy Online Communities (BHOC) in partnership with Emory University and NASTAD, developed the National Home Test Kits program for state and local health departments to offer confidential HIV and STD testing. This map developed by NASTAD shows states providing free at-home self-testing services, including those partnering with BHOC.

NCSD has hosted a series of webinars on self-collect by mail testing that covers the rationale, regulatory environment, examples of testing, an exploration of the range of possibilities, and discussion of cost as a barrier. NASTAD has also held webinars on self-HIV testing, as a part of the "Self-Testing Strategies

for HIV Testing and PrEP Access" series. While self-collection has shown to be a promising alternative to in-person testing, preliminary data presented at NCSD's 2020 Engage conference indicates that these innovative self-collection by mail programs do not elicit comparable STD morbidity rates to brick-and-mortar STD clinic prior to the pandemic, which suggests that there may be key demographics that are still not being reached through these innovations as the pandemic continues.

When evaluating PrEP access points and PrEP delivery models in the context of COVID-19, telePrEP programs come to mind immediately as providers seek to support PrEP maintenance while adhering to current public health recommendations for social distancing. Increased access to telehealth and HIV/STD self-testing has helped make it possible for more jurisdictions to add telePrEP programs to their offered services. NASTAD has seen an increase in telePrEP programs becoming available over the course of the pandemic, state-specific telePrEP services can be shown on this map. For programs interested in designing and implementing a telePrEP program, the telePrEP hub toolkit provides helpful resources to assist clinics getting stated.

CLINIC SPOTLIGHT

- When COVID-19 hit Jackson, Mississippi in the Spring of 2020, the **Express Personal Health Clinic** managed by the University of Mississippi Medical Center quickly pivoted to offering telePrEP to ensure patient adherence, particularly as a significant portion of the clinic's patient population were college students being sent home as campuses faced critical closures. The program had exceptional success keeping patients on PrEP from wherever they sheltered in place. The clinic continues to offer this convenience as a sustainable innovation in response to COVID-19.

- The **Testing123 program** housed in the Harris County Public Health HIV and STD Prevention in Houston, Texas, is an HIV prevention program in its fourth year that conducts rapid HIV testing and conventional syphilis testing 24 hours per day, seven days per week by way of a mobile van. Services are available by texting a phone number which prompts the van to come to the individual seeking testing at any location. The Testing123 program plans to expand due to decreases in traditional services secondary to COVID-19 and through support from EHE funding. Testing123 provides an immediate connection to on-call linkage to care services if needed around the clock.

TECHNICAL ASSISTANCE IS AVAILABLE

As part of NCSD's Clinic+ initiative, technical assistance is available to clinics around the nation. If you have clinic-related requests, questions, or responses, please contact NCSD's Jennifer Mahn.

CDC funded health departments and community-based organizations in the South are eligible to receive technical assistance and capacity building support! The South includes: AL, AR, Baltimore, DC, DE, FL, GA, Houston, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, and WV. Capacity building in the South is provided by, My Brother's Keeper, Inc., the Latino Commission on AIDS, and NASTAD.

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