LOS ANGELES COUNTY COMMISSION ON HIV
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PREVENTION PLANNING WORKGROUP
Virtual Meeting Agenda
Wednesday, July 27, 2022 @ 5:30 – 7:00pm

To Join by Computer:
https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=mc0e8e6f96c3b00fb9b807469b5b6b5cb
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AGENDA

1. **Welcome and Introductions (5:30-5:45pm)**

2. **Co-Chairs' Report (5:45-6:10pm)**
   a. Highlights from July 19 Planning, Priorities and Allocations (PP&A) Committee Meeting
   b. Knowledge, Abilities, and Beliefs (KAB) survey to assess Commissioner's understanding and capacity to engage effectively in integrated planning
   c. **New meeting time starting August 24 | 4:00 PM to 5:30PM**

3. **Discussion: Select Key Areas of Focus or Activities for the Remainder of 2022 (6:10-6:35pm)**
   a. Breakout Groups (10 mins)| What is missing from the list of potential activities?
   b. Group Work (15mins)| Rank/Prioritize Key Activities

4. **Comprehensive HIV Plan 2022-2026 Updates (6:35-6:45pm)**

5. **Next Steps and Agenda Development for Next Meeting (6:45-6:50pm)**
   a. Long-acting injectables for prevention presentation on August 24 by Dr. William King
   ***** Meeting time 4-5:30PM****

6. **Public Comment + Announcements (6:50-7:00pm)**

7. **Adjournment (7:00pm)**

VIRTUAL MEETING—PREVENTION PLANNING WORKGROUP (PPW)
Wednesday, June 22, 2022 | 5:30-7:00PM
MEETING SUMMARY

Attendees:

William King, MD (Co-Chair)	**Greg Wilson (Co-Chair)**	Kevin Donnelly
AJ King		
Commission on HIV (COH) Staff: Cheryl Barrit		
Division of HIV and STD Programs (DHSP) Staff: Pamela Ogata, Richard Salazar, Paulina Zamudio		

1. **Welcome and Introductions**
   Greg Wilson, Co-Chair welcomed attendees and led introductions.

2. **Co-Chairs' Report**
   a. **Highlights from June 21 Planning Priorities Allocations (PP&A) Committee Meeting**
      - Dr. William King commended DHSP staff for their analysis of the potential outcomes of moving individuals 50 years and older from the Ryan White Program (RWP) to Medicaid (known as Medi-Cal in California). The analysis is necessary to anticipate the impact of the expansion of Medi-Cal to individuals 50 years and older regardless of documentation status on the RWP system. This care system change would affect the PP&A Committee's resource allocation process and decisions. Dr. King noted that this analysis was well-informed and thought-provoking.
      - Pamela Ogata, DHSP staff, stated that there is an anticipated rollover in funding for the Minority AIDS Initiative (MAI) of $1.8 to $2 million dollars from fiscal year 2021 to 2022. PP&A discussed the Medicaid expansion and its impact on the RWP. An estimated $4 million in savings is anticipated by transitioning persons aged 50 and over who are 138% below the federal poverty level out of the RWP and into Medi-Cal.
      - PP&A voted on the approval of a revised funding allocation table which now includes allocations for emergency financial assistance.
      - Paulina Zamudio, DHSP staff noted that Medi-Cal expansions now cover undocumented individuals living in California. California Advancing and Innovating Medi-Cal (CalAIM) will now cover various enhanced support services. Dr. King inquired about the impact on finding a specialist through Medi-Cal. P. Zamudio responded that clients are allowed one year of treatment extensions under RWP until they can find a mental health provider who specializes in HIV and is culturally competent.

3. **Discussion: Review updated/revised draft survey to assess Commissioner's understanding and capacity to effectively engage in integrated planning**
    - Cheryl Barrit went over the suggested changes to the draft survey. The suggestions can be found in the meeting packet. The revised questions focus on knowledge of sexually transmitted infections (STIs). Feedback from the group was as follows:
        - P. Zamudio suggested removing the question on STI symptoms and adding a question on how STIs interact with HIV risk.
        - G. Wilson suggested adding a question that would rank STIs based on their relationship to HIV risk.
        - Dr. King suggested removing "Having sex while using drugs or alcohol. Using drugs and alcohol can affect your judgement, which can lead to risky behaviors" from the answer choices for Question #1.
        - Richard Salazar suggested including injectable pre-exposure prophylaxis (PrEP) as an answer choice for HIV prevention modalities.
        - Dr. King suggested removing "vaccine" from the term "vaccine injectables."
        - AJ King suggested adding the question, "What is the difference between PEP and PrEP?"
        - Kevin Donnelly and Dr. King suggested ranking HIV prevention intervention in order of importance. P. Ogata recommended adding an "other" option in this section.

4. **Comprehensive HIV Plan 2022-2026 Update**
    - AJ King informed the group that he is working on scheduling listening sessions for each of the seven priority populations identified in the Los Angeles County Ending the HIV Epidemic (EHE) Plan. The CHP is including PLWH over 50 as one of the priority populations.
    - AJ King is working with Commission staff to plan a data-focused meeting at the July PP&A meeting.
    - K. Donnelly inquired if the CHP would include more information on the prevention pillar. AJ King indicated that harm reduction and syringe exchange programs and PrEP and long-acting injectables are included in the prevention pillar. The CHP will also include treatment as prevention.

5. **Revisiting PPW Meeting Time**
    - P. Zamudio suggested meeting at an earlier time to allow for more people to attend during work hours.
    - The group decided to change their meeting time to 4:00 PM to 5:30 PM starting in August.

6. **Select Key Areas of Focus or Activities for the Remainder of 2022**

- The PPW will hold an in-depth discussion of key areas of focus or activities for the remainder of 2022 at their July meeting.

7. **Next Steps and Agenda Development for Next Meeting**
   - The PPW will continue their discussion of the knowledge, attitudes, and beliefs (KAB) survey on HIV prevention.
   - A. King will provide an update on the community listening sessions.
   - P. Zamudio suggested holding a discussion on how to encourage people to engage in in-person HIV testing.
   - **Long-acting injectables presentation in August by Dr. William King -** Dr. King will host an educational presentation on long-acting injectables at the August PPW meeting. The presentation will contain data showing the effectiveness of injectables and will answer key questions regarding access to and utilization of the injectables.

8. **Public Comments + Announcements**
   - K. Donnelly commended P. Zamudio for receiving an award for her long-standing service at the Coping with Hope annual conference. PPW members congratulated P. Zamudio for her accomplishments.

9. **Adjournment**
   - The meeting adjourned at approximately 6:45 PM.

REVISED DRAFT (Version 4; 07.13.22)

LOS ANGELES COUNTY COMMISSION ON HIV

PREVENTION PLANNING WORKGROUP

PREVENTION PLANNING KNOWLEDGE, ATTITUDES, AND BELIEFS SURVEY

Purpose:
To create a baseline for an annual assessment of the knowledge, attitudes, and beliefs (KABs) of members of the Los Angeles Commission on HIV to increase the capacity of members to engage in prevention-focused planning activities.

Audience: Commission members, including committee members only. Secondary focus on anyone in attendance at a Commission meeting within the past 6 months.

Timeline: 3 months. Develop the survey during the months of May and June. Administer survey in July with recommendations developed in August/September.

A. DEMOGRAPHIC INFORMATION

A1. Age

- 13-19
- 20-29
- 30-39
- 20-29
- 30-39
- 40-49
- 50-59
- 60+

A2. Race/Ethnicity ***Please select all that apply***

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latinx
- Multi-Race
- Native Hawaiian or Other Pacific Islander
- White or Caucasian
- Other

A3. Gender Identification

- Non-Binary/Gender Non-Conforming
- Transgender: Female to Male
- Transgender: Male to Female
- Female

- Male
- If your gender identity is not listed above, please use this space to share how you self-identify:

A4. How long have you served as a Commissioner and/or Alternate on the Los Angeles County Commission on HIV?

- Less than 1 year
- Between 1-2 years
- Between 3-4 years
- 5 years or more

A5. What is the highest level of education you have completed?

- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Doctorate degree

B. KNOWLEDGE

B1. What do you think are elements of prevention? What are examples of interventions that prevent HIV?

B2. What are the top three barriers to HIV prevention in Los Angeles County?

B3. What is Pre-Exposure Prophylaxis (PrEP)?

- A pill that individuals can take daily before HIV exposure to prevent HIV acquisition
- A pill that individuals can take daily after HIV exposure to prevent HIV acquisition
- An experimental drug that might prevent HIV, research is still being done
- I don't know.

B4. To your knowledge, how effective is PrEP at preventing HIV transmission when having sex without a condom?

- Not at all effective
- Minimally effective
- Somewhat effective
- Very/completely effective
- I don't know

B5. PrEP is currently offered via which route of administration?

- One (1) oral tablet

- Two (2) oral tablets
- Three (3) oral tablets
- Long-acting injectables

B6. What is the current recommended dose for PrEP to effectively prevent HIV infection?

- Every 12 hours (twice per day)
- Once per day
- Every other day
- Once per week
- Once per month
- Once per six months

B7. Which of the following drugs are current FDA-approved administrations of PrEP? **Select all that apply.**

- Apretude
- Atripla
- Biktarvy
- Descovy
- Triumeq
- Truvada
- I don't know.

B8. What is Post-Exposure Prophylaxis (PEP)?

- A pill that individuals can take daily before HIV exposure to prevent HIV acquisition
- A pill that individuals can take daily after HIV exposure to prevent HIV acquisition
- An experimental drug that might prevent HIV, research is still being done
- I don't know.

B9. HIV treatment (antiretroviral medication) works to:

- Increase HIV viral load and decrease CD4 cells
- Decrease HIV viral load and decrease CD4 cells
- Decrease HIV viral load and increase CD4 cells
- Increase HIV viral load and increase CD4 cells

B10. Bacterial sexually transmitted infections (STIs) (Chlamydia, Gonorrhea, and Syphilis) are curable.

- Yes
- No
- I don't know

B11. A person must start PEP within _____ after a potential HIV exposure.

- 120 hours

- 24 hours
- 48 hours
- 72 hours

B12. What activities can put you at risk for STIs? Check all that apply.

- Having anal, vaginal, or oral sex without a condom
- Having sex with multiple partners, especially anonymous partners
- Having sex while using drugs or alcohol

B13. What STIs can likely lead to HIV? Check all that apply.

- Chlamydia
- Genital herpes
- Gonorrhea
- Human Papillomavirus (HPV)
- Syphilis
- Trichomoniasis

B14. What are 5 ways that STIs can be transmitted?

- Vaginal sex
- Anal sex
- Oral sex
- Skin contact
- Sharing personal items, such as toothbrushes or razors, with someone who has an STI

B15. How can STIs be prevented?

- Practice abstinence
- Use condoms
- Have fewer partners
- Get vaccinated
- Talk with your partner
- Get tested

C. ATTITUDES:

C1. Treatment as prevention means: (Check all that apply).

- Knowing your HIV status
- Being in care if HIV positive
- Being in care if HIV positive and viral load is undetectable

C2. What does serostatus neutral mean?

- knowing your HIV status

- prevention services or interventions targeting persons regardless of HIV status.
- not knowing your HIV status

C3. What are the most important tenets of HIV community planning to you? Please list two.

C4. How comfortable are you with utilizing health districts as the geographic lens for planning efforts? (1 = very uncomfortable, 2 = uncomfortable, 3 = neutral, 4 = comfortable, and 5 = very comfortable).

C5. If you answered 1-3, would you want to have an in-service on the utilization of health districts for planning purposes? (Y/N)

C6. How confident are you in understanding prevention-related data? (1 = Not confident at all, 3 = somewhat confident, 5 = very confident).

C7. If you answered 1-3, would you want to have an in-service on the utilization of prevention-related data for planning purposes? (Y/N)

C8. Which is not part of a sex-positive approach to working with individuals

- Discussing human anatomy
- Using non-judgmental language
- Urging them to be sexually active with other people
- Supporting them in choosing their identity

D. BELIEFS

D1. Please rank the following interventions based on what you think are the most important ways to prevent HIV.

- Barriers (e.g. external condoms)
- Abstinence
- Biomedical approaches (e.g., Post-exposure prophylaxis (PEP) and Pre-exposure prophylaxis (PrEP)
- Structural interventions (e.g., effecting policy or legal changes; enabling environmental changes; shifting harmful social norms; catalyzing social and political change; and empowering communities and groups)
- HIV screening
- Mental health
- Substance use prevention and treatment
- Harm reduction and syringe exchange
- Health education (e.g., individual and group level interventions)
- Navigation and linkage

D2. Please indicate how much you agree or disagree with the following statements. (Strongly disagree; Somewhat disagree; Neither agree nor disagree; Somewhat agree; Strongly agree)

a. Pre-exposure prophylaxis (PrEP) could be effective at reducing new HIV infections in Los Angeles County.
b. Treatment as Prevention (TasP)/Undetectable = Untransmittable (U=U) could reduce new HIV infections in Los Angeles County.
c. Suppressing HIV viral loads to undetectable levels with antiretroviral treatment reduces the risk of transmitting HIV to others.
d. If an agency has the capacity and infrastructure, PrEP and TasP are tools that can drastically reduce new HIV infection rates and community viral loads in my community.
e. I believe the use of PrEP could obstruct existing HIV prevention efforts in any of the following ways: providing a false sense of security, lead to reduced condom use, or lead to other high-risk behaviors.
f. I have the proper knowledge and training to advocate for my community to use PrEP
g. I have the proper knowledge and training to advocate for my community to use TasP to prevent new HIV infections.
h. There are sufficient programs to address access to PrEP in Los Angeles County.
i. I have the proper knowledge and training to advocate for my community to use long-acting Injectables to prevent new HIV infections.
j. I believe that we have the proper knowledge and training to incorporate long-acting antiretrovirals in Los Angeles County.
k. I believe that PLWH who take medication and are virally suppressed (undetectable) cannot transmit HIV.
l. I believe it is an important part of the role of an HIV tester to link people who receive an HIV-negative test result who are at risk for HIV exposure to PrEP and primary care at every test encounter.
m. I believe that most HIV treatment regimens are highly toxic drugs with many side effects.
n. I would trust condoms to protect me against HIV and STIs.
o. I believe it is an important part of the role of an HIV tester to link individuals to HIV treatment if they receive a positive test result.
p. I believe immediate linkage to HIV care and treatment for people who test HIV-positive is important.
q. I believe PrEP causes people to make riskier choices around their sexual practices.
r. I would recommend PrEP to a friend or family member who is at risk for continued HIV exposure.
s. I see HIV testers as a critical part of ending the HIV epidemic.
t. I believe insurance is a barrier to accessing PrEP services, medical visits, labs, and medication.
u. I believe Partner Services is key service to help end the HIV epidemic.
v. I believe outreach to priority populations is key for successful HIV testing programs.

w. I believe PrEP is safe and highly effective.

E. Training Needs

E1. What areas of HIV and STI prevention would you like to learn or gain more knowledge?

E2. What is your preferred way of learning? In what ways would you like to learn? (e.g., reading materials, self-study, workshops, lectures)

E3. Do you have any comments you would like to share?

LOS ANGELES COUNTY COMMISSION 2022 PREVENTION PLANNING WORKGROUP WORK PLAN
DRAFT/FOR REVIEW (07.13.22)

Prioritization Considerations: Select activities that are feasible and within the influence/capacity of the Prevention Planning Workgroup (PPW).		
Approval Date:	**Revision Dates:**	
#	**TASK/ACTIVITY**	**TARGET COMPLETION DATE**
	Develop and implement a survey of Commission members to look at knowledge, attitudes, and beliefs (KAB) regarding prevention to guide further activities.	
	Conduct a thorough evaluation of existing directives to infuse prevention focus.	
	Recenter conversations and planning back to health districts including requesting prevention indicators (HIV and STD testing, PrEP uptake) by health district.	
	Advocate for a minimum number of prevention-focused presentations each year.	
	Look at creating space for supporting the assessment of readiness for injectable PrEP (at the provider level).	
	Support PrEP Center(s) of Excellence for women (in line with recommendations with B/AA task force). -- Contracts have been awarded.	
	Look at ways to support the development of resources to build the capacity of smaller orgs to respond to RFAs/WOS.	
	Engage in conversations around syringe exchange.	
	Review B/AA Task Force recommendations to identify prevention-focused items.	
	Request data regarding HIV/STD testing, diagnosing, and PrEP for aging population.	
	Identify Strategies to Encourage In-Person HIV Testing	

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

October 10, 2019

Introduction

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

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

Healthcare Disparities in the Black/AA Community

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

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

The highest rate of stage 3 diagnoses (Acquired Immunodeficiency Syndrome) (AIDS) **was among African Americans (18 per 100,000).** The rate of stage 3 diagnoses for **African American females (6 per 100,000)** was 9 times higher than the rate for white females (<1 per 100,000) and 3 times higher than the rate for Latinas (2 per 100,000). Among **males**, the rate of stage 3 diagnoses for **African Americans (32 per 100,000)** was 4 times higher than the rate for whites (9 per 100,000) and 3 times higher than the rate for Latinos (13 per 100,000).(2)

Black/AA Care Continuum as of 2016[3]

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

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

Objectives:

- **Identify** strategies on how the COH can support Black/AA leaders and community stakeholders in an effort to end HIV in the Black/AA community
- **Identify** HIV prevention, care and treatment best practices in the Black/AA community
- **Identify** specific strategies to reduce HIV stigma in the Black/AA community

General/Overall Recommendations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Population-Specific Recommendations:

Black/African American Trans Men:

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

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

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

Black/African American Trans Women:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

Endnotes

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

BLACK/AFRICAN AMERICAN WORKGROUP TASK TRACKER

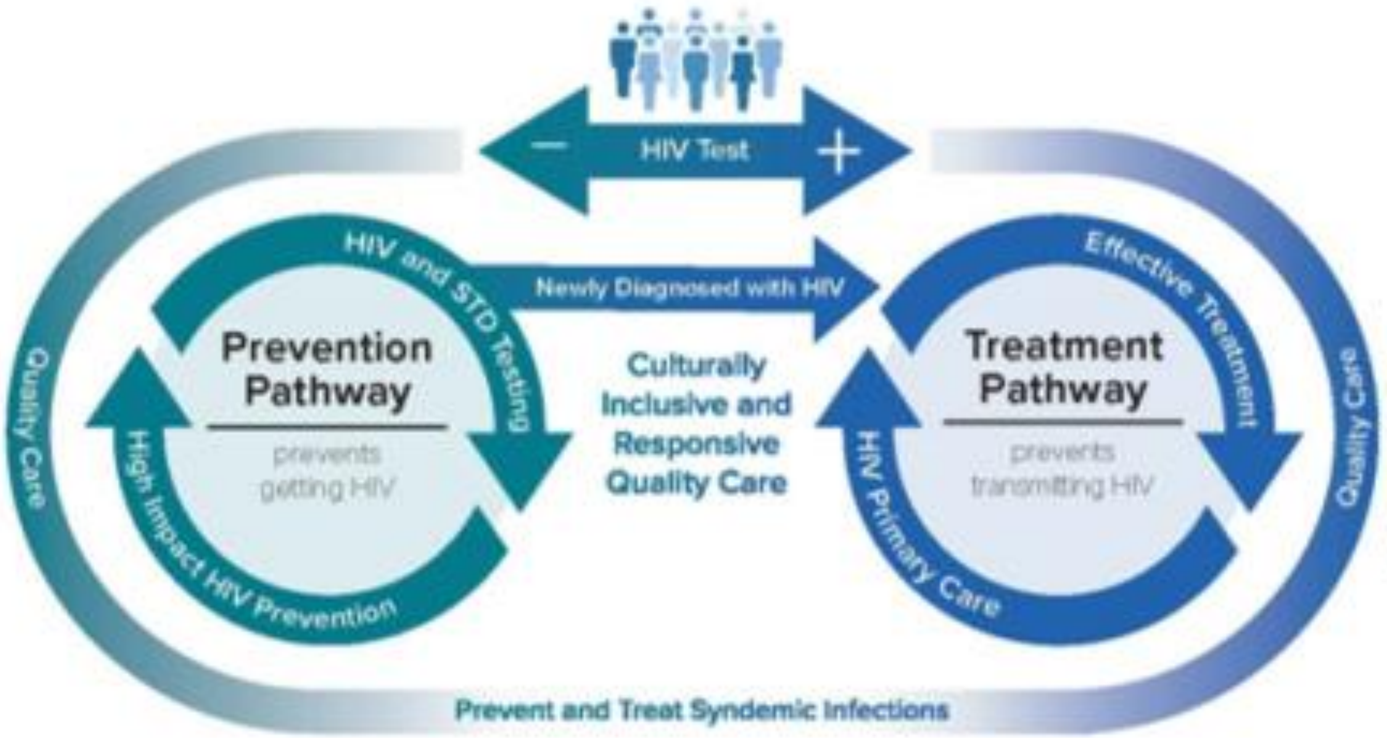
Updated 12.2.21 (Revised)

	TASKS	CORRESPONDING BAAC TF RECOMMENDATION(S)	STATUS	UPDATES+NEXT STEPS
1	**PREP MARKETING CAMPAIGN FOR THE BLACK COMMUNITY AND ITS SUBPOPULATIONS** *Develop list of 20-30 participants for DHSP to coordinate a focus group via vendor, Audacy (fka Intercom) to solicit feedback on a PrEP campaign*	General Recs #3, 6, 13, 14 Black Trans Men Rec #4 Women & Girls Recs #1, 7	**10.12.21:** Workgroup submitted list of 47 potential participants to DHSP on 10.21.21. DHSP to provide progress updates.	**12.2.21:** DHSP is reviewing resources to identify funding to support PrEP marketing for Black community; participant list submitted to Intercom/Audacy to coordinate focus group; will solicit Raniyah Copeland's assistance to help shepherd the focus group. DHSP also working on a much broader marketing solicitation. **Workgroup to follow up in early 2022**
2	**REVISE RFP MINIMUM MANDATORY REQUIREMENT (MMR) LANGUAGE TO BE MORE INCLUSIVE TO YIELD MORE SUCCESSFUL SOLICITATION AWARDS TO BLACK/AA LED ORGANIZATIONS** *Develop 3-5 specific recommendations on how to adjust Minimum Mandatory Requirements (MMR)s to allow more Black/AA led orgs to compete; i.e. allow DHSP latitude to override application scoring, waive/reduce specific requirements, etc. *Refer to example of MMRs* *DHSP to provide MMR "non-negotiables" especially around clinical licensure and billing*	General Rec #11	**10.21.21:** Workgroup agreed to amend Task #2 to a "4-bucket" strength-based approach which is to be coordinated w/ Task #3: 1. <u>Support + Mentorship Initiative</u>. Create an "incubation" period to allow smaller & larger organizations to "pair" with each other to support and mentor each other by filling capacity gaps and leverage funding and other resources. 2. <u>Administration</u>. Provide organizations technical assistance, i.e., grant writing and strengthening internal financial systems. 3. <u>Customer Service</u>. Ensure customer service is centered around cultural humility. I.e., mandatory workforce Implicit Bias training, etc. 4. <u>Minimum Mandatory Requirements (MMRs)</u>. Create a solicitation infrastructure that does not "box" out Black/AA orgs from successfully competing for RFPs while ensuring optimum service delivery without compromising quality or service integrity	**12.2.21:** DHSP developed and is currently conducting Implicit Bias training; 300 provider staff signed up for training. DHSP is developing a proposed staffing plan to aggressively train providers without compromising its training portfolio. DHSP reported current proposal pending w/ Gilead to provide TA grant to providers to assist with EHE efforts. *DHSP will provide updates*. DHSP is coordinating with the Center for Health Equity in support of its program launch to provide equitable contract opportunities for CBOs. Will continue to discuss opportunities that will help advance Black led/servicing orgs to successfully apply for County contracts. *DHSP will provide updates*. DHSP continues to communicate and relay to its DPH leadership in conjunction with the County's Anti-Racism Initiative, the workgroup's efforts to create an equitable contracting and procurement system. **Workgroup to follow up in early 2022**
3	**TECHNICAL ASSISTANCE FOR BLACK/AA LED PROVIDERS TO PROVIDE A MORE EQUITABLE PLAYING FIELD TO SUCCESSFULLY COMPETE FOR SOLICITATIONS** *Identify 5-10 agencies (preferably agencies who have not been previously awarded DHSP contracts) who would benefit from DHSP/County Technical Assistance (TA) support in competing for solicitations.* *Develop 3-5 TA recommendations Black/AA led orgs need to compete for solicitations, i.e.:* *- create an incubation period for orgs in which DHSP could provide special TA until they are able to function fully* *- provide grant writing services*	General Rec #9	**11.10.21:** Leads met to discuss the preliminary work needing to be performed before a TA/mentorship pairing program can be developed by DHSP. DHSP agreed to develop a needs assessment for potential Black led/servicing orgs to assess their needs, gaps, and barriers in applying for and successfully performing under DHSP/County contracts. Leads/Workgroup to provide list of orgs, to include: Dr. William King, Umma Community Clinic, Black Women for Wellness, Invisible Men, & Unique Women's Coalition	**12.2.21:** *Create a cohort model for the Needs Assessment & TA program.* *Workgroup to finalize list of Black led/servicing orgs that would benefit from a needs assessment. Final list to be submitted to DHSP.* *Workgroup to review DHSP 2020 Surveillance Report to identify specific examples/suggestions for increased HIV disparity data which would allow agencies to successfully compete for RFPs by having surveillance data accurately reflected for certain populations, i.e. transgender community, Asian, Native Hawaiian and Pacific Islander American communities, etc. I.e. Add additional Race/Ethnicity breakdowns by Gender, transmission categories, and age groups (D. Lee).* *Coordinate mtg w/ DHSP incl. Dr. Andrea Kim to determine ways to reformat surveillance data according to race/ethnicity breakdowns by gender, etc., prioritizing the transgender community.*

	TASKS	CORRESPONDING BAAC TF RECOMMENDATION(S)	STATUS	UPDATES+NEXT STEPS
4	**ESTABLISHMENT OF PREP CENTERS OF EXCELLENCE FOR WOMENOF COLOR** *Develop 3-4 attributes agencies should possess that should be included in RFP language re: women-centered services and/or PrEP Centers of Excellence (for Women).*	Women & Girls Rec #2	**11.22.21** D. Campbell submitted recommendations to P. Zamudio; see 11/22/21 email for details.	**12.2.21**: Paulina Zamudio (DHSP) working with contracted agencies to make updates to RFP scope of work. RFP to be released soon; services will be funded effective July 1, 2022.

Status Neutral HIV Prevention and Care

People whose HIV tests are negative are offered powerful prevention tools like PrEP, condoms, harm reduction (e.g. SSPs), and supportive services to stay HIV negative.



People whose HIV tests are positive enter primary care and are offered effective treatment and supportive services to achieve and maintain viral suppression.

Follow CDC guidelines to test people for HIV. Regardless of HIV status, quality care is the foundation of HIV prevention and effective treatment. Both pathways provide people with the tools they need to stay healthy and stop HIV.