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, May 26, 2021

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

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://tinyurl.com/nbx4mwkb

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Access code: 145 182 2673

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

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, May 26, 2021 @ 5:30 – 7:00pm

To Register + Join by Computer: https://tinyurl.com/nbx4mwkb
To Join by Phone: +1-415-655-0001 | Access code: 145 182 2673

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 5:45pm – 6:05pm
    a. Previously Presented Prevention Data - Questions and Answers

4. Review Commission Approved Prevention Standards 6:05pm – 6:55pm
    a. What Are Prevention Standards?
    b. When Were Prevention Standards Established?
    c. Any Prevention Standard Enhancements/Modifications?

5. Steps and Agenda Development for Next Meeting 6:55pm – 6:58pm

6. Public Comment + Announcements 6:58pm – 7:00pm

7. Adjournment 7:00pm

LOS ANGELES COUNTY
COMMISSION ON HIV

VIRTUAL MEETING—PREVENTION PLANNING WORKGROUP
Wednesday, April 28, 2001 | 5:30-7:00PM
MEETING SUMMARY

Miguel Martinez (Co-Chair)	Maribel Ulloa (Co-Chair)	Everardo Alvizo
Jayshawnda Arrington	Genevieve Clavreul	Kevin Donnelly
Lawrence Fernandez	Wendy Garland (DHSP Staff)	Bridget Gordon
Grissel Granados	Michael Green (DHSP Staff)	Katja Nelson
Pamela Ogata, (DHSP Staff)	Jose Ortiz (HHS, Staff)	Alberto Pina
Terri Reynolds	Natalie Sanchez	Victor Scott (DPH, Staff)
Julie Tolentino (DHSP Staff)	Greg Wilson	Cheryl Barrit (COH Staff)
Carolyn Echols-Watson (COH Staff)	Abdul-Malik Ogunlade, (COH Intern)	

1. Welcome & Introductions

Maribel Ulloa welcomed and thanked participants for attending. Participants were asked to enter their name and organization in the chat box.

M. Ulloa provided a brief overview of the workgroups March 2021 meeting which included an overview of the local Ending the Epidemic (EHE) plan with a focus on prevention activities.

The meeting packet for this meeting can be found on the Commission website at the following link
http://hiv.lacounty.gov/LinkClick.aspx?fileticket=3HAtw20SQis%3d&portalid=22

2. Executive Director Comments

Cheryl Barrit emphasized that the Commission on HIV is an integrated prevention and planning body and the Workgroup's efforts assist in enabling the Commission to fully synchronize prevention and care priority setting and resource allocation planning efforts.

C. Barrit reminded the Workgroup that the Co-Chairs inform the Commission on issues and ideas addressed in the Workgroup as they relate to prevention and the planning and priorities and allocations process.

Additionally, C. Barrit encouraged the Workgroup to include a racial justice and equity lens when addressing prevention planning.

3. Division of HIV and STD Programs (DHSP) Prevention Program Overview

Miguel Martinez reminded the Workgroup of their requests to DHSP to provide data in key areas which included prevention funding, contract performance, prevention indicators HIV such as testing and PrEP, and STD Express Clinics data. It was explained, information is meant to enhance the group's understanding of how and who are receiving prevention services administered by the County of Los Angeles (LAC).

Programmatic Funding Overview

The first presenter was Pamela Ogata who provided and overview of prevention funding, and its restrictions as well as expenditures for prevention services in FY 2020 and 2021. (Tables are included in the meeting packet.) The following are some presentation highlights.

- Prevention funding include Center for Disease Control (CDC) grants, limited federal grants as well as State and County funding. (County funds are used for prevention and/or care services.) These funds support some of the following programs and/or services.
    - DHSP coordination efforts include the California Department of Public Health STD Management and Collaboration project and collaboration efforts with Substance Abuse Prevention and Control (SAPC).
    - Home Self-Test kits are distributed to providers, PrEP sites, and other partner services programs through the "Take Me Home Test Kit program".
    - Prevention programs administered by LAC include referral services, testing and biomedical prevention programs (PrEP/PEP) and a contract with the City of Long Beach.
    - DHSP will request to carry over prevention funding into the new fiscal year due to underspending.
- DHSP administers $35.3 Million in prevention contracts and direct services.
- Estimated expenditure information was provided, due to outstanding invoices for PY 30 (March 2020 - February 2021) and County expenditures which will not be complete until June 30, 2021 (fiscal year closing). Final expenditures for PY 30 are anticipated to be completed by August 2021.

Programmatic Data (PowerPoints are included in the meeting packet.)

Wendy Garland presented information on how data is collected, demographic data and limitation of data on contracted HIV prevention, HIV and STD Testing and Screening and biomedical prevention services.

- Data presented is not from a centralized data system. Monthly reports are submitted at a high level omitting individual client information. An aggregated report is prepared

from the data.

- DHSP is working with providers to obtain complete data. When information is incomplete DHSP groups individuals based on the information provided which may skew the results.
- Outreach and linkage services for vulnerable populations is not available.
- ➢ W. Garland will provide a written summary of the source and limitations of data used for the presentation.
- Due to limited staff in 2020 and delays in reporting and processing, 2019 information is more accurate information.
- ➢ DHSP administered a series of surveys with contract providers to obtain information on the impact of COVID on service administration. The information collected includes prevention services. The report is available for review.
- PrEP use increased. DHSP thought it may be due to increased PrEP messaging both by DHSP as well as contract providers and pharmaceutical companies.
- Health Education/Risk Reduction (HERR) Services and Vulnerable Population program data have limitations.
- PrEP data was, pulled from a number of sources. This includes Pride Initiative administered by the CDC. PrEP data was through the use a software application as well as information from Centers of Excellence.
- Centers of Excellence include 13 clinics across LA County. There were minimal changes in PrEP and PEP use through the Centers of Excellence.
- Women of color use of PrEP was gathered through public health clinic data.
- DHSP is working to make PrEP and PEP services more accessible to woman of color and transgender persons.
- DHSP testing data was defined as follows.
    - The data measured represented the number of tests performed within an observation period.
    - Positivity data represents the total number of clients with a positive test result out of all of the tests performed within the observation period.
    - New positivity is represented by the number of clients with a positive test result not previously reported in the surveillance system.
    - Linkage to care is the percentage of clients diagnosed with HIV within 30 days of their diagnosis. This is verified by evidence of a medical visit.
    - Approximately 1 and 3 new diagnosis occurred in Los Angeles County.
    - 48% of those tested were client's with evidence of a previous diagnoses. The data is being analyzed to determine why the percentage is so high.
    - Testing services are being targeted to focus on newly diagnosed persons and less on previously diagnosed individuals.
    - Testing volume was highest among cisgender males. Transgender women tested positive higher than all other categories.

    - 2020 testing data is incomplete, but from what has been collected, a third of individuals tested positive. It was noted linkage to care rates decreased as well. However, more analysis and data collection efforts are needed before finalizing the data.
    - 3 out of 4 tests performed are in community settings. The majority of new diagnoses were identified in non-healthcare settings.
    - Mobile units identified two thirds of those diagnoses as previously diagnosed individuals.
    - It was noted, DHSP testing volume positivity and linkage varies by setting and client population. In addition, incomplete reporting of race, ethnicity and gender identity may misrepresent some test positivity data.
    - Of the total test conducted in 2019, half were conducted in healthcare settings and about a quarter were from mobile test settings.
    - There was a drop in testing volume in 2020.
    - DHSP wants to analyze risk behavior data from those tested. To that end, 2020 high risk behavior data could be compared to 2019 data.
- As for linkage to care, it is much lower among populations 18 and under and those 60 and older.
- Data shows efforts to link newly diagnosed individuals to care decreases as time passes from the initial diagnosis.
- Health care settings include community clinics, jails, and public health clinics. Community based clinics include non-healthcare settings such as storefronts, multiple morbidity testing units, commercial sex venues, and drug treatment programs.

DHSP Future Collection Efforts Surrounding Testing and Prevention Data

- Client data to be captured at the point of entry to testing services.
    - Currently biomedical and behavioral prevention services data are collected across various testing modalities.
- Development and launching of efforts that include promotion of routine and opt out testing at clinics.
- A pilot project with medical settings implemented to improve rapid linkages to care from testing sites.
- Inclusion of PrEP services in medical settings to increase and expand access to testing are being implemented.
- Work is being done with non-traditional partners to offer testing and increasing access and capacity of syringe service programs to provide prevention services and linkage to testing services.
    - There is no race/ethnicity reported from testing providers. So, collecting data is challenging.
    - 15 providers that serve PLWH provide prevention services and are focused on Native American women, people who inject drugs (PWID), transgender individuals and gay and non-gay identifying males.

- DHSP noted there is no effective strategy to encourage women to utilize prevention and testing services. Through conversations with women, many are not aware of their status. DHSP is analyzing limited data to develop a prevention strategy.
- DHSP continues to analyze previous services data to determine how to effectively reach women to reduce positivity rates. DHSP's current data collection efforts were incomplete and thus may not yield answers.
- There are 2 ways to identify those who are undiagnosed. One is to do more HIV test and the 2nd is to target testing.
- Demographics and risk behavior are limited. A recommendation was made to survey counseling and testing staff who are on the frontline.
- Further discussion included using collected data to inform mobile testing and where to place testing services.
- DHSP recommended the Workgroup review newer testing contracts because it may have contributed to 2020 testing data changes. This includes where the services are being provided and the modalities used. It was noted more innovative efforts surrounding testing may increase effectiveness. Additionally, these new contracts may provide some best practices/lessons learned.
- DHSP noted, new contracts include more storefronts, local community-based organizations, testing programs and express clinics.
- DHSP recommended the Workgroup request an updated presentation on surveillance data as a way to advance prevention.
- It was noted in the future the Workgroup may want to ask for limited information and allow more time for conversation.
- M. Martinez noted, the Workgroup has a lot of interest around testing modalities.
- Some issues discussed as possible barriers to women utilizing prevention services include
    - Women not wanting to be public about their use of prevention services.
    - Prevention services tend to target men and ignore women.
    - Women not having input or needs being recognized.

Review Commission Approved Prevention Standards

- The Prevention Standards review was moved to the May meeting agenda in the interest of time.

4. Steps and Agenda Development for Next Meeting

Due to the large amount of information presented, the Workgroup has requested DHSP to return an answer question. This will provide time for the Workgroup to digest the data.

- Workgroup requested Vulnerable Populations program, geographic testing, and express clinic data from DHSP
- A recommendation was made to include a conversation with the Women's Caucus to determine effective methods of reaching women to decrease positivity rates and encourage the use of biomedical services.

- Attendees were encouraged to read the Prevention Standards included in the meeting packet in preparation for the May 26, 2021 meeting.
- Attendees were encouraged to reach out with comments or ideas for future meetings. They can be sent to Commission staff.

5. **Public Comment and Announcements:** There were no public announcements.

6. **Adjournment:** The meeting was adjourned at approximately 7:05PM.

Questions and Comments included in the chat box.

- ...HIV Net County Costs (NCC) can be spent on care and prevention, unlike Ryan White (RW) which is only care?
- It appears there are some funds that are underspent (e.g. EHE at 708,000 of 3.36 million). Are any of these unused funds available for carryforward for next year?
- What communities are the focus of the H.E.R.R. Services category?
- Any plans to track PrEP for cisgender women?
- Does women of color = cisgender women?
- Are you having the people being surveyed identify what their challenges may be... going from willing to use PrEP to Actually Using it?
- I would love to have discussion about what was different that impacted positivity rate even when volume dropped dramatically. Is it just that people who really need to come in came in? or what are other factors?
- Since new HIV diagnosis are higher in women 30 plus (an older age group that MSM) is there a strategy to reach and target cisgender with prevention, testing and PrEP services?
- …We have to do a better job of letting the community know HIV impacts all people not just gay men. But understand it's been a challenge
- CDPH reported 172 new HIV diagnosis in LA County in 2019
- And LA County accounts for 36% of the newly diagnosed cisgender women in California
- I don't understand why it's so difficult to reach women....
- I'd love to see us have a focus and add cisgender women of color as a priority population and developing a strategy for this population
- Any conversation must be a collaborative full-scale effort.

CONTRACTED HIV PREVENTION SERVICES 2019

Unlike other contracted services, there is no centralized data collection system for HIV Prevention Services. Data are reported to DHSP through monthly reports using Excel spreadsheets to provide counts of clients served, types of services provided. Because these are submitted on a monthly basis in aggregate and not the client-level, it is difficult to deduplicate the data.

The data presented below is based on these monthly reports for 2019.

HEALTH EDUCATION/RISK REDUCTION (HERR) 2019

The HERR portfolio consists of a total of 21 programs targeting men who have sex with men who use crystal meth (MSM), people who use injection drugs (PWID), women, and people living with HIV (PLWH) across 13 contracted agencies.

Across all programs, these contractors were funded to conduct outreach encounters (which includes providing linkages to HIV testing, STD screening, PrEP/PEP, substance abuse, and mental health services)

- A total of 10,529 individuals received outreach encounters, of which 40% (N=4,227) were linked to HIV/STD testing, prevention and/or other support services (as identified above).

In addition, programs implemented navigation services to assist clients with accessing more individualized prevention services. These were provided during a 1:1 counseling session with a navigator who conducted a risk assessment and developed personalized plan of action with the client.

- A total of 1,742 individuals participated in navigation services, of which 71% (N=1,234) completed a 30-day follow up session.

Finally, some providers implemented group-level interventions that included implementation of CDC-Effective Interventions (SISTA, Healthy Relationships, MPowerment).

A total of 515 people participated and completed the three required sessions in these multi-session groups.

HERR CLIENT DEMOGRAPHICS:
Demographic data was collected for 2,862 clients.

- 58% were Male; 28% were cis-gender Women; and 6% were Transgender individuals
- The majority were older than 45 (36%) and 30-45 (34%)
- 67% reported substance use

Contracted agencies reported that a total of 62,565 condoms were distributed to HERR clients during the reporting period.

VULNERABLE POPULATION (VP) 2019
The Vulnerable Populations contracts consist of eight programs: six targeting YMSM (African-American and Latino); and two targeting transgender Individuals

In order to better engage agencies in the development of prevention programming, the SOW vary across providers, but the following categories are included across all programs:

- Community Advisory Boards (CAB): A total of 366 individuals participated in the various CABs (duplicated)
- Outreach Encounters: A total of 2,704 individuals were reached through outreach

VP CLIENT DEMOGRAPHICS

Demographic information was available for 3,800 VP clients:

- 67% were Male
- 33% identified as transgender individuals

- 42% 15-23 years old
- 41% 24-29 years old
- 12% 30-45 years old
- 6% over age 45

- 45% African-American
- 37% Latino

- 22% reported substance use

Contracted agencies reported that a total of 47,983 condoms were distributed to HERR clients during the reporting period.

RESPONSE TO PREVENTION PLANNING WORKGROUP MEETING, APRIL 28, 2021

Data Sources for "Overview of Contracted HIV Prevention and Testing Services in Los Angeles County" presentation

1. Los Angeles County Apps Based Survey
    a. The main purpose of this annual survey is to track trends in PrEP knowledge, awareness and use as well as U=U knowledge. It also collects feedback on social marketing messages related to PrEP and U=U among Black and Latino MSM and transgender person in LAC.
    b. Key data collected: sociodemographic characteristics, PrEP knowledge, awareness and use, U=U knowledge, medical mistrust, sexual and drug using risk behaviors, HIV status, and social marketing message exposure.
    c. Key indicators: PrEP knowledge, awareness and use, U=U knowledge, and social marketing exposure and message acceptability.
    d. Recruitment: Potential candidates are recruited through advertisements on selected dating apps and through social network referrals on social media. Candidates must report they live in an LAC zip code. To ensure representation among the priority populations for this survey, recruitment of Black or Latino MSM and transgender persons is emphasized.
    e. Eligible candidates complete an online survey that is self-administered.
    f. Limitations include:
        i. Respondents surveyed represent a convenience sample of Black and Latino MSM and transgender persons who could be reached through the online recruitment strategies and may not represent the experience of all Black and Latino MSM or transgender persons.
        ii. Data represent only a single point in time (cross sectional) and are only descriptive – causation cannot be inferred.
        iii. Data are self-reported and may be subject to social desirability and other types of bias however as it was an anonymous survey completed online, this may have resulted in more realistic responses from respondents.

2. Contracted Biomedical Services
    a. This dataset includes PrEP and PEP service data reported by the 12 PrEP Centers of Excellence (COE).
    b. Key data collected: sociodemographic characteristics, PrEP and PEP prescriptions, PrEP and PEP retention, sexual and drug using risk behaviors
    c. Key indicators: PrEP and PEP referrals, PrEP and PEP uptake (prescriptions, use) and PrEP persistence (adherence and retention)
    d. Limitations
        i. Data completeness: Missing data may be a result of agency not collecting, agency collecting but not reporting or client not reporting. Additionally, all data from clients are self-reported to the provider and may be subject to social desirability or other biases.

ii. Data timeliness: Frequency and timeliness of data vary by the agency, so data reports are based on the data available at the time of analysis.
iii. Representativeness: While data may be representative of clients accessing biomedical services at the COEs, they may not represent all clients accessing biomedical services in LAC.

3. HIV/STD Testing Services
    a. This dataset includes reported HIV testing and STD screening services conducted at contracted agencies, public health clinics, jails, court-ordered testing, and DHSP events.
    b. Key data collected: sociodemographic characteristics, sexual and drug using risk behaviors, HIV testing history, referrals to prevention, risk reduction and support services, PrEP, HIV care, provision of behavioral prevention services
    c. Key indicators: testing volume, test positivity (all tests), new test positivity (newly identified positive results), linkage to care within 30 days, linkage to partner services (through 2019), and PrEP knowledge and use (since 2017).
    d. Match with HIV surveillance data to verify client and provider reports of new positivity and linkage to care.
    e. Testing Modalities

CONTRACTED TESTING MODALITES	
2012-2019	2020-2022 (+2 optional years)
Routine Screening (HIV) • Routine Screening • Community Clinic • Community STD Clinic • Events • Public Health STD Clinic • Urgent Care	Category 1: STD SDT (chlamydia, gonorrhea, syphilis)
Targeted Screening and Treatment of STDs (chlamydia, gonorrhea, syphilis, HIV) • Community Clinic	Category 2: Sexual Health Express Clinics (SHEx-C) (chlamydia, gonorrhea, syphilis, HIV)
Targeted Screening (HIV) • Storefront • Sexual and Social Networks	Category 3a and 3b: HIV Screening and Referrals (HIV) • Storefront • Sexual and Social Networks
Targeted HIV and STD	Category 4: Commercial Sex Venues (HIV and syphilis)
Integrated HIV/STD Screening (chlamydia, gonorrhea, syphilis, HIV) • Community Clinics • Storefront • Mobile testing units	Category 4: Commercial Sex Venues (chlamydia, gonorrhea, syphilis, HIV)

City of Long Beach (April 2019) (chlamydia, gonorrhea, syphilis, HIV)	City of Long Beach (through December 2021) (chlamydia, gonorrhea, syphilis, HIV)
Vulnerable Populations (start in 2017) (chlamydia, gonorrhea, syphilis, HIV)	Vulnerable Populations (chlamydia, gonorrhea, syphilis, HIV)
HEALTH DEPARTMENT TESTING MODALITIES	
Department of Public Health Sexually Transmitted Disease Clinics (chlamydia, gonorrhea, syphilis, HIV)	
Jails (DHSP) • Men's Jail (chlamydia, gonorrhea, syphilis, HIV • Women's Jail (chlamydia, gonorrhea) • Juvenile Hall (chlamydia, gonorrhea, syphilis)	
Court Ordered (DHSP)	

f. Limitations
    i. Data completeness: Missing data may be a result of agency not collecting, agency collecting but not reporting or client not reporting. Additionally, all data from clients are self-reported and may be subject to social desirability or other biases.
    ii. Data timeliness: Frequency and timeliness of data vary by the agency, so data reports are based on the data available at the time of analysis
    iii. Representativeness: Data for clients seeking testing services is at the test level and not the client level so it may not be reflective of clients accessing testing services at DHSP HIV/STD testing sites or in Los Angeles County. Client level data is collected for those clients with a positive test result. These clients who test positive may be representative of clients with a positive test result at DHSP HIV/STD testing sites but may not represent all clients receiving positive test results in LAC.
    iv. From 2012-2019, forms and variables collected varied by modality so PrEP use and sexual and drug using risk behavior data are not available for Routine, Jails, Court Ordered settings.
        1. Within the Targeted and Integrated Screening settings, test counselors only asked the risk behavior and PrEP questions if the client reported any generally so those who did not report any generally to the counselor were excluded from further risk behavior or PrEP questions.
    v. As a result of COVID-19, transition to new HIV testing forms were delayed, requiring providers to continue using the forms for the 2012-2019 contracts. The new forms, which collect the same data across all testing modalities, were implemented January 1, 2021. These data will be subject to the same limitations as indicated above (i-iv).

Los Angeles County HIV Prevention Standards

Los Angeles County Commission on HIV

June 8, 2017

COUNTY OF LOS ANGELES
Public Health

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.

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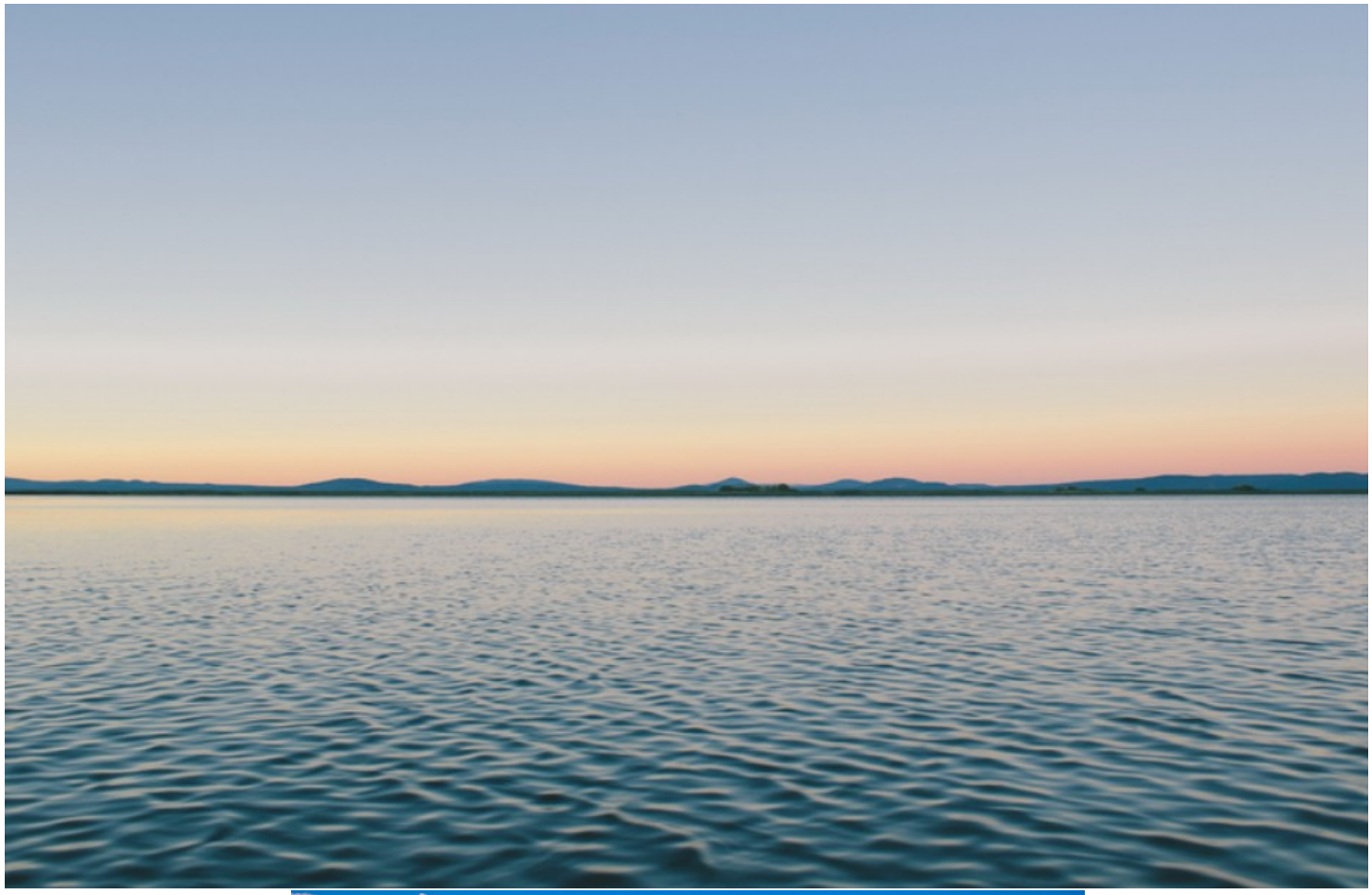
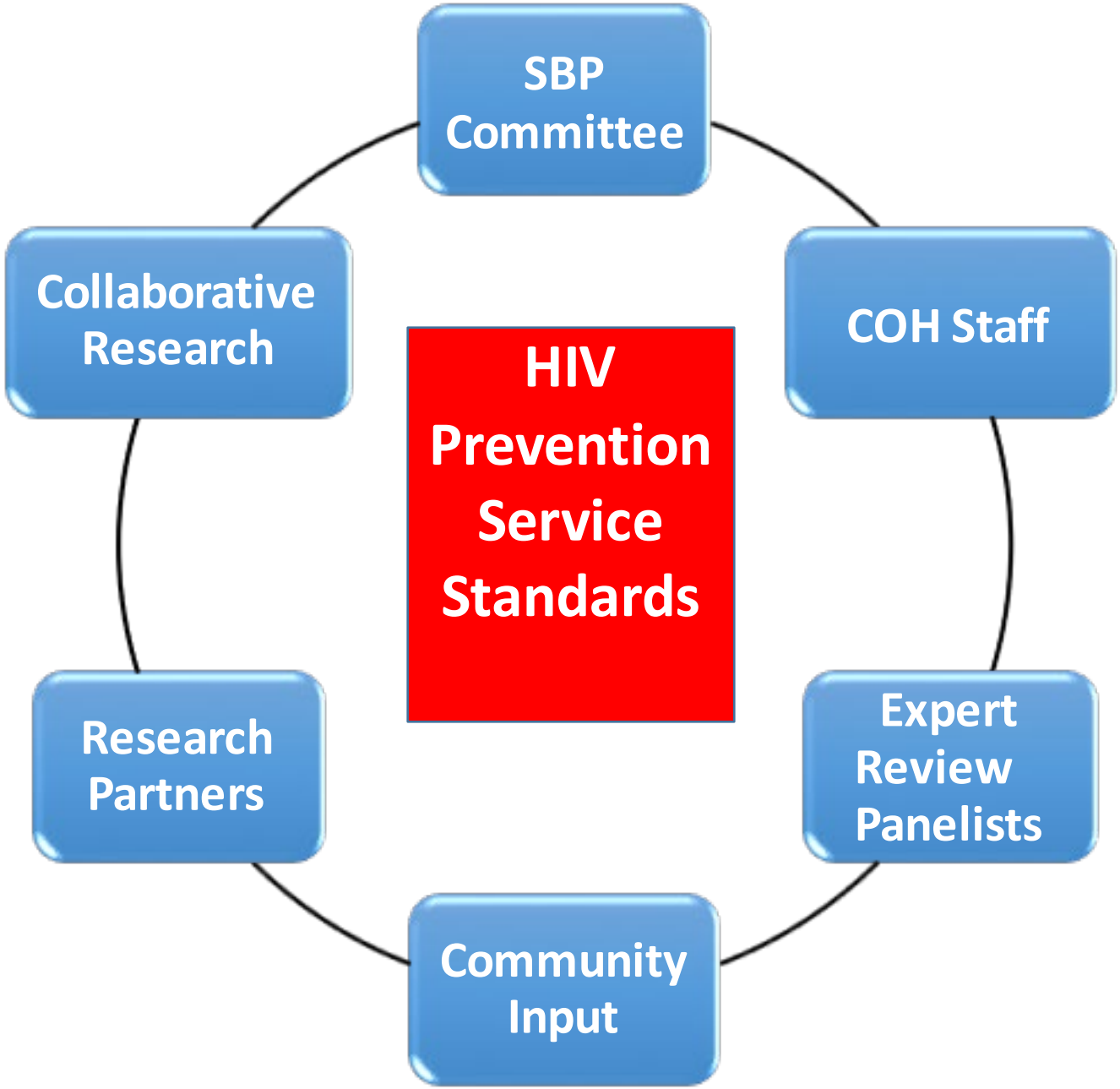
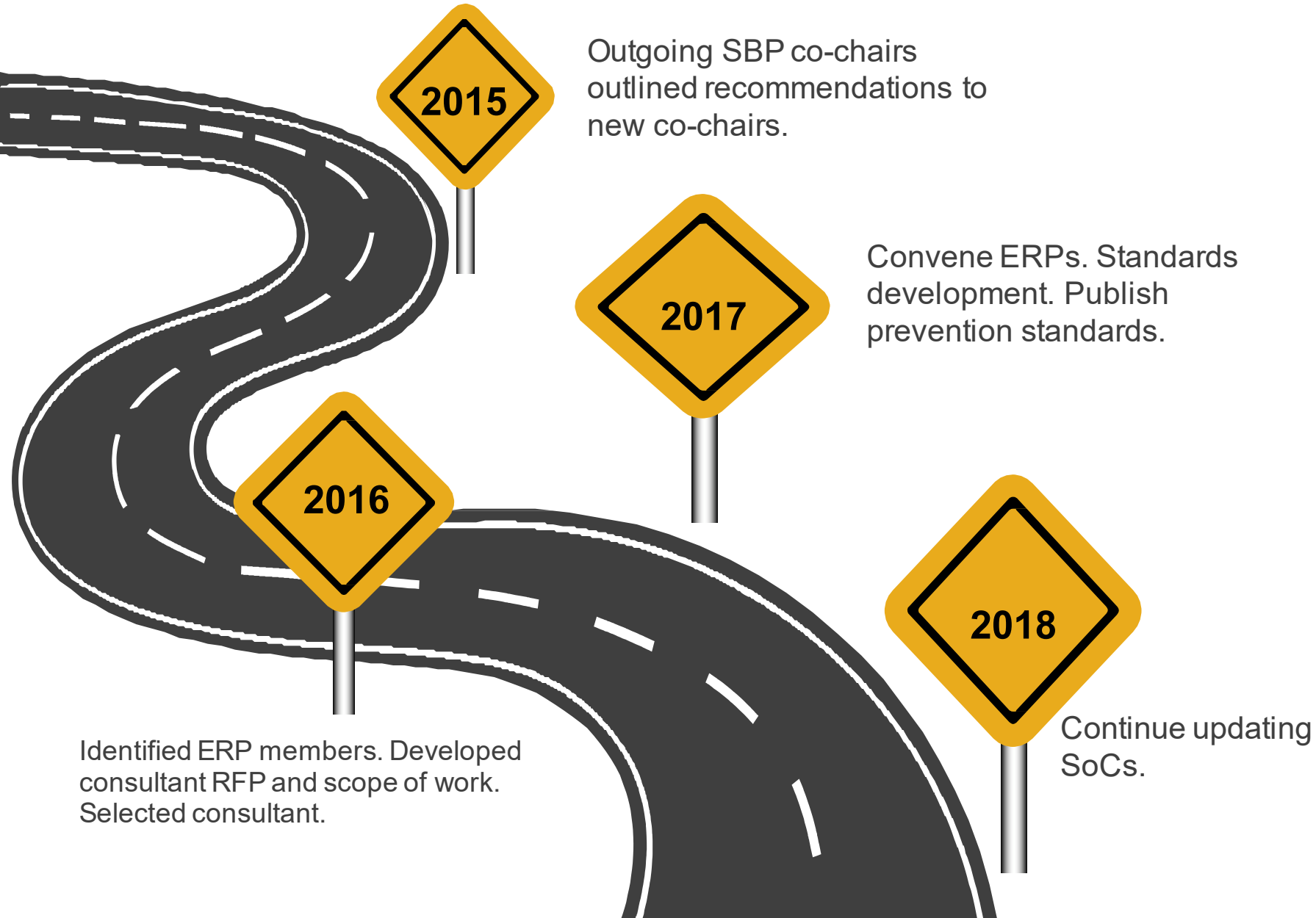


Project Team and Knowledge Partners



Roadmap for Development of New Prevention Standards



Roles and Responsibilities

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

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Expert Review Panelists

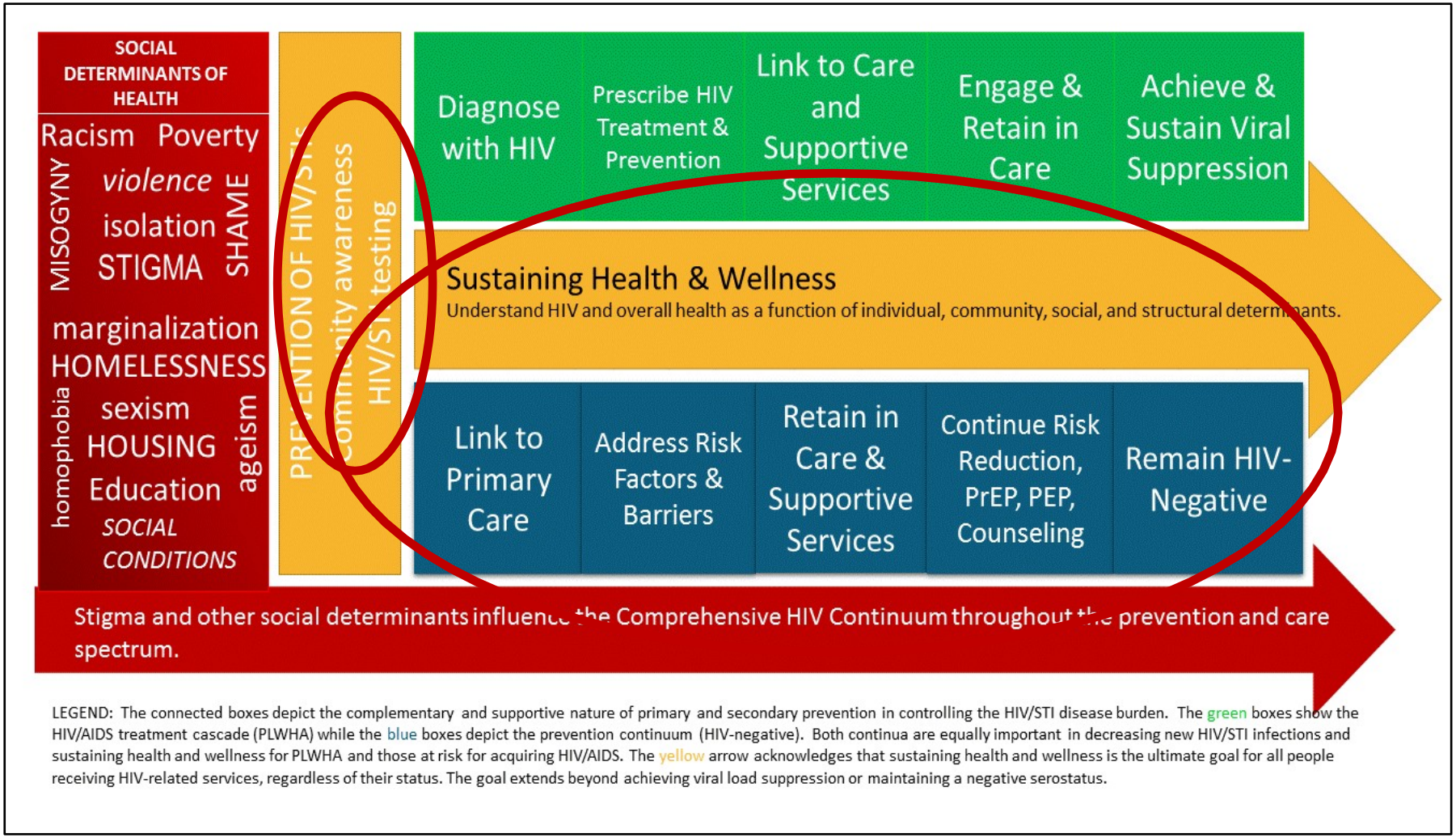
- Panelists review draft documents and other materials before the meeting
- Grantee representative/subject matter experts
- Current providers
  - Public/private
  - Ryan White, CDC-funded, and outside the system
  - Diversity with respect to race/ethnicity, gender, population served, etc.
- Professionals/experts
  - Researchers
  - Academics
  - Consumers

Guiding Questions

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services described meet consumer needs? In this context, "consumers" are defined as those at risk for contracting HIV and STDs.
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?

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

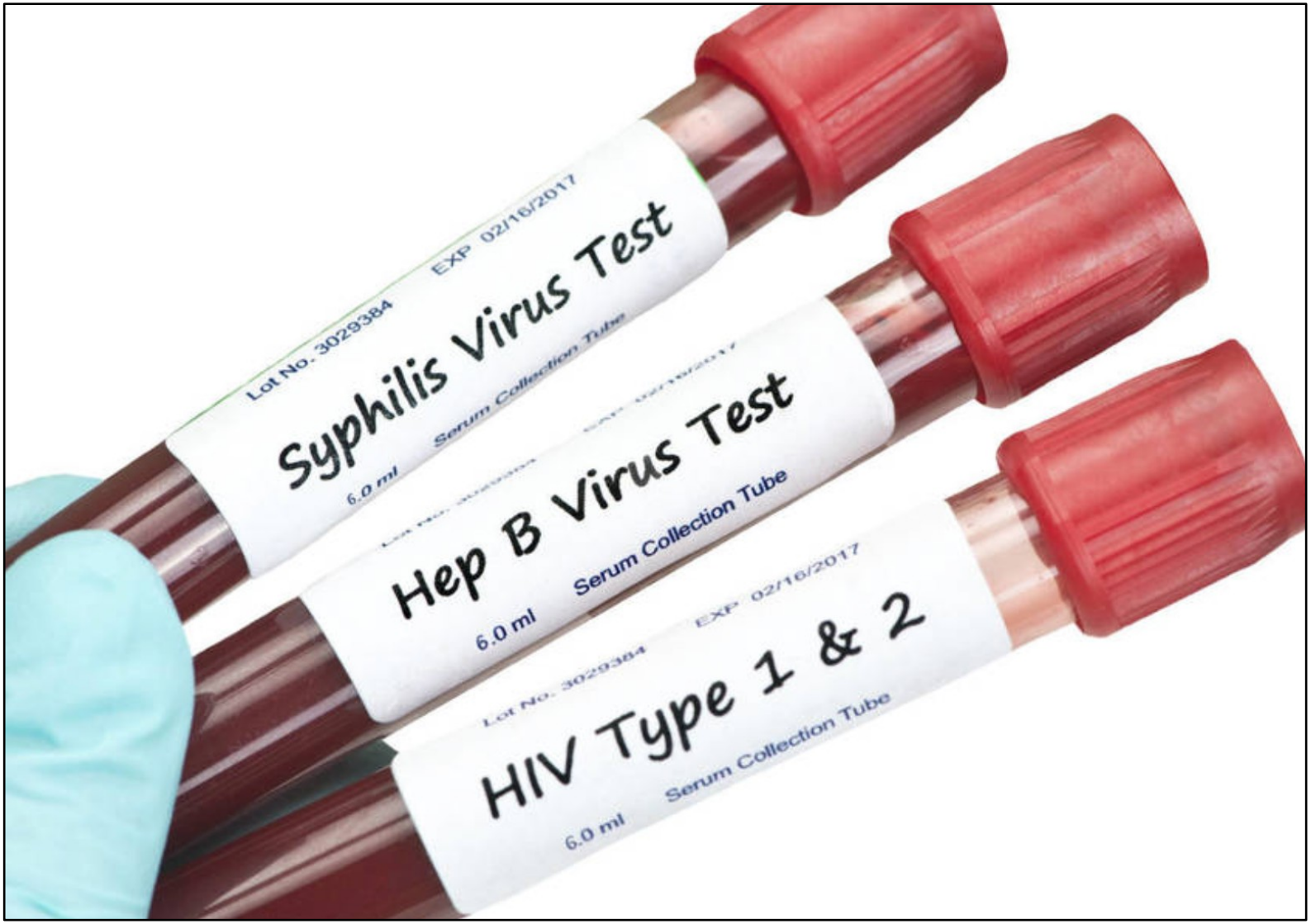
1. Assessment
2. HIV and STD Testing
3. Linkage to Biomedical Prevention Services
4. Referral and Linkage to Non-Biomedical Prevention Services
5. Retention and Adherence to Prevention Services

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

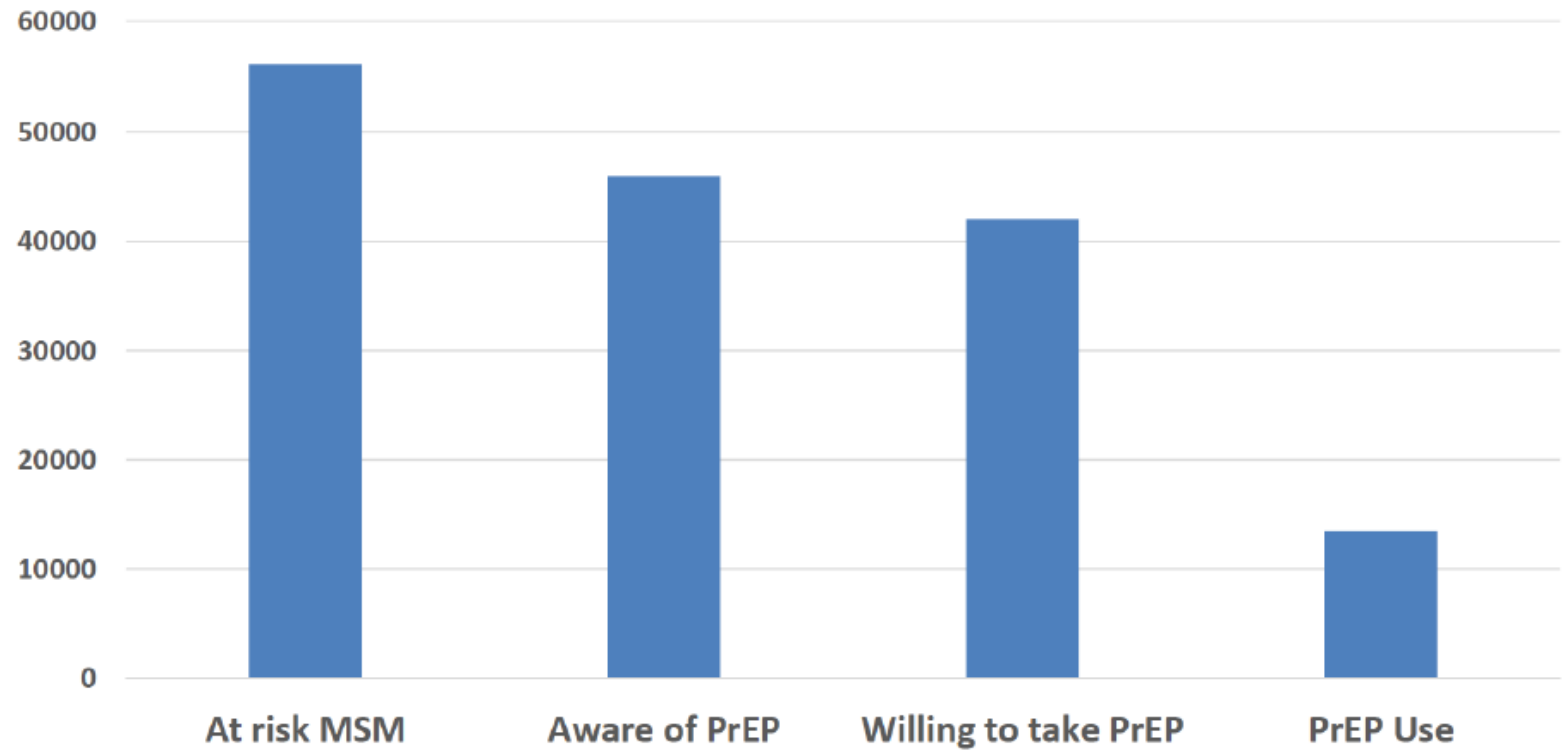


HIV and STD Testing: Key Components

- 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.

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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)

Next Steps

- 30-day public comment period (6/8-7/7)
- Email comments to hivcomm@lachiv.org
- Access document via COH website
- http://hiv.lacounty.gov/
- Update/edit as necessary
- Present final document for approval at the Los Angeles County Commission on HIV meeting

Thank you!

Any questions?

LOS ANGELES COUNTY COMMISSION ON HIV PREVENTION SERVICES STANDARDS

Approved the Commission on HIV 06/14/18

TABLE OF CONTENTS

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:

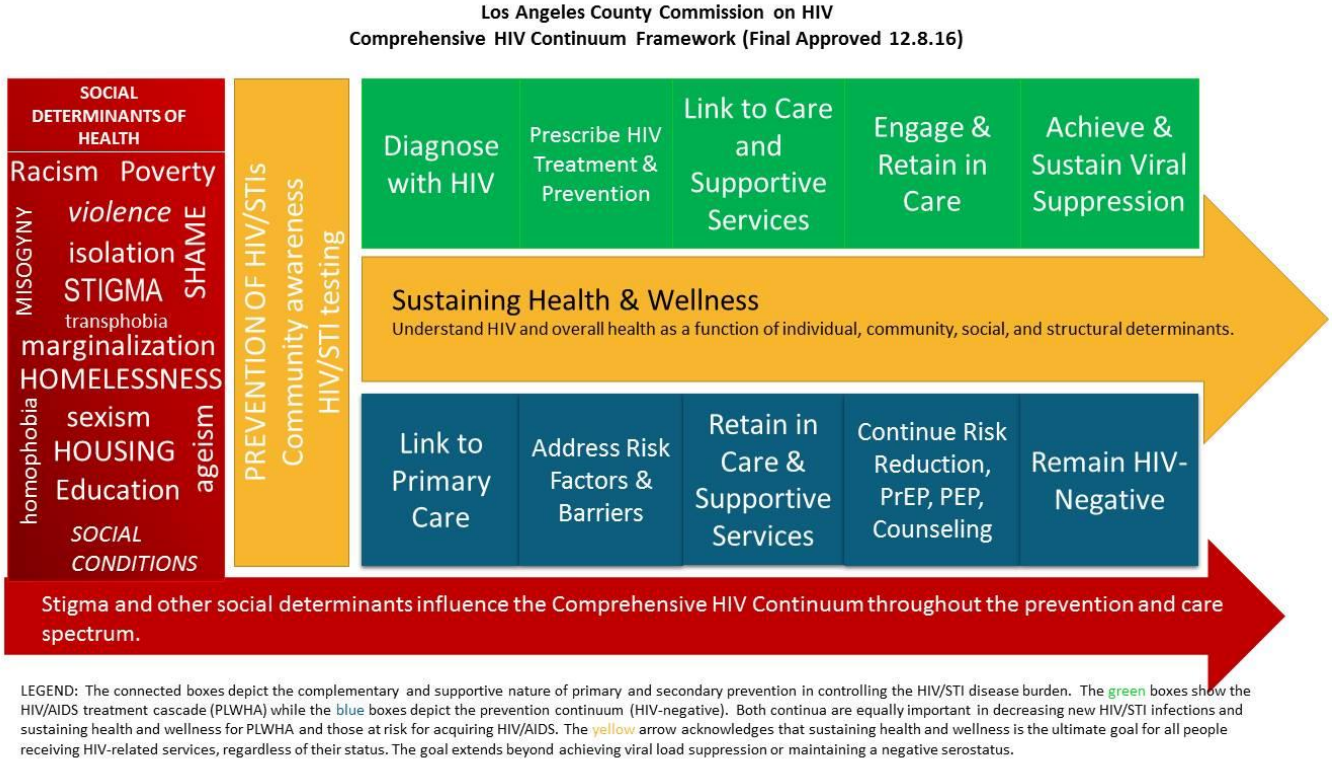
- Persons who inject drugs (PWID)
- Youth (18-29 years)
- Cisgender women
- Transgender persons
- Blacks/African Americans
- American Indians/Alaska Natives

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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Key Resources Used to Help Inform the Development of the Prevention Service Standards

Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014: Summary for Health Departments and HIV Planning Groups. 2014. http://stacks.cdc.gov/view/cdc/26065.

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Sexually Transmitted Diseases in Los Angeles County, 2019[1]

(excludes Long Beach and Pasadena)

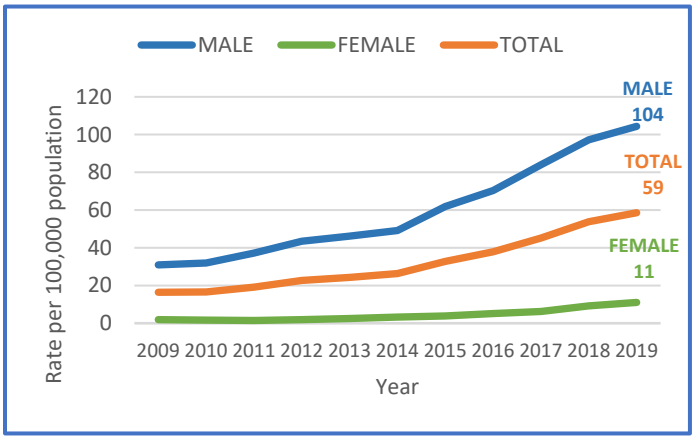
Sexually transmitted diseases (STDs) continue to rise in Los Angeles County (LAC). In 2019, there were a total of 98,427 cases of STDs reported to the LAC Department of Public Health. The majority of reported cases (66%) were chlamydia followed by gonorrhea (25%) and syphilis (9%). Sixty-five percent of the syphilis cases were early syphilis.[2] Data do not include Long Beach and Pasadena due to reporting delays.

Early Syphilis

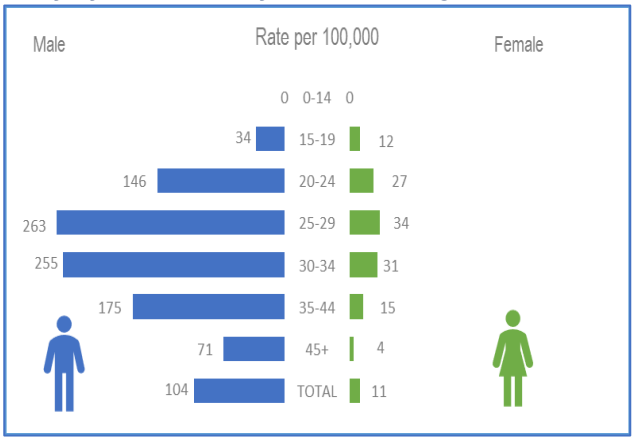
Syphilis is a sexually transmitted infection caused by the bacteria, Treponema pallidum and is a known risk factor for HIV. While it is the least prevalent of the reportable STDs, if untreated, it can cause significant health issues including damage to the brain, nerves, eyes, or heart. Early syphilis includes the infectious stages of syphilis infection.

In 2019, 5,643 early syphilis cases were reported to LAC with a rate of 59 per 100,000, reflecting a 9% rate increase compared with the 2018 rate. In 2019, early syphilis among males occurred at 9.5 times the rate as that of females; however, from 2018 to 2019, there was a lower relative increase in early syphilis rates among males (7%) compared to females (20%). Transgender individuals represented 2.5% of the early syphilis cases.[3] Among both males and females, rates were highest among persons aged 25-29 years. By race, rates were highest among Pacific Islanders (141 per 100,000) and African Americans (135 per 100,000).

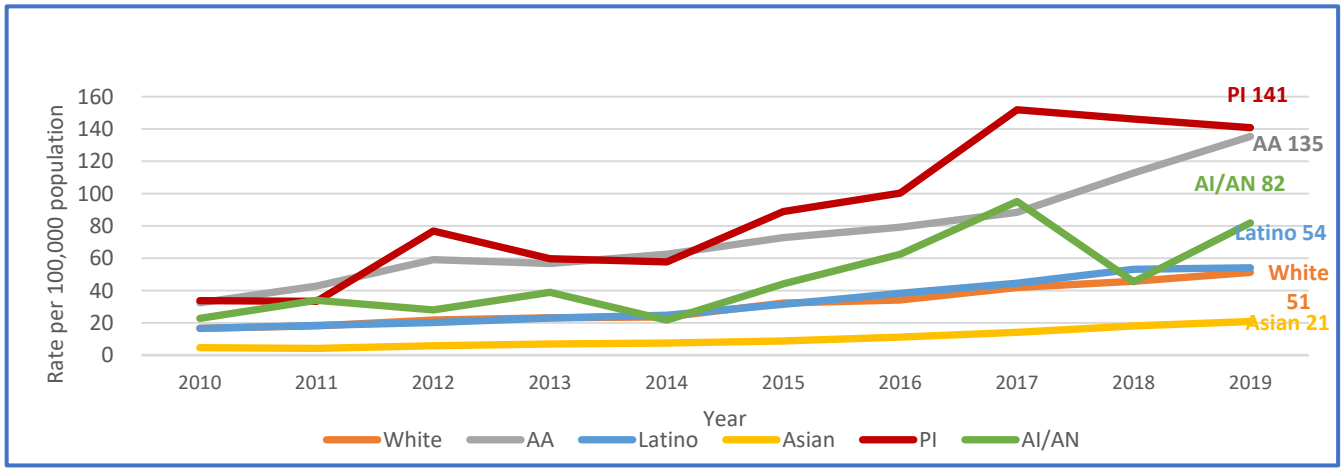
Early Syphilis Rates by Gender, 2010-2019



Early Syphilis Rates by Gender and Age Group, 2019



Early Syphilis Rates by Race/Ethnicity, 2010-2019



[1] Data are provisional and subject to change due to reporting delays. Data do not include Long Beach and Pasadena. This document will be updated to include these jurisdictions when data become available.

[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent). Note that syphilis rates are unstable for PI (2010-2011, 2013-2014) and AI/AN (2010-2016) due to small numbers.

[3] Male-to-female transgender individuals represented 2.4%, 0.6% and 0.2% of the early syphilis, gonorrhea, and chlamydia cases, respectively.

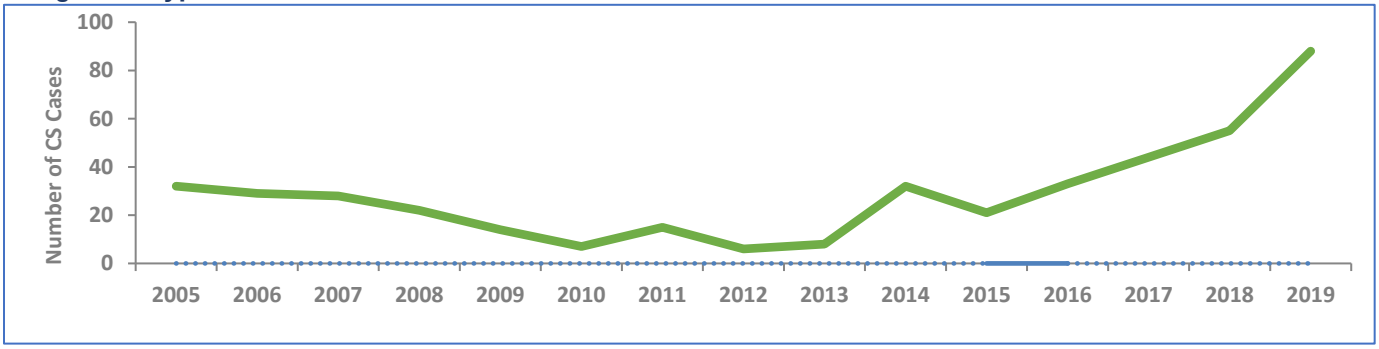
Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

Congenital Syphilis

Congenital syphilis is a multi-system infection caused by the bacteria, Treponema pallidum, in a fetus or infant, passed during pregnancy. It can cause preterm birth, miscarriage or stillbirth. It can also lead to serious birth defects.

In 2019, the number of congenital syphilis cases continued to rise (N=88) with an increase of 60% since 2018. Since 2012, the number of reported congenital syphilis cases has increased over 1,300%. Latinx (57%) females represented the majority of mothers of infants with congenital syphilis.

Congenital Syphilis Cases, 2005-2019

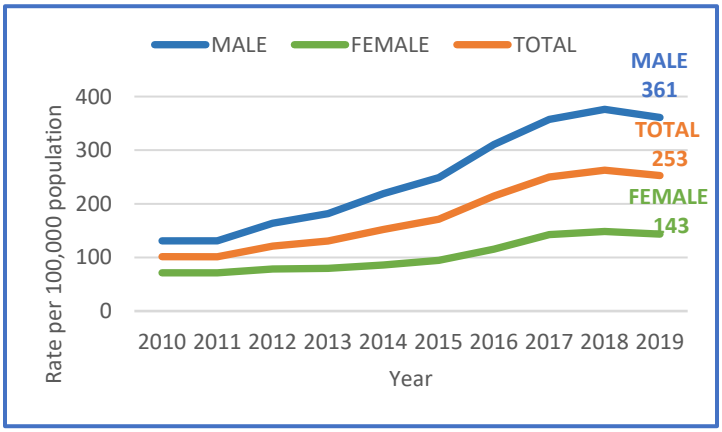


Gonorrhea

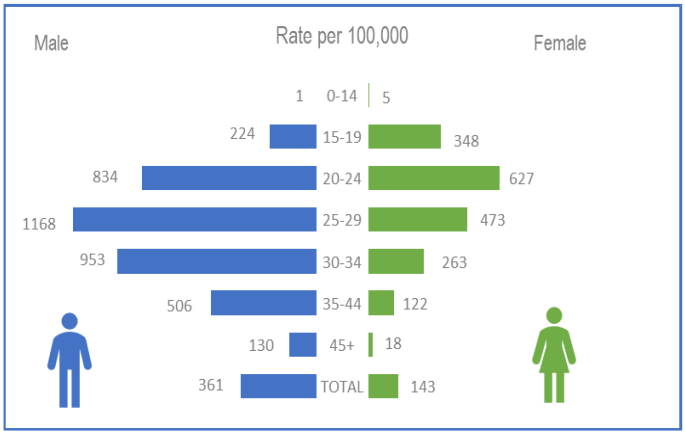
Gonorrhea is one of the most commonly reported sexually transmitted infections. It can cause infection in the genitals, rectum, and throat. If untreated, gonorrhea can cause serious health problems including infertility for men and women. It may also increase the chances of getting HIV. Though gonorrhea is treatable, it has progressively developed resistance to the antibiotic drugs prescribed for treatment.

In 2019, 24,342 gonorrhea cases were reported to LAC with a rate of 253 per 100,000, reflecting a 4% rate decrease compared with the 2018 rate. Among males, gonorrhea rates were 2.5 times higher than among females in 2018. Male gonorrhea rates decreased 4% and female rates decreased 3% since 2018 with rates highest among males 25-29 years and females 20-24 years. Transgender individuals represented 0.7% of the gonorrhea cases.[3] By race, African Americans had rates (666 per 100,000) 3.9 times higher than Whites (171 per 100,000).

Gonorrhea Rates by Gender, 2010-2019



Gonorrhea Rates by Gender and Age Group, 2019



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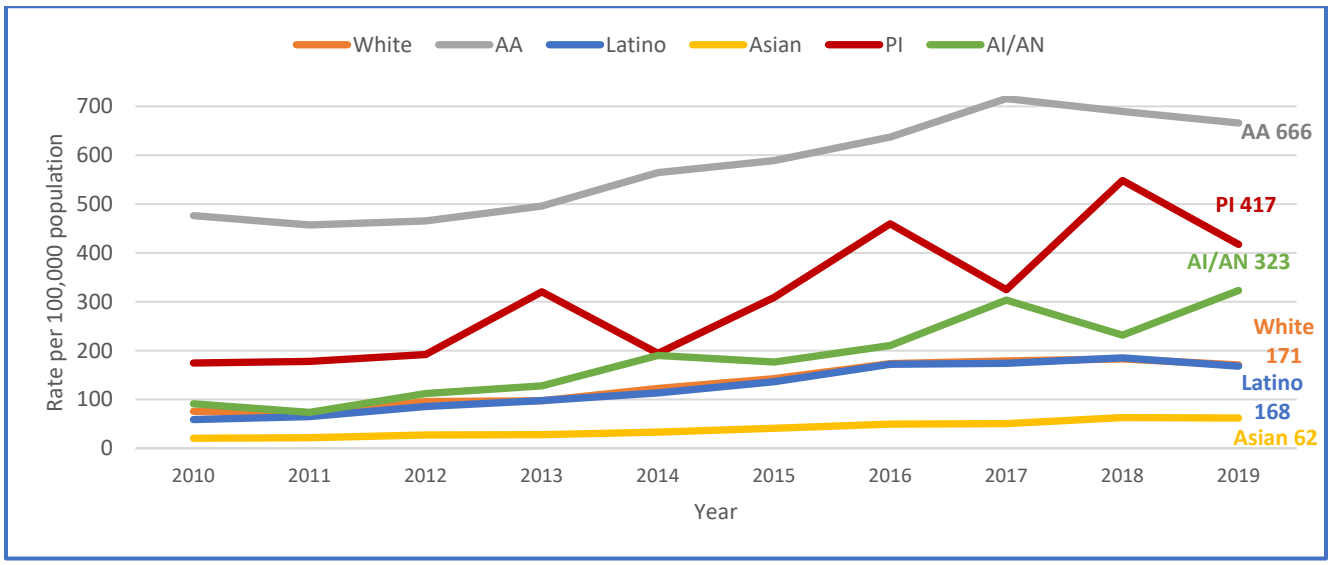
[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent).
[3] Male-to-female transgender individuals represented 2.4%, 0.6% and 0.2% of the early syphilis, gonorrhea and chlamydia cases, respectively.

Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

Gonorrhea Rates by Race/Ethnicity, 2010-2019

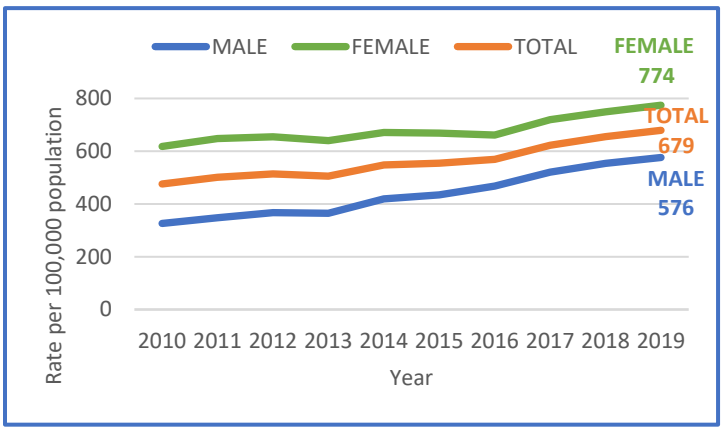


Chlamydia

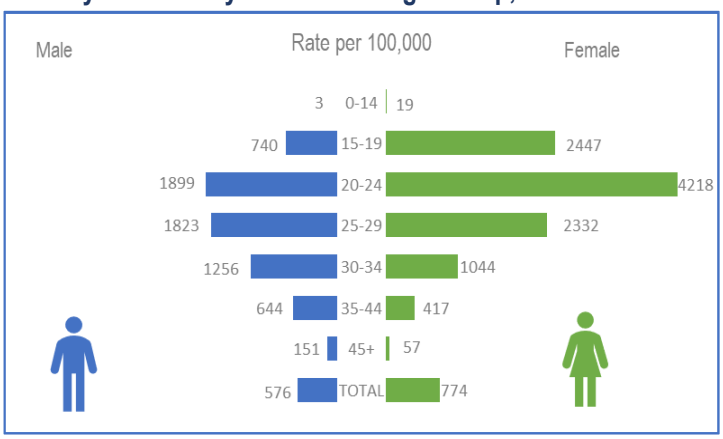
Chlamydia is the most commonly reported sexually transmitted infection and can be transmitted via vaginal, rectal or oral sex. If untreated, it can cause infertility in women.

In 2019, 65,431 chlamydia cases were reported to LAC with a rate of 679 per 100,000, reflecting a rate increase of 4% compared with the 2018 rate. Rates among males increased 4% while females increased 3% since 2018. Transgender individuals represented 0.2% of the chlamydia cases.[3] Chlamydia was most prevalent among youth 15-29 years old. Due to changes in chlamydia reporting in the State of California in which providers are no longer required to report cases, race/ethnicity information are not complete for chlamydia cases and therefore case rates are not reported for race/ethnicity categories.

Chlamydia Rates by Gender, 2009-2019



Chlamydia Rates by Gender and Age Group, 2019



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Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

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May 6, 2021

Dear Division of HIV and STD Programs Colleagues:

On April 13, 2021, the federal Centers for Disease Control and Prevention (CDC) released its 2019 Annual Sexually Transmitted Disease (STD) Surveillance Report which can be accessed at (https://www.cdc.gov/std/statistics/2019/default.htm). The national report showed that the number of reported STDs reached an all-time high with a combined 2.6 million cases of chlamydia, gonorrhea, and syphilis reported. The highest increase was observed in cases of syphilis among newborns which has quadrupled in the United States over the last 5 years. The inaugural Sexually Transmitted Infection (STI) National Strategic Plan, released in 2020, has set forth five high-level goals to develop, improve, and bring to scale STD prevention and control programs over the next five years. These goals include:

1. Preventing new STDs through increased awareness, expansion of high-quality programs, improving Human Papilloma Virus vaccination coverage, and increasing the public health and health care capacity to prevent STDs.
2. Improving health by expanding high-quality STI prevention in communities most impacted by STDs and increasing the capacity to identify, diagnose and provide care and treatment for persons with STDs.
3. Accelerating progress in STD research, technology and innovation in vaccines, preventive strategies, diagnostic technologies, and therapeutic agents.
4. Reducing health inequities by addressing stigma and discrimination, expanding culturally competent and linguistically appropriate STD programs, and addressing social determinants of health and co-occurring conditions among those most vulnerable to disease.
5. Achieving a coordinated STD response by addressing the syndemics of STDs, HIV, viral hepatitis, and substance abuse disorders in STD programs; improving the quality, timeliness, and use of STD data, and improving systems for measuring, monitoring, evaluating, reporting, and disseminating progress.

The Los Angeles County (LAC) Department of Public Health's Division of HIV and STD Programs (DHSP) has prepared a STD snapshot highlighting key findings from STD case surveillance data reported to DHSP through the end of 2019. Similar to the trends outlined in the CDC report, LAC showed increases in the number of syphilis and chlamydia cases in 2019. In LAC, syphilis cases among infants reached its highest level in 2019, reflecting a 1,300% increase since 2012 when congenital syphilis cases were at a nadir. Conversely, gonorrhea cases have plateaued after a peak in 2018, reflecting a difference from the national trend.

Disparities in STD disease persist across age, gender, and racial/ethnic groups in LAC, underscoring the need for STD programs to address the barriers that prevent the most at-risk communities from accessing the services needed to improve health. This includes improved access to sex-positive and culturally appropriate programs that provide integrated services for persons with low health literacy, persons who are unstably housed or experiencing homelessness, persons with substance use disorders, and persons experiencing poverty. To reverse the STD epidemic, LAC Public Health will continue to focus the STD response on four priorities that aim to strengthen policy efforts and intensify screening, treatment, and awareness, particularly for at-risk populations.

1. Improve early detection of cases through testing of at-risk populations.
2. Interrupt disease transmission through the appropriate treatment of cases and their partners.
3. Educate consumers and community to raise awareness of STDs.
4. Create effective policies to impact health care provider behavior.

For your reference, LAC's 2019 STD snapshot is attached and can be accessed on the DHSP website at: http://publichealth.lacounty.gov/dhsp/Reports.htm.

Sincerely,

Mario J. Pérez, MPH
Director

Sonali Kulkarni, MD, MPH
Medical Director

Andrea Kim

Andrea Kim, PhD, MPH
Chief of HIV and STD Surveillance

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