LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Virtual Meeting

Tuesday, May 18, 2021

1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission website at:

http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

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**Link is for non-Committee members only*

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PUBLIC COMMENTS

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

TUESDAY, MAY 18, 2021|1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/ys6ah8e7
**Link is for non-committee members only*

To Join by Phone: 1-415-655-0001
Access code: 145 875 4307

Planning, Priorities and Allocations Committee Members:			
Raquel Cataldo, Co-Chair	Frankie Darling Palacios, Co-Chair	Alexander Luckie Fuller	Everardo Alvizo, LCSW
Al Ballesteros, MBA	Kevin Donnelly	Felipe Gonzalez	Joseph Green
Karl T. Halfman, MS	Damontae Hack, Alternate	William King, MD, JD (LOA*)	Miguel Martinez, MPH, MSW
Anthony M. Mills, MD	Derek Murray	LaShonda Spencer, MD	Maribel Ulloa
Guadalupe Velasquez	DHSP Staff		
QUORUM:	9		

AGENDA POSTED May 13, 2021 * Leave of Absence

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

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

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Comisión en HIV al (213) 738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 horas antes de la junta.

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

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting

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

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

Call to Order | Introductions | Statement – Conflict of Interest 1:00 P.M. – 1:02 P.M.

I. ADMINISTRATIVE MATTERS 1:02 P.M. – 1:04 P.M.

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:04 P.M – 1:06 P.M.

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

III. COMMITTEE NEW BUSINESS 1:06 P.M. – 1:10 P.M.

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

IV. REPORTS 1:10 P.M. – 1:20 P.M.

5. **EXECUTIVE DIRECTOR'S/STAFF REPORT**

a. Commission and Committee Updates
b. Ending the HIV Epidemic Activities

6. **CO-CHAIR REPORT** 1:20 P.M. – 1:35 P.M.

a. "So, You Want to Talk about Race" by I. Oluo Reading Activity
Excerpts only from Chapters 4 **or** 5

7. **DIVISION OF HIV AND STD PROGRAMS (DHSP)** 1:35 P.M. – 1:45 P.M.

a. Fiscal and Programmatic Update

i. PY 31 (FY 2021) Revised Allocation **MOTION #3**

b. Contracts and Procurement Update

8. **PREVENTION PLANNING WORKGROUP** 1:45 P.M. – 2:10 P.M.

a. Update from April Meeting

b. Challenges, Workgroup Feedback and Timeline, Committee Expectations

9. **V. DISCUSSION** 2:10 P.M. – 2:55 P.M.

a. Housing Opportunities for Person with AIDS (HOPWA) – Special Projects of National Significance (SPNS) Grant

b. Paradigms and Operating Values Readability

c. DHSP Directives PY 30, 31, & 32

10. **VI. NEXT STEPS** 2:55 P.M. – 2:58 P.M.

a. Task/Assignments Recap

b. Agenda Development for the Next Meeting

11. **VII. ANNOUNCEMENTS** 2:58 P.M. – 3:00 P.M.

a. Opportunity for Members of the Public and the Committee to Make Announcements

12. **VIII. ADJOURNMENT** 3:00 P.M.

a . Adjournment for the Meeting of May 18, 2021.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	**Approve the Agenda Order, as presented or revised.**
MOTION #2:	**Approve Meeting Minutes as presented.**
MOTION #3:	**Approve PY 31 Revised Allocation, as presented or revised.**

DRAFT

LOS ANGELES COUNTY
COMMISSION ON HIV

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

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.
Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
MEETING MINUTES

April 20, 2021

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Raquel Cataldo, Co-Chair	P	Karl T. Halfman, MS	P
Frankie Darling Palacios, Co-Chair	A	Damontae Hack, Alternate	A
Alexander Luckie Fuller	A	William King, MD, JD (Leave of Absence)	EA
Everardo Alvizo, LCSW	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA	A	Anthony M. Mills, MD	P
Kevin Donnelly	P	Derek Murray	P
Felipe Gonzalez	P	LaShonda Spencer, MD	P
Joseph Green	EA	Maribel Ulloa	P
Michael Green, PhD, MHSA	P	Guadalupe Velasquez	A
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit and Carolyn Echols-Watson Catherine LaPointe, Academic Intern			
DHSP STAFF			
Pamela Ogata, Victor Scott, and Jane Bowers			

*

Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website at
http://hiv.lacounty.gov/Portals/HIV/Commission%20Meetings/2021/Packet/PPAVrtMtg%20-Final%20Packet%20042021-merged%20File-updated.pdf?ver=VbkPLeG97uWyvQGW0Mc1FA%3d%3d

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

I. ADMINISTRATIVE MATTERS

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

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approve the Planning, Priorities and Allocations Committee Meeting Minutes, as presented ***(Passed by Consensus)***.

II. PUBLIC COMMENT

3. OPPORTUNITY FOR PUBLIC TO ADDRESS COMMISSION ON ITEMS OF INTEREST WITHIN COMMISSION JURISDICTION: There were no comments.

III. COMMITTEE NEW BUSINESS ITEMS

OPPORTUNITY FOR COMMISSIONERS TO RECOMMEND ITEMS FOR FUTURE AGENDAS, OR ITEMSREQUIRING IMMEDIATE ACTION DUE TO AN EMERGENCY, OR IF NEED FOR ACTION AROSE AFTER POSTING AGENDA:

Maribel Ulloa, on behalf of Housing Opportunities for Persons with AIDS (HOPWA) Program, requested Committee feedback and ideas on Special Projects of National Significance grant (SPNS) offered through the Department of Housing and Urban Development (HUD). HOPWA is submitting grant application(s).

- The SPNS will be on the May 18, 2021 PP&A agenda.

IV. REPORTS

4. EXECUTIVE DIRECTOR/STAFF REPORT

a. Commission and Committee Updates

- Cheryl Barrit, Executive Director reported on the following issues.
  The Health HIV survey was completed with an 80% response rate. The results will be presented at the May Commission meeting and will include responses from the key informant interviews.

  The Standards and Best Practices Committee (SBP) are reviewing Substance Use and Residential Treatment standards. It was noted, SBP is informed by PP&A service priorities and allocations recommendations and standards inform DHSP in preparing Request for Proposals (RFP).

  DHSP reported to SBP the results of their childcare and language surveys. These results will be presented at the Commission's May 2021 meeting. It was noted, the County of Los Angeles, County Counsel will only support licensed childcare services.

  Laurie Aranoff will present on needs assessment for legal services at the consumer caucus. She looking to ensure a strong provider and consumer response to the survey.

  It was asked if there was a standard for the use of Long Acting Injectables (LAI). It was pointed out standards are written for Ryan White service categories.
  - However, the question would be taken back to SBP.

  The Service Standards Revision Date Tracker was reviewed. The tracker includes approved standards and standards revision dates. DHSP included current program funding and contract expiration dates.

b. Ending the HIV Epidemic Activities

It was recommended the DHSP EHE plan be a standing item on the PP&A agenda for the purpose of discussing Committee activities that advance the goals of the DHSP EHE plan and synchronize efforts between the DHSP EHE Steering Committee and the Commission.

- EHE will become a standing item on the PP&A agenda.

5. CO-CHAIR REPORT

a. "So, You Want to Talk About Race?" Book Reading Activity. Alasdair Burton read Chapter 3 beginning at Page 45.

6. DIVISION OF HIV AND STD PROGRAMS (DHSP) REPORT

a. Fiscal Updates

DHSP reviewed Program Year (PY) 30 preliminary expenditure report. Expenditures are anticipated to exceed PY 30 allocations by $1.7 million. DHSP is anticipating additional invoices for February 2021 expenditures before finalizing the PY 30 fiscal report. The County of Los Angeles closes their fiscal year June 30, 2021 and that will impact the completion of the fiscal report. The final report for PY30 expenditures is anticipated in August 2021.

b. Contracts and Procurement Update

There were no contract or procurement updates.

7. PREVENTION PLANNING WORKGROUP

a. Maribel Ulloa reminded the Committee of the Prevention Planning Workgroup (PPW) meeting scheduled for April 28, 2021 from 5:30PM to 7:00PM. DHSP is scheduled to provide prevention program information. Committee members were encouraged to attend.

V. DISCUSSION

b. Paradigms and Operating Values

The Committee reviewed and discussed Paradigms and Operating Values. The following recommendations were made.

- Reverse the order of Compassion and Equity within the Paradigm (decision making) values. (Equity will be the leading value supported by compassion.)
- As part of Operating Values, it was recommended the definition for "Humility" should be modified to read as follows "…. and **willingness** to listen carefully to others."
- The Committee discussed the readability of Paradigms and Operating Values. It was noted the word Paradigms provide a barrier to understanding because it is not a commonly used word. The language used can provide barriers to those the Commission is charged to serve. It was noted, language should be plain and unintimidating.

- The Committee committed to a workgroup to modify readability of values expressed in the Paradigm and Operating Values.

b. Multi-Year Allocations Review

The Committee reviewed approved allocations for PY 30, 31, & 32 as part of the DHSP Directives review.

c. DHSP Directives PY 30, 31, & 32

The Committee discussed Directives and asked about the benefits of multi-year planning. It was noted, DHSP contract and allocation efforts uses Commission service standards when preparing Request for Proposals (RFP)s. However, due to COVID-19, staff responsible for contract preparation and execution are re-assigned. This has slowed contracting efforts.

The Committee recommended the Consumer Caucus are kept informed and encourage to participate in the planning process.

- The Paradigms and Operating Values, multi-year allocations and DHSP PY 30,31 & 32 Directives will be shared with the Consumer Caucus.
- Engage the Consumer Caucus to encourage active decision making within the planning process by providing ongoing training.
- Committee members are requested to read DHSP Directives to prepare for a conversation at the May 18, 2021 meeting.

V. NEXT STEPS

8. TASK/ASSIGNMENTS RECAP:
There were no additional tasks.

9. AGENDA DEVELOPMENT FOR NEXT MEETING: There were no additional items.

VI. ANNOUNCEMENTS

- Catherine La Pointe, Student Intern announced an upcoming National Youth HIV/AIDS Awareness Day (NYHAAD) Youth/Young Adult Panel Presentation. The event will include HIV 101, statistics and a question and answer with a youth panel. The event is scheduled for Thursday, April 29, 2021 from 5:00PM to 6:30PM.
- The Aging Task Force is hosting Age Sensitivity Training: Trading Ages. It is scheduled for May 6, 2021 from 11:00AM to 1:00PM.

10. OPPORTUNITY FOR PUBLIC AND COMMITTEE TO MAKE ANNOUNCEMENTS: There were none.

VII. ADJOURNMENT

11. ADJOURNMENT: The meeting adjourned at approximately 2:46 pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 4/27/21

The following list identifies "conflicts-of-interest" for Commission members who represent agencies with Part A/B –and/or CDC HIV Prevention-funded service contracts with the County of Los Angeles. According to Ryan White legislation, HRSA guidance and Commission policy, Commission members are required to state their "conflicts-of-interest" prior to priority- and allocation-setting and other fiscal matters concerning the local HIV continuum of care, and to recuse themselves from discussions involving specific service categories for which their organizations have service contracts.

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
ALVIZO	**Everardo**	Long Beach Health & Human Services	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
BALLESTEROS	**Al**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis, and Treatment
			Health Education/Risk Reduction (HERR)
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
BURTON	**Alasdair**	No Affiliation	No Ryan White or prevention contracts
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CATALDO	**Raquel**	Tarzana Treatment Center	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Case Management, Home-Based
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Mental Health
			Substance Abuse, Transitional Housing (meth)
			Transitional Case Management-Jails
			Transportation Services
COFFEY	**Pamela**	Unaffiliated consumer	No Ryan White or prevention contracts
DANIELS	**Michele**	Unaffiliated consumer	No Ryan White or prevention contracts
DARLING-PALACIOS	**Frankie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
FULLER	**Luckie**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testng Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
GARTH	**Gerald**	AMAAD Institute	No Ryan White or Prevention Contracts
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GRANADOS	**Grissel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management-Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HACK	**Damontae**	Unaffiliated consumer	No Ryan White or prevention contracts
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KAMURIGI	**Nestor**	No Affiliation	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
LEE	**David**	Charles R. Drew University of Medicine and Science	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
PRECIADO	**Juan**	Northeast Valley Health Corporation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Oral Healthcare Services
			Mental Health
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
			Transportation Services
RAY	**Joshua**	Unaffiliated consumer	No Ryan White or prevention contracts
RODRIGUEZ	**Isabella**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
SPEARS	**Tony**	Capitol Drugs	No Ryan White or prevention contracts
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
STEVENS	**Reba**	No Affiliation	No Ryan White or prevention contracts
ULLOA	**Maribel**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
VALERO	**Justin**	California State University, San Bernardino	No Ryan White or prevention contracts
VELAZQUEZ	**Guadalupe**	Unaffiliated consumer	No Ryan White or prevention contracts
WALKER	**Kayla**	No Affiliation	No Ryan White or prevention contracts
WALKER	**Ernest**	Men's Health Foundation	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
WILSON	**Amiya**	Unique Women's Coalition	No Ryan White or prevention contracts

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CODE OF CONDUCT

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

All participants and stakeholders should adhere to the following:

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

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

COUNTY OF LOS ANGELES
Public Health

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

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

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Director, Disease Control Bureau

MARIO J. PÉREZ, M.P.H.
Director, Division of HIV and STD Programs
600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005
TEL (213) 351-8001 • FAX (213) 387-0912

www.publichealth.lacounty.gov

May 12, 2021

TO: Planning, Priorities and Allocation Committee

FROM: Michael Green, Ph.D., MHSA
Chief of Planning, Development and Research

SUBJECT: RYAN WHITE HIV/AIDS PROGRAM PART A and MAI FISCAL YEAR 2021 RECOMMENDED ALLOCATIONS

The Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP) drafted fiscal year (FY) 2021 recommended allocations for Ryan White HIV/AIDS Program (RWP) Part A and MAI for your review and approval. Every year, DHSP and the Commission must submit an allocation table and letter from the Commission to HRSA that reflects any changes from what was submitted with the application. The FY 2021 recommended allocation table references the FY 2021 allocations that were agreed upon by PP&A in 2020, prior to the HRSA Part A application submission, as well as the recommended FY 2021 allocations based on programmatic changes discussed since the application submission. Some contextual factors include:

1. In FY 2020 the Linkage and Re-engagement Program (LRP) was supported by HRSA Part A under Outreach Services, but we recommend shifting these services to HRSA's Ending the HIV Epidemic (EHE) grant. **The LRP is uniquely aligned with HRSA's EHE grant's goals and vision,** and other HRSA EHE programmatic activities also contribute to the LRP.
2. **In FY 2020 HIV testing by DHSP community workers was supported by HRSA Part A under Early Intervention Services (EIS), but the majority of HIV Testing Services is supported by a CDC grant.** Data reporting will be simplified if LRP and EIS are supported by grants other than RWP Part A and MAI.
3. Projected FY 2020 Part A and MAI expenditures show that expenditures for all contracted services exceed the grant award. Transferring LRP and EIS to another grant will assist DHSP in maximizing other grant awards.

Because we recommend transferring LRP and EIS to other grants, the allocation percentages need to be revised for the remaining service categories under RWP HRSA Part A and MAI. Therefore, we have made recommended allocations changes to compensate.

DHSP is requesting your approval on the FY 2021 Recommended Allocation Table. If you have any questions or need additional information, please contact me at mgreen@ph.lacounty.gov, or Pamela Ogata at pogata@ph.lacounty.gov. Thank you.

DRAFT

	Service Category	FY 2021 HRSA Application Allocations		FY 2021 HRSA Recommended Allocations	
		Part A %	MAI %	Part A %	MAI %
CORE SERVICES (77.4%)	Outpatient/Ambulatory Health Services	27.26%	0.00%	26.38%	0.00%
	AIDS Drug Assistance Program (ADAP) Treatments	0.00%	0.00%	0.00%	0.00%
	AIDS Pharmaceutical Assistance (local)	0.00%	0.00%	0.00%	0.00%
	Oral Health	14.10%	0.00%	15.10%	0.00%
	Early Intervention Services	0.59%	0.00%	0.00%	0.00%
	Health Insurance Premium & Cost Sharing Assistance	0.00%	0.00%	0.00%	0.00%
	Home Health Care	0.00%	0.00%	0.00%	0.00%
	Home and Community Based Health Services	6.67%	0.00%	7.67%	0.00%
	Hospice Services	0.00%	0.00%	0.00%	0.00%
	Mental Health Services	0.60%	0.00%	0.75%	0.00%
	Medical Nutritional Therapy	0.00%	0.00%	0.00%	0.00%
	Medical Case Management (MCC)	29.88%	0.00%	34.69%	0.00%
	Substance Abuse Services Outpatient	0.00%	0.00%	0.000%	0.00%
SUPPORT SERVICES (22.6%)	Case Management (Non-Medical) BSS/TCM	5.92%	6.14%	3.81%	9.25%
	Child Care Services	0.00%	0.00%	0.00%	0.00%
	Emergency Financial Assistance	0.00%	0.00%	0.00%	0.00%
	Food Bank/Home-delivered Meals	5.95%	0.00%	7.95%	0.00%
	Health Education/Risk Reduction	0.00%	0.00%	0.00%	0.00%
	Housing Services RCFCI/TRCF/Rental Subsidies with CM	1.42%	93.86%	1.15%	90.75%
	Legal Services	0.16%	0.00%	0.25%	0.00%
	Linguistic Services	0.00%	0.00%	0.00%	0.00%
	Medical Transportation	1.88%	0.00%	2.25%	0.00%
	Outreach Services (LRP)	5.57%	0.00%	0.00%	0.00%
	Psychosocial Support Services	0.00%	0.00%	0.00%	0.00%
	Referral	0.00%	0.00%	0.00%	0.00%
	Rehabilitation	0.00%	0.00%	0.00%	0.00%
	Respite Care	0.00%	0.00%	0.00%	0.00%
	Substance Abuse Residential	0.00%	0.00%	0.00%	0.00%
	Treatment Adherence Counseling	0.00%	0.00%	0.00%	0.00%

Grant	FY 2020 Award	Estimated FY 2020 Expenditures	FY 2021 Award	Funding Restrictions
CDC EHE (PS 20-2010) (August 1 - July 31)	$ 3,360,658	$ 708,010	$ 3,360,658	Cannot use funds for construction, purchase of needles or medication, research, advocacy and lobbying, and staff must be on budget for at least 50%
CDC IHSPP (PS18-1802) Component A - Surveillance (January 1 - December 31)	$ 2,561,928	$ 1,526,287	$ 2,561,928	Cannot use funds for construction, purchase of needles or medication, research, or advocacy and lobbying
CDC IHSPP (PS18-1802) Component A - Prevention (January 1 - December 31)	$ 15,388,167	$ 13,795,454	$ 15,388,167	Cannot use funds for construction, purchase of needles or medication, research, or advocacy and lobbying
CDC STD PCHD (PS19-1901) (January 1 - December 31)	$ 3,266,404	$ 3,040,656	$ 3,324,265	Cannot use funds for construction, advocacy or lobbying
CDC NHBS (January 1 - December 31)	$ 699,495	$ 459,476	$ 489,303	Cannot use funds for construction, purchase of needles or medication, advocacy, or lobbying
SAPC (Non-DMC) (July 1 - June 30)	$ 4,449,000	$ 3,254,011	$ 3,249,000	Cannot be used for non-substance use/abuse related services, advocacy, or lobbying
CA DPH STD Management and Collaboration Project (July 1 - June 30)	$ 497,400	$ 78,394	$ 497,400	Funds must be used to implement evidence-based public health activities with an emphasis on the prevention and control of infectious syphilis, congenital syphilis, gonorrhea, and chlamydia trachomatis infection
CA DPH STD General Funds (July 1 - June 30)	$ 547,050	TBD	$ 547,050	Funds must be used to implement public health activities to monitor, investigate, and prevent sexually transmitted diseases (STD). 50% of funds are required to be used to implement activities in conjunction with community based organizations (CBO).
HIV NCC (July 1 - June 30)	$ 18,340,000	TBD	TBD	

HIV and or STD Prevention Activity	Approximate FY 2020 Funding	Funding Source(s)
HIV Counseling, Testing, and Referral Services	$9,377,000	CDC Integrated HIV Surveillance and Prevention Program (IHSPP) Component A, HIV NCC
Storefront, healthcare settings, social and sexual networks, and HIV testing with syphilis screening		
STD Testing and Screening Services (Category 1 and 2)	$6,590,000	CA DPH STD Management and Collaboration Project, CDC Strengthening STD Prevention and Control for Health Departments (STD PCHD), Tobacco Settlement Funds, Infectious Disease Funds
STD testing and screening and sexual health express clinics		
Home HIV Self-test Kits	$888,000	CDC Ending the HIV Epidemic
HIV test kits provided through DHSP pilot program targeted to substance use treatment and resource centers, PrEP sites, and partner services. At-home HIV test kits provided through the National Association of State and Territorial AIDS Directors (NASTAD) "Take Me Home" at-home testing program.		
Health Education/Risk Reduction Services	$3,500,000	CDC IHSPP, HIV NCC
Outreach encounters that assist in providing client-centered linked referrals to HIV and STD testing services and PrEP and individual or group-level education services		
Vulnerable Populations	$5,700,000	CDC IHSPP, CDC STD PCHD, HIV NCC, STD NCC
HIV and STD prevention services to African American and Latino YMSM and transgender individuals in the central and south areas of Los Angeles County		
HIV Biomedical Prevention	$2,400,000	Non Drug Medical (Non DMC), HIV NCC
Biomedical HIV Prevention Navigation Services aimed at recruiting, linking and retaining in care those at highest risk for contracting and/or transmitting HIV.		
Comprehensive HIV and STD Testing in the City of Long Beach	$1,200,000	STD NCC, CDC IHSPP Component A
Comprehensive HIV and STD testing and STD treatment services in Long Beach to reduce HIV and STD transmission. Funding amount only represents one FY 2020 contract.		
National HIV Behavioral Survey (NHBS)	$490,000	CDC NHBS
Los Angeles County's participation in this four-cycle national survey (MSM, IDU, Heterosexuals, and TG). Survey findings are used for the program development, resource allocation, and ending the HIV epidemic planning		
Community-based Sexual Health Programs	$4,900,000	STD PCHD, CA DPH STD Management and Collaboration Project, STD NCC
STD testing, screening, diagnosis, treatment, and prevention services		
Social Marketing	$75,000	CA DPH STD Management and Collaboration Project
HIV/STD prevention social marketing campaign targeted for those at highest risk for HIV/STDs through the expansion of LAC's condom distribution program		
CT/GC Medication	$92,000	CA DPH STD General Funds
Patient delivered partner therapy medication distribution		
Rapid Syphilis Test Kits	$97,028	CA DPH STD Management and Collaboration Project
Point-of-care testing of persons at risk for syphilis in settings where routine clinical follow up of laboratory testing may not be possible		

LOS ANGELES COUNTY
COMMISSION ON HIV

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

October 9, 2020

To: Mario J. Perez, Director of HIV and STD Programs (DHSP), Department of Public Health

From: Alvaro Ballesteros and Bridget Gordon, Co-Chairs, Commission on HIV

Re: Program Directives for Maximizing Ryan White Part A and MAI Funds for Program Years 30, 31, 32

In keeping with the Commission on HIV's commitment to engage in multi-year priority setting and resource allocation planning for the next three years, the PP&A Committee has developed a set of program directives for program years (PY) 30, 31, and 32. The multi-year service rankings and allocations aim to assist DHSP in your programmatic planning and initiating the solicitations process so that services are in place by the start of the upcoming Ryan White program years.

Part A Planning Councils are required to "establish priorities for the allocation of funds within the eligible area, including how best to meet each such priority and additional factors that a Recipient should consider in allocating funds under a grant based on numerous factors including: "size and demographics of the population of individuals with HIV disease;" "priorities of the communities with HIV disease;" and "capacity development needs resulting from disparities in the availability of HIV-related services in historically underserved communities."

Along with service priorities, the Planning Council (i.e., Commission on HIV) gives the Recipient (i.e., Division of HIV and STD Programs) directives for how to best meet the priorities. Directives are instructions that the Recipient must follow in developing requirements for providers for use in procurement and contracting. While the Planning Council has no involvement in the procurement process, it is responsible for providing guidance on service models or strategies, population priorities, and methods for overcoming barriers to care. (Mosaica for the HRSA/HAB TAC – 2007 – TARGET Center – http://careacttarget.org)
This document is a comprehensive list of program directives for the Division of HIV and STD Programs (DHSP) aimed at informing the design and implementation of HIV/STD program and service delivery in Los Angeles County (LAC). The Commission on HIV will review the document at least annually to ensure

alignment with funding, priorities, service needs and opportunities to advance the goals of ending the HIV epidemic in Los Angeles County.

Based on epidemiological data, the disproportionately impacted populations in Los Angeles County are **young MSM (YMSM), African American MSM, Latino MSM, and transgender persons**. Given the physiologic role that sexually transmitted diseases (STDs) play in HIV transmission, it is recognized that maximizing HIV prevention will require significant reduction in syphilis and gonorrhea cases, among these aforementioned groups and **women of color** (LACHAS, pg. 14).

The 2019 HIV Surveillance Report notes following areas of disparities:

- Largest gaps in awareness of HIV-positive status existed for persons aged <35 years, where over 50% of HIV-infected persons aged 13-24 years and one third of HIV-infected persons aged 25-34 years were unaware of their infection. Disparities also existed for persons who inject drugs (PWID), with over one-third of HIV-infected PWID unaware of their HIV-positive status and only 55% having been tested for HIV in the past 12 months.

- There are continued disparities in HIV diagnosis by population and geographic location. Rates of new HIV diagnosis are higher among men than women. Across age groups, young men aged 20-29 years and women aged 30- 39 years had highest HIV diagnosis rates. Black men and women had higher rates of HIV diagnosis compared with other race/ethnicity groups. Among men the highest rates of diagnoses were seen in the Central, South, and Hollywood-Wilshire Health Districts, and the highest rates for women were seen in the Central, South, and Southeast Health Districts.

- Populations with lowest achievements in linkage to care were females, Blacks, adolescents, persons aged ≥ 60 years, and persons with injection drug use (IDU) or heterosexual transmission risk. Health Districts with greatest need for interventions to improve linkage to HIV care services were Antelope Valley, El Monte, and South Health Districts where linkage rates were ≤ 70%.

- Approximately 9 in 10 people living with diagnosed HIV were on HIV treatment. Of those, 8 in 10 had adhered to their drugs in the past 3 days. Treatment coverage was lowest for Black populations and persons aged < 40 years, while adherence was lowest for younger persons aged <30 years and the Latinx population.

- Greatest disparities in viral suppression were among Black populations, females, persons aged 30-49 years, and persons whose transmission risk included injection drug use. Geographically, unsuppressed viral load was highest in the Central Health District, followed by South, Southeast, Hollywood-Wilshire, and West Health Districts.

With the unprecedented opportunity and infusion of additional resources to end the HIV epidemic in the next 10 years, we recommend that Ryan White funded services be expanded to address the unacceptable disparities in HIV health outcomes (both prevention and care) that continue to persist for African Americans, Latinos, transgender individuals and youth. Furthermore, funds released under the HRSA NOFO 20-078, should be used to overcome income

and service standards restrictions set forth under the Ryan White Part A requirements. Given the more flexible nature of the HRSA Ending the HIV Epidemic dollars, every effort should be made to fund previously prohibited items that would help achieve optimal health for PLWH. These items include but are not limited to, refrigerators for food, ability for providers to procure dental chairs, computers, and other equipment necessary to expand access to services.

It is important to note that during the Committee's service ranking deliberations, the consumers, ranked housing as their number one service need for PY 31 and 32. This speaks to the need for keeping PLWH stably housed to support their retention to care, viral suppression and overall health. Medical/outpatient care also remains a top priority for consumers.

The program directives below expand on the directives sent to DHSP on April 23, 2019:

1. Across all funding sources, prioritize investments in populations most disproportionately affected and in health districts with the highest disease burden and prevalence, where service gaps and needs are most severe.

2. Implement the recommendations developed by the Black/African Community (BAAC) Task Force (TF) which set a progressive and inclusive agenda to eliminate the disproportionate impact of HIV/AIDS/STDs in all subsets of the African American/Black diaspora. PP&A is calling special attention to the following recommendations from the BAAC TF as key priorities for RFP development, funding, and service implementation starting in 2020:

    - Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum.
    - In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women.
    - Assess available resources by health districts by order of high prevalence areas.
    - Conduct a study to identify out of care individuals, and populations who do not access local services and why they do not.
    - Fund mental health services for Black/African American women that are responsive to their needs and strengths.
    - Ear mark funds for peer support and psychosocial services for Black gay and bisexual men.
    - It is recommended that DHSP collaborate with SBP to convene subject matter experts from the African American community to ensure that mental health and psychosocial support services are culturally tailored to the needs of the community.

3. Provide Non-Medical Case Management services in non-traditional and traditional

locations to support improved service referrals and access points to Ryan White services for identified priority populations, such as young men who have sex with men (YMSM), African American men and women, Latinx communities, transgender individuals, and older adults.[1]

4. Continue to enhance Foodbank and Home Delivered Meals services to include dietary guidance, better quality foods (specifically more high quality nutrient rich fruits, vegetables and lean proteins), and increase the amount of food available for clients based on their individual needs or by gaps observed or reported by agencies and clients; cover essential non-food items such as personal hygiene products (to include feminine hygiene items), household cleaning supplies, and personal protective equipment (PPE). Permit contracted agencies to provide grocery, gas, and transportation support (e.g., Metro Tap cards, ride share services) to clients to facilitate expanded access to food.

5. Support intensive case management services for people living with HIV served in Ryan White HIV housing programs and increase target number of clients served during the reallocation process. Funds should also be used to support additional training for housing specialists to serve the housing needs of families.

6. Continue to support the expansion of medical transportation services.

7. Continue efforts to develop Ryan White client eligibility cards and welcome packets, with information on Ryan White-funded services in Los Angeles County; train providers on the use of eligibility cards to reduce paperwork burden on clients. Develop and implement eligibility cards without the need to issue a Request for Proposals (RFP) to hasten distribution of eligibility cards as stated by DHSP representatives.

8. Augment contracts to permit agencies to have an operational line item budget for childcare and transportation to facilitate consistent engagement in care and support services. This strategy would avoid releasing a stand-alone RFP for childcare and transportation and give service providers the flexibility to provide these services to all clients with children.

   Expand flexibility to provide emergency financial support for PLWH. Augment Medical Case Management/Medical Care Coordination services to include Emergency Financial Assistance (EFA) and Childcare services. Priority populations such as women and their families, YMSM and transgender women, may have unique needs for emergency financial assistance due to domestic and intimate partner, or community violence.

9. Fund mobile care teams or clinics that provide holistic care for women. Mobile teams should be available for all agencies and link women to services where they reside, congregate, or prefer to be engaged.

10. Fund psychosocial services and support groups for women. Psychosocial support services must

[1] The Aging Task Force will provide further guidance on the age parameters for "older adults."

include peer support in order to build a stronger sense of community, empowerment and resilience among women living with HIV.

In order to inform the Commission's planning efforts around HIV/STD prevention and care services, we direct DHSP to provide written fiscal reports and status updates on these directives to the PP&A Committee and full Commission on a regular basis.

In support of the recommendations from the PP&A Committee, Standards and Best Practices (SBP) will continue updating and/or developing service standards for the following service categories. These service categories were prioritized by the PP&A Committee as recommended by DHSP and because of the feasibility of releasing solicitations in 2020-2022. Status updates on the development of service standards are noted below.

1. **Universal Service Standards -**Completed; updated and approved on 9/12/19
2. **Non-Medical Case Management –** Completed; updated and approved on December 12, 2019
3. **Psychosocial Support -**in progress and on the 9/10/20 Commission agenda for approval
4. **Emergency Financial Assistance –** Completed; approved by the Commission on 6/11/20
5. **Childcare** - in progress; public comment period 9/11-9/23; target month for Commission approval is October/November

The Commission is committed to ongoing collaborations with DHSP and we seek your feedback on how we can work together to implement these directives. We thank DHSP for ongoing regular progress reports on implementing directives and efforts to maximize Ryan White funds and activities to end the HIV epidemic. Furthermore, we appreciate feedback from DHSP in updating service standards. Thank you, we appreciate the ongoing partnership and support from you and your staff.

cc: Raquel Cataldo, PP&A Co-Chair
Kevin Stalter and Erika Davies, SBP Committee Co-Chairs
Miguel Martinez and Jason Brown, 2019 PP&A Committee Co-Chairs

ATTACHMENT: Black/African American Task Force Recommendations

Attachment

(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

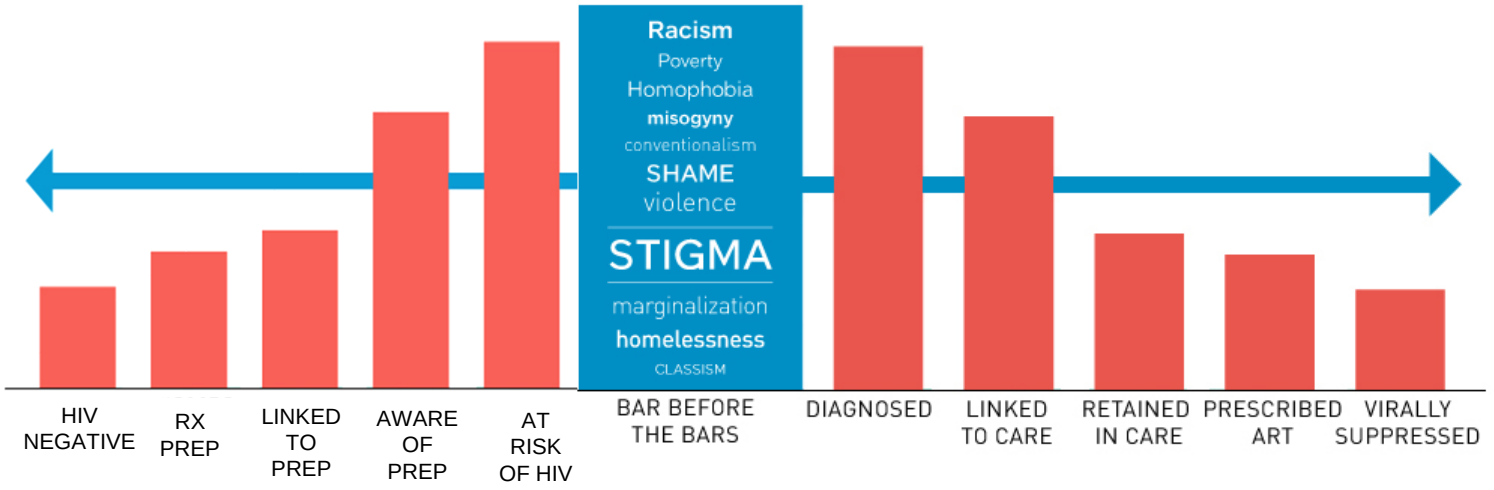
1. Census.gov/quickfacts/fact/table/losangelescountycalifornia; RH1225218
2. 2017 Annual HIV Surveillance Report; Ryan White program Clients Living with HIV YR 28 (03/01/2018 – 02/28/19)[i]
3. Los Angeles County HIV/AIDS Strategy (LACHAS) – P26; Table 5
4. Ryan White Program Clients YR 28 (3/1/18-2/28/19)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

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

Division of HIV and STD Programs
April 28, 2021

COH Prevention Workgroup
Apriil 28, 2021

Status Neutral Continuum



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

Biomedical Prevention Services

Prevention Data Sources

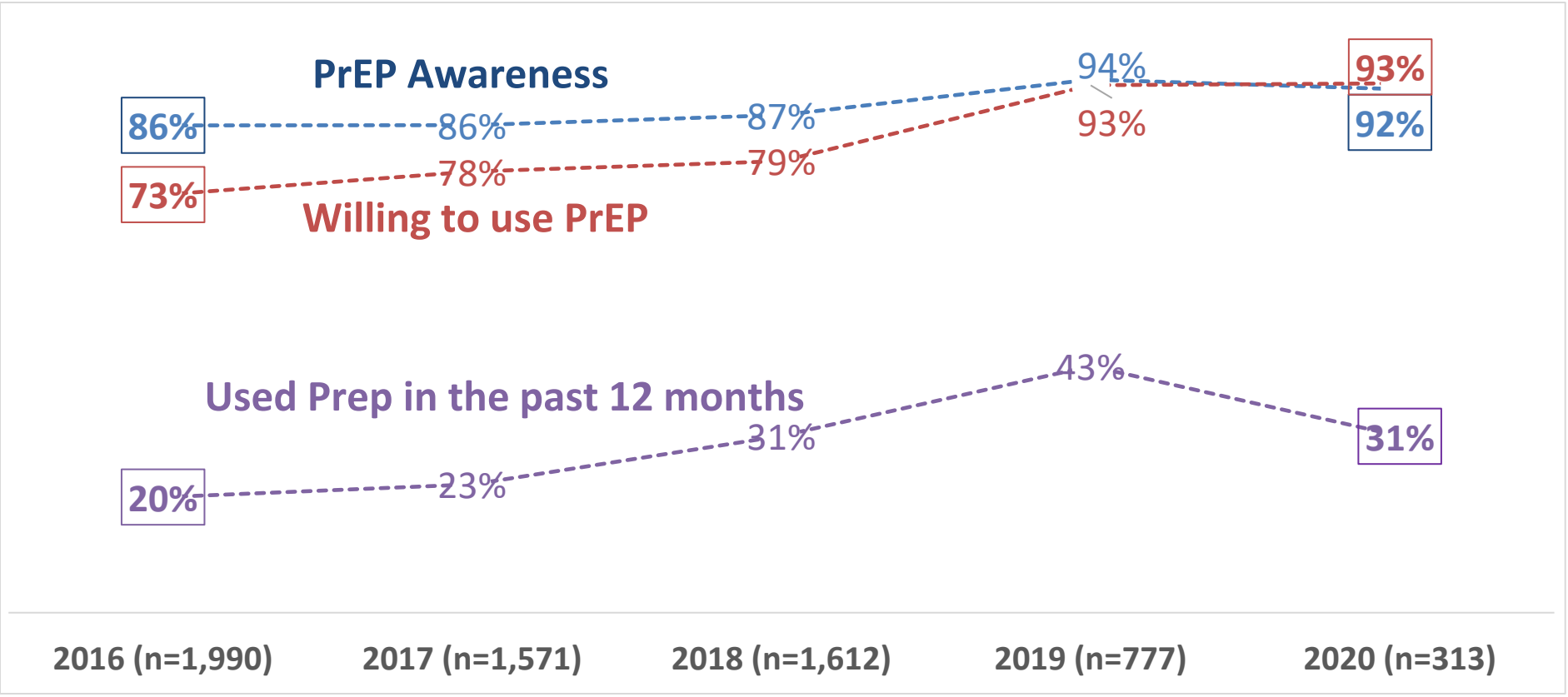
- HIV/STD Testing Services
- National HIV Behavioral Surveillance Project
- **LAC Apps-Based Survey**
- **Contacted Biomedical Services**
- Contracted HIV Education and Risk Reduction (HERR) Services
- Contracted Vulnerable Populations Services

Online PrEP Monitoring PrEP

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

Have Core PrEP Outcomes Changed in LAC?

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

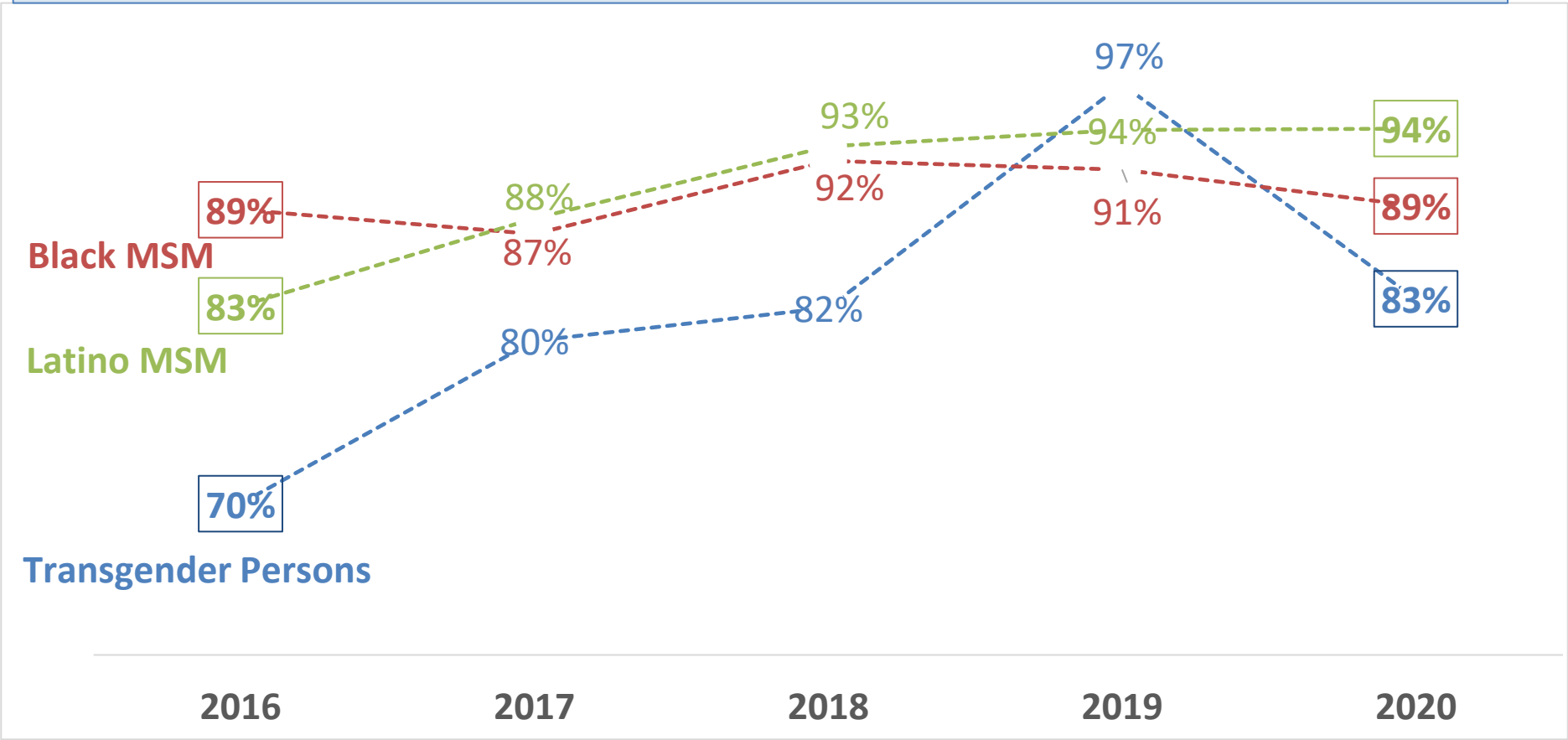


*p<0.001

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

Which Priority Groups Saw Increased PrEP Awareness?

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

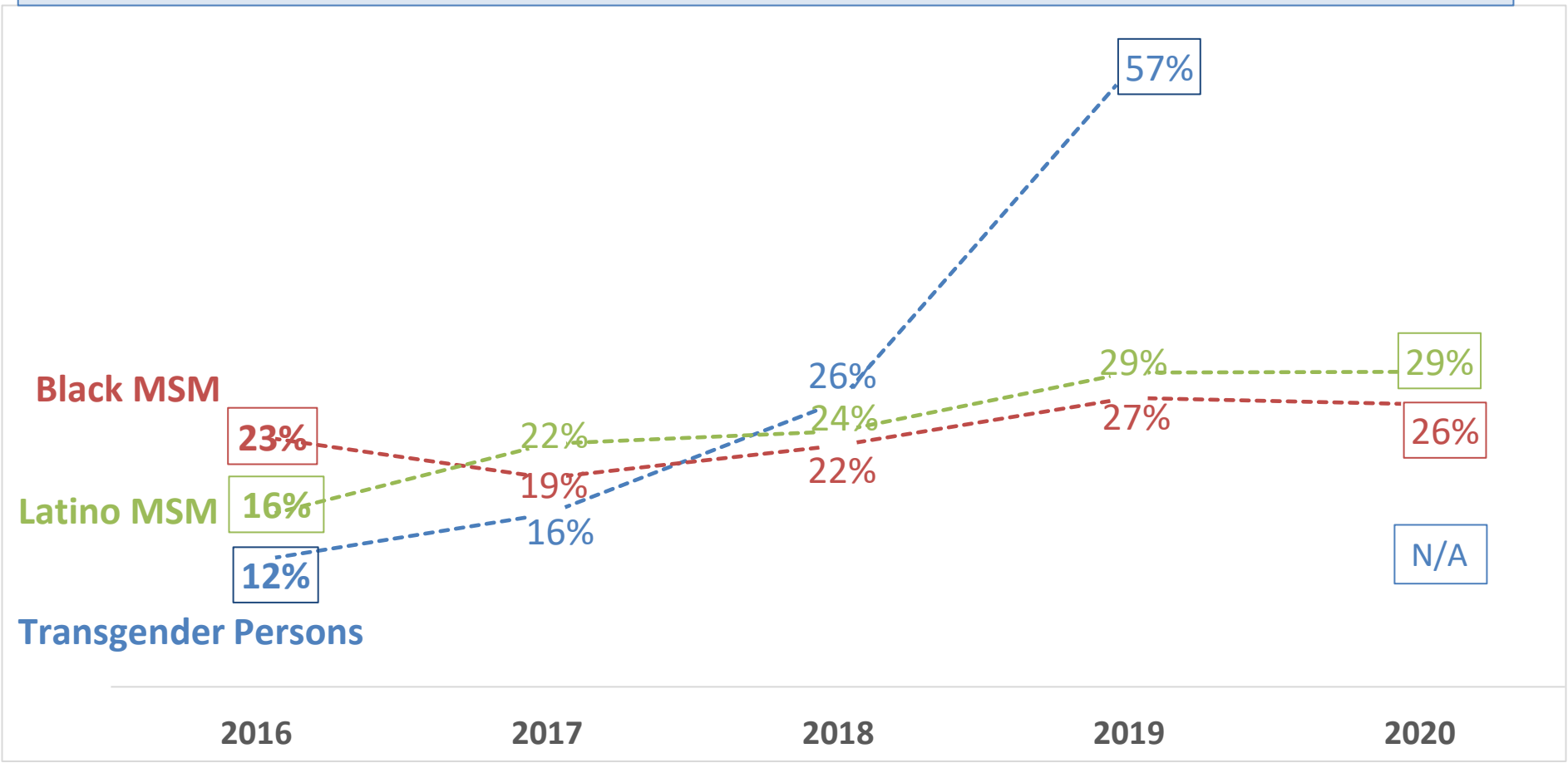


*LMSM and TGP p<0.001

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

Which Priority Groups Saw Increased PrEP Use?

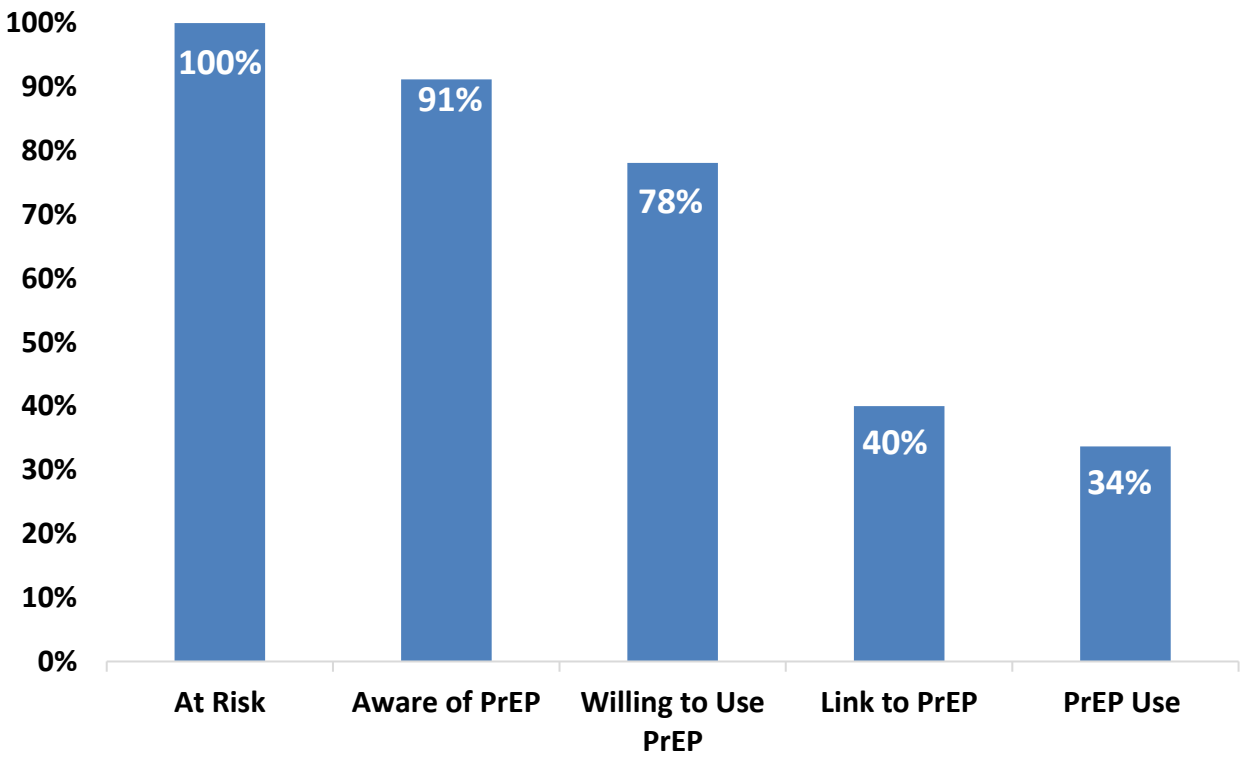
PrEP use within the past 12-month significantly increased across all groups since 2016*



*p<0.001

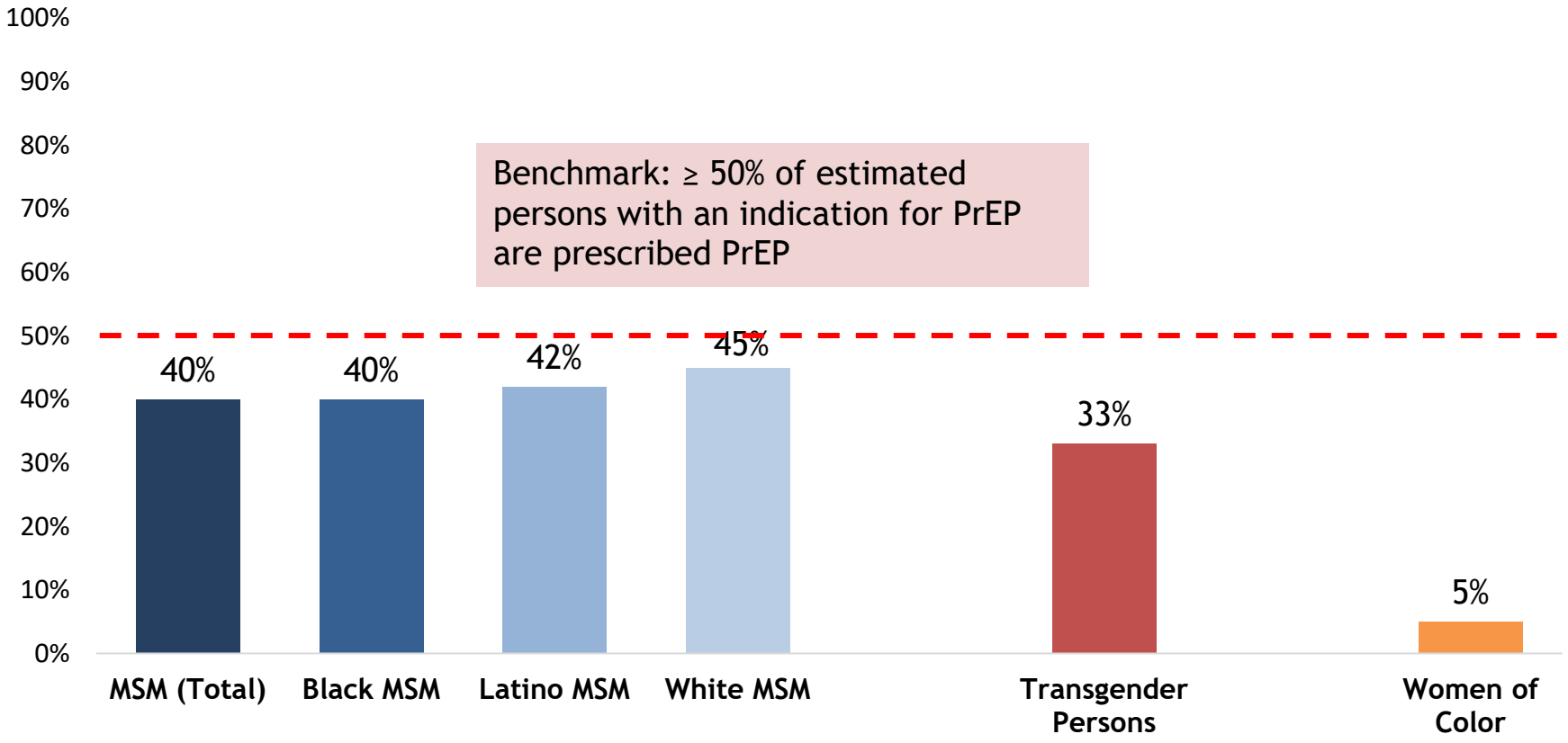
[1]Collected at baseline in April 2016 and in all follow up surveys (October 2016, February 2017, August 2017, February 2018, July 2018, December 2019, December 2020); MSM recruited via app TGP all source; TGP data for 2020 not presented due to low sample size

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



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

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

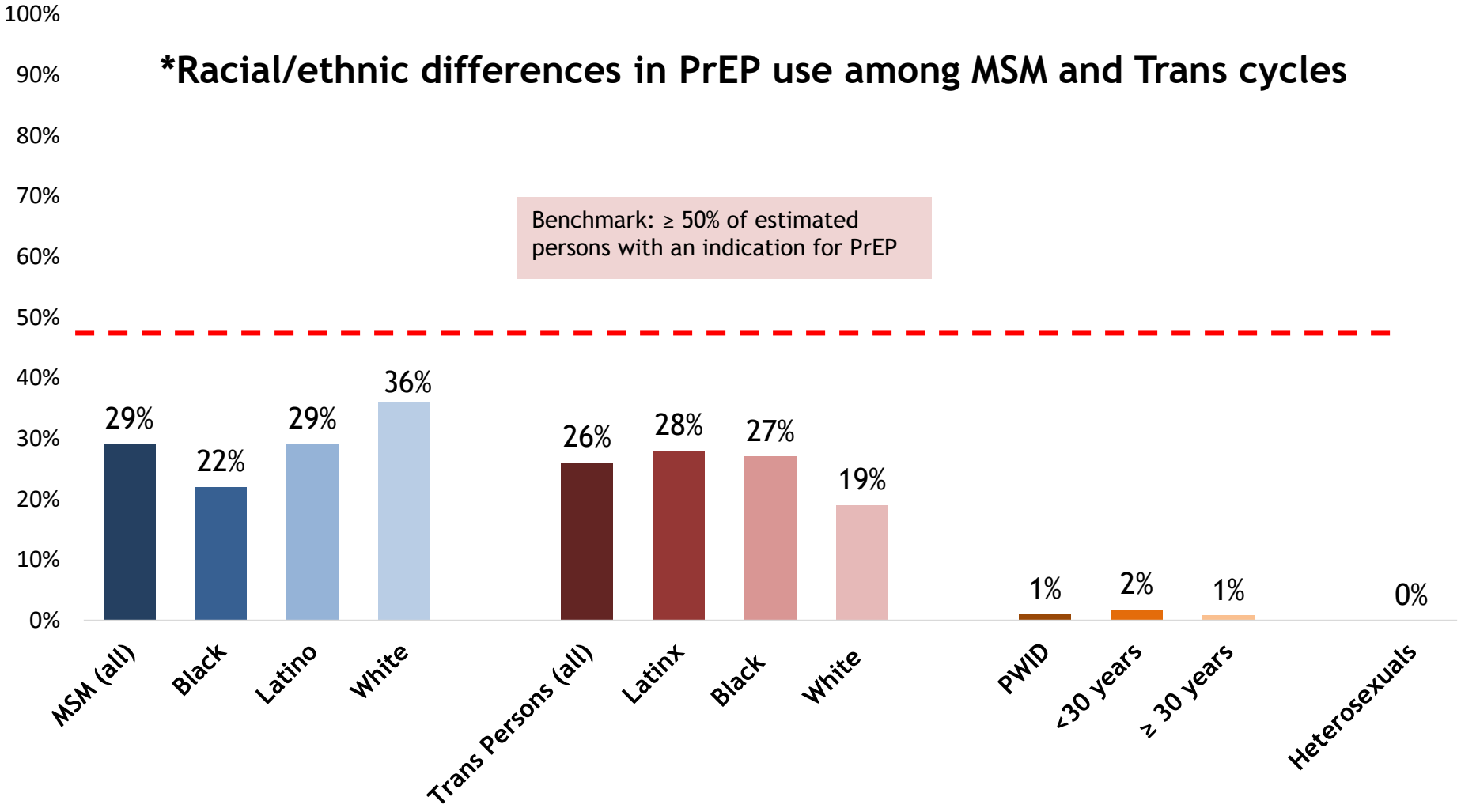


Main Sources: LAC Health Survey 2018 (MSM), NHBS (MSM, WoC), CDC PrEP Indication Calculator, DPH STD Clinics (WoC), DHSP PrEP Survey (MSM, TGP), and DHSP Partner Services (MSM, TGP, WoC)

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

*PrEP lowest among PWID and HET cycles

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



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

PrEP Centers of Excellence (COEs)

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

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

6,025 unduplicated clients prescribed PrEP

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

2,420 unduplicated clients prescribed PEP

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

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

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

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

*Biomedical Contracts began in August 2016

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

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

Clients served from August 2016-September 2018

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

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

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

*Biomedical Contracts began in August 2016

Contracted HIV and STD Testing and Screening Services

HIV Testing Data Sources

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

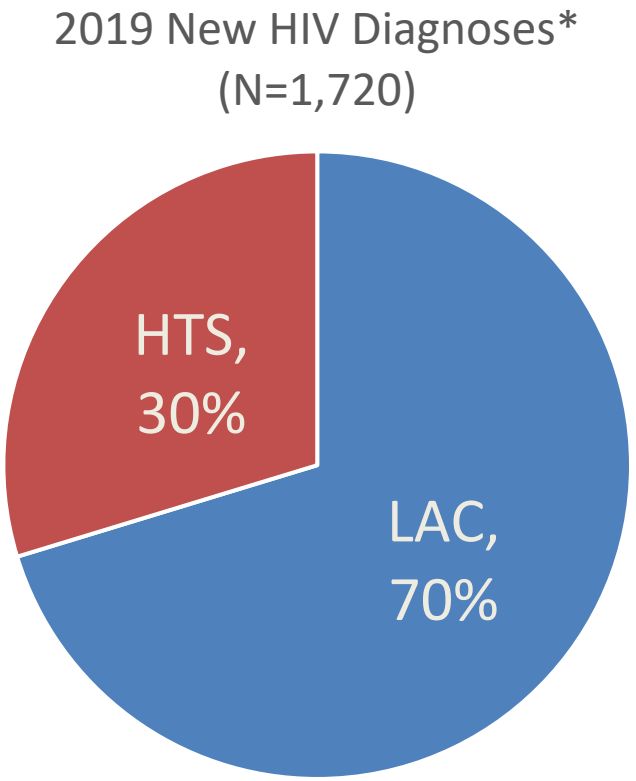
2019 HTS Measures

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

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

Scope of Contracted HIV Testing Services

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



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

Contracted HIV Testing Services, 2019

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

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

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

2019 HIV Testing Modalities by Setting

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

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

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

Contracted HIV Testing Services Settings

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

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

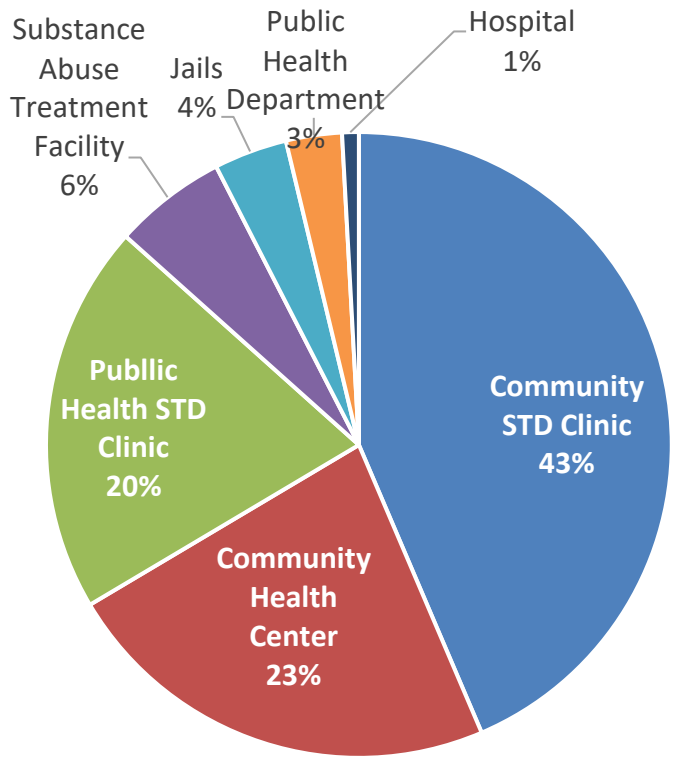
- Despite having the lowest testing volume, new positivity was highest in non-healthcare setting

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

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

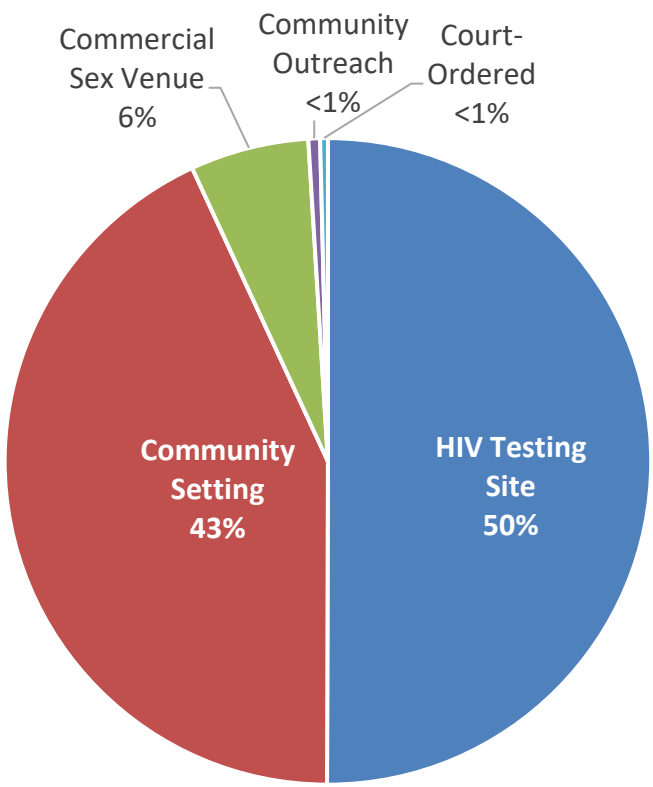
Health care settings=64,484 tests

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



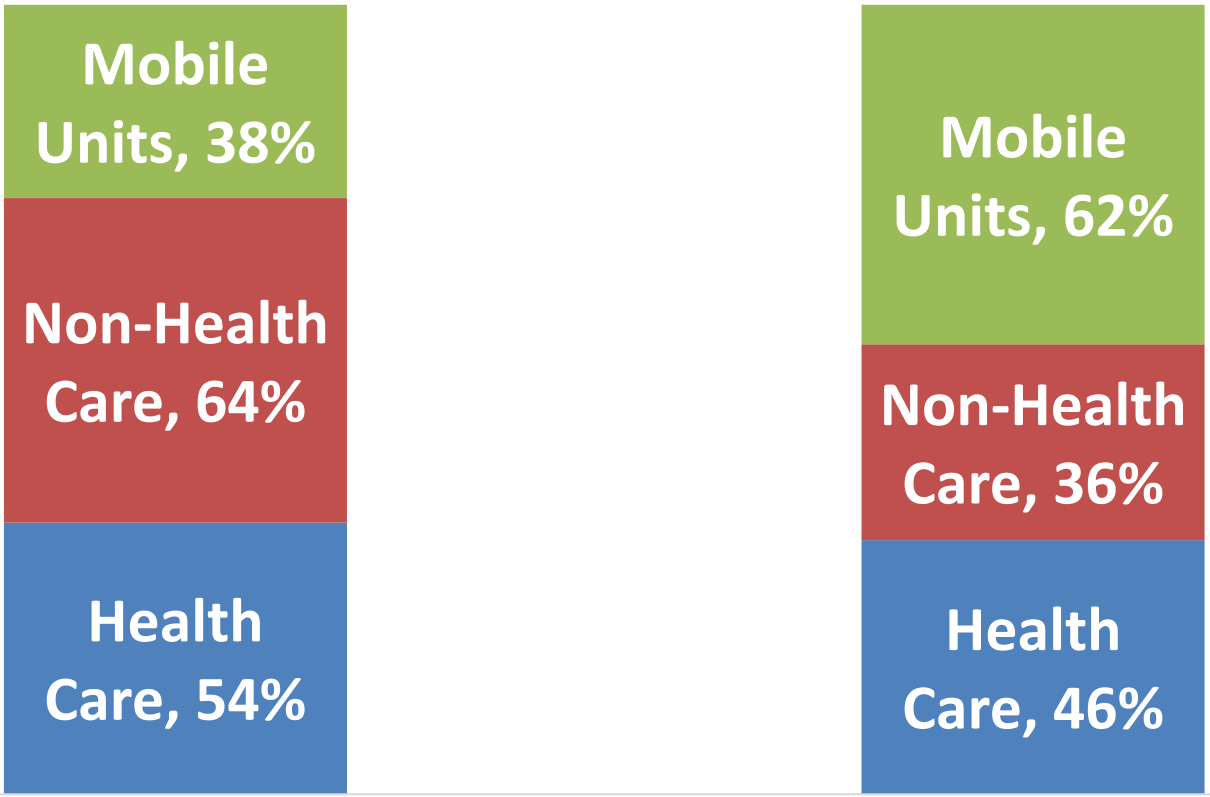
Non-healthcare settings=27,931 tests

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



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

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



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

Linkage to Care in Contracted HTS Settings

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

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

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

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

Contracted HIV Testing Outcomes by Race/Ethnicity, 2019

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

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

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

Contracted HIV Testing Outcomes by Gender Identity, 2019

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

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

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

Contracted HIV Testing Outcomes by Age, 2019

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

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

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

Contracted HIV Testing Outcomes by HIV Risk, 2019

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

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

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

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

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

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

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

Summary

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

Next Steps

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

Questions?

Wendy Garland, MPH
Chief Epidemiologist, Research and Evaluation
Planning, Development and Research, DHSP
wgarland@ph.lacounty.gov

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

Additional Resources on DHSP Website

- 2019 Annual HIV Surveillance Report

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

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

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

(excludes Long Beach and Pasadena)

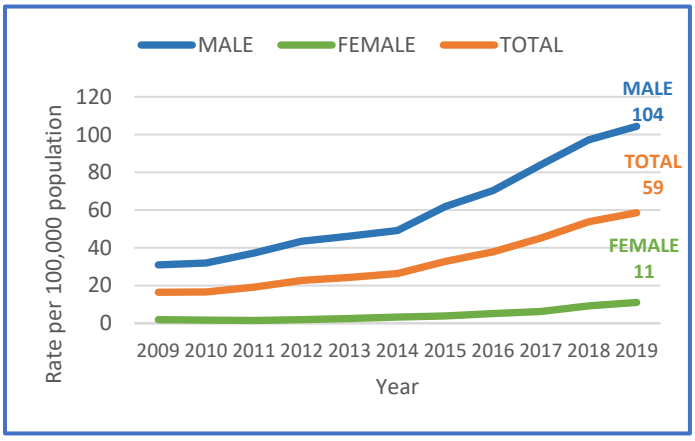
Sexually transmitted diseases (STDs) continue to rise in Los Angeles County (LAC). In 2019, there were a total of 98,427 cases of STDs reported to the LAC Department of Public Health. The majority of reported cases (66%) were chlamydia followed by gonorrhea (25%) and syphilis (9%). Sixty-five percent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

Early Syphilis

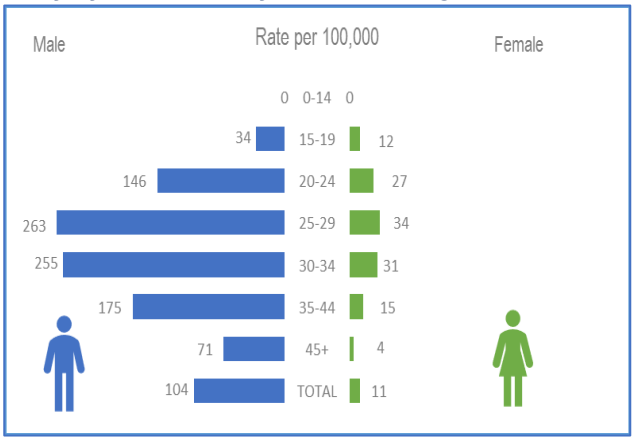
Syphilis is a sexually transmitted infection caused by the bacteria, Treponema pallidum and is a known risk factor for HIV. While it is the least prevalent of the reportable STDs, if untreated, it can cause significant health issues including damage to the brain, nerves, eyes, or heart. Early syphilis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

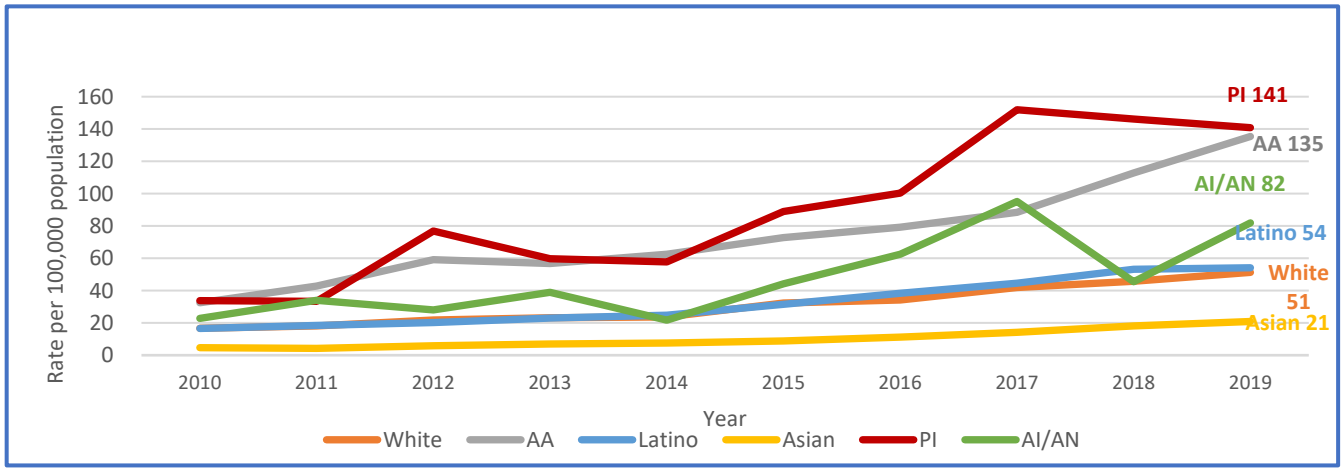
Early Syphilis Rates by Gender, 2010-2019



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.

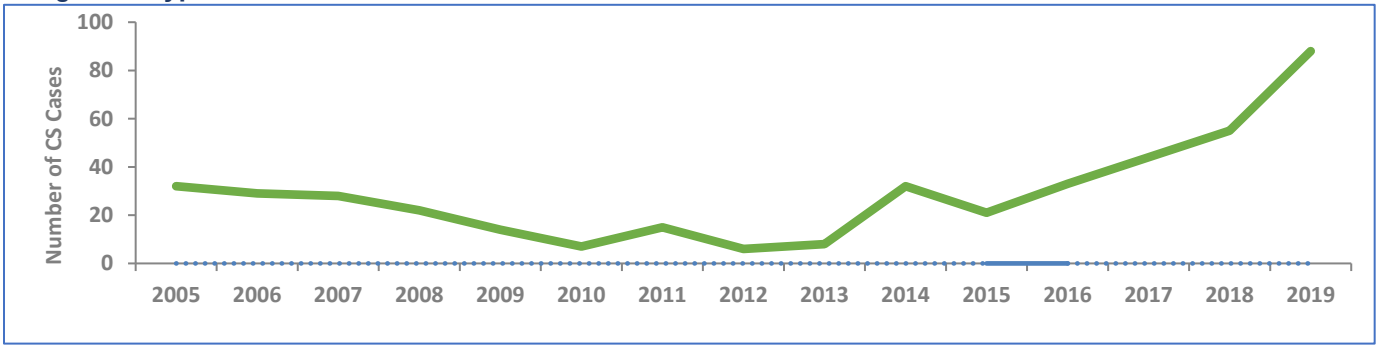
Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

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

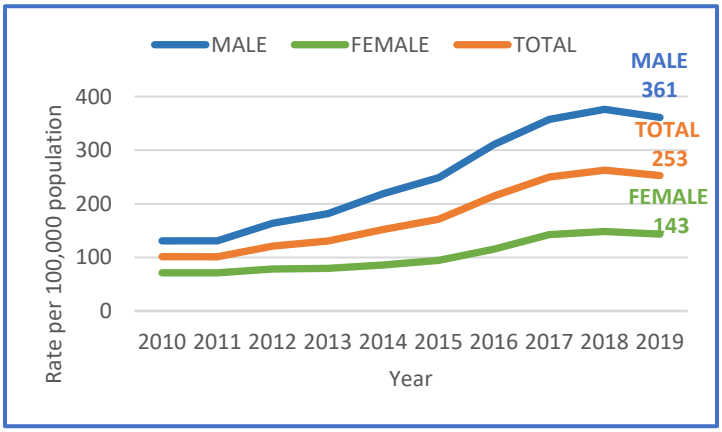


Gonorrhea

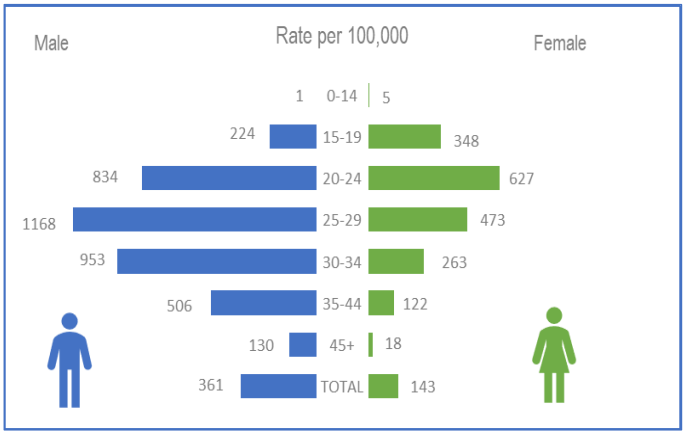
Gonorrhea is one of the most commonly reported sexually transmitted infections. It can cause infection in the genitals, rectum, and throat. If untreated, gonorrhea can cause serious health problems including infertility for men and women. It may also increase the chances of getting HIV. Though gonorrhea 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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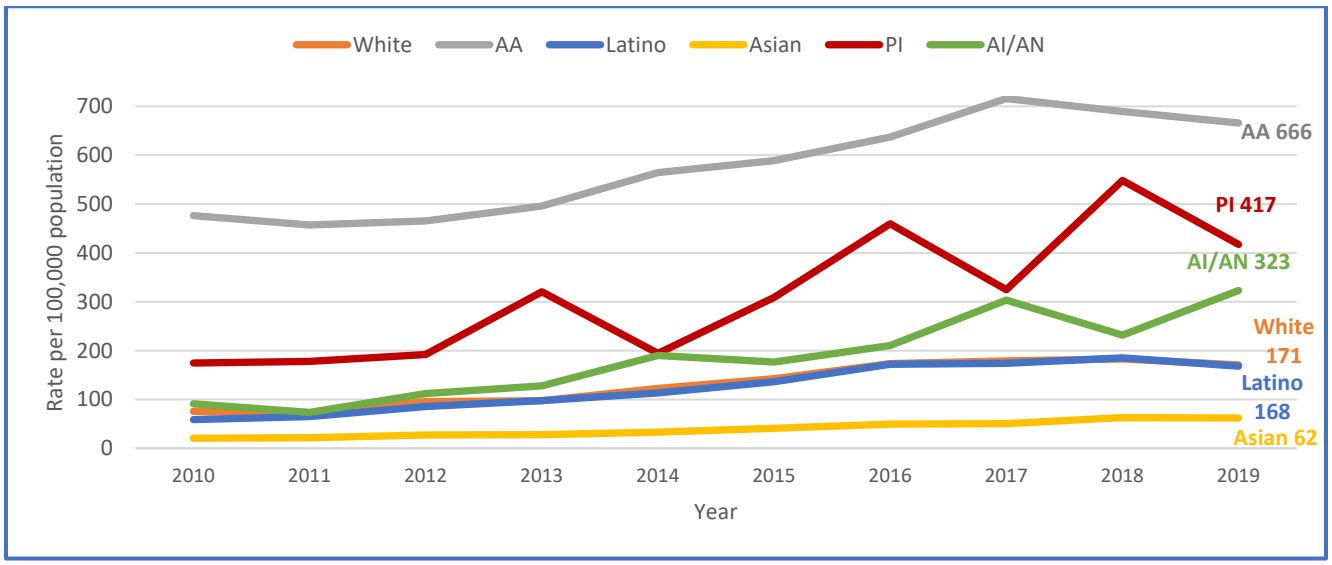
[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent).
[3] Male-to-female transgender individuals represented 2.4%, 0.6% and 0.2% of the early syphilis, gonorrhea and chlamydia cases, respectively.

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

Gonorrhea Rates by Race/Ethnicity, 2010-2019

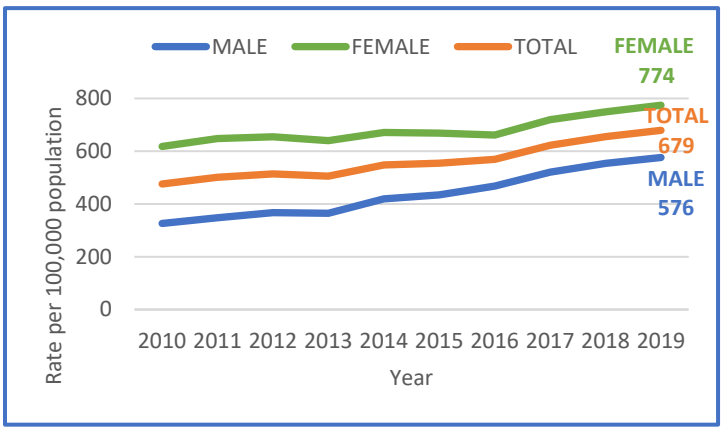


Chlamydia

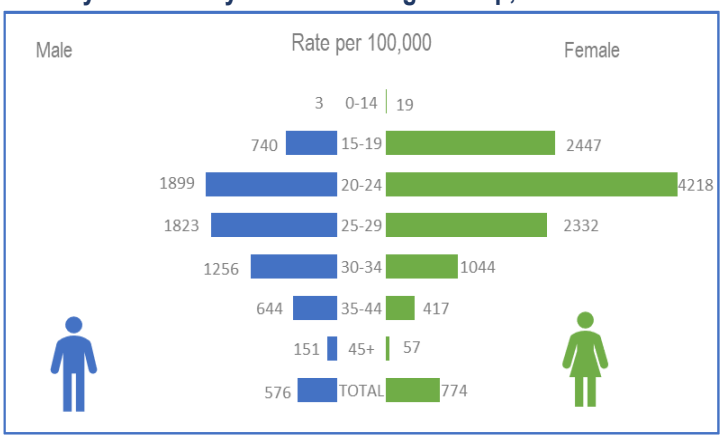
Chlamydia is the most commonly reported sexually transmitted infection and can be transmitted via vaginal, rectal or oral sex. If untreated, it can cause infertility in women.

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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[2] Early syphilis includes all cases staged as primary, secondary, or early non-primary, non-secondary (previously early latent).
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Sources: LAC Division of HIV and STD Programs; Centers for Disease Control and Prevention

COUNTY OF LOS ANGELES
Public Health

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

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

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

JEFFREY D. GUNZENHAUSER, M.D., M.P.H.
Director, Disease Control Bureau

MARIO J. PÉREZ, M.P.H.
Director, Division of HIV and STD Programs

600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005
TEL (213) 351-8001 • FAX (213) 387-0912

www.publichealth.lacounty.gov

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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Update on HIV and STD Surveillance in Los Angeles County

Intersections and Opportunities

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

County of Los Angeles Public Health

Updates in HIV Surveillance

Ending the HIV Epidemic in Los Angeles County

By utilizing the right data, right tools & right leadership

Diagnose

- Increase routine opt out HIV testing in healthcare & institutional settings
- Increase HIV testing programs in non-healthcare settings including home testing
- Increase client's yearly HIV re-screening

Prevent

- Utilize data to better identify persons with indication for PrEP and link to services
- Expand PrEP service delivery & provider options, including telehealth and pharmacies
- Improve PrEP retention in care through provider and consumer programming
- Expand Syringe Services Programs

Treat

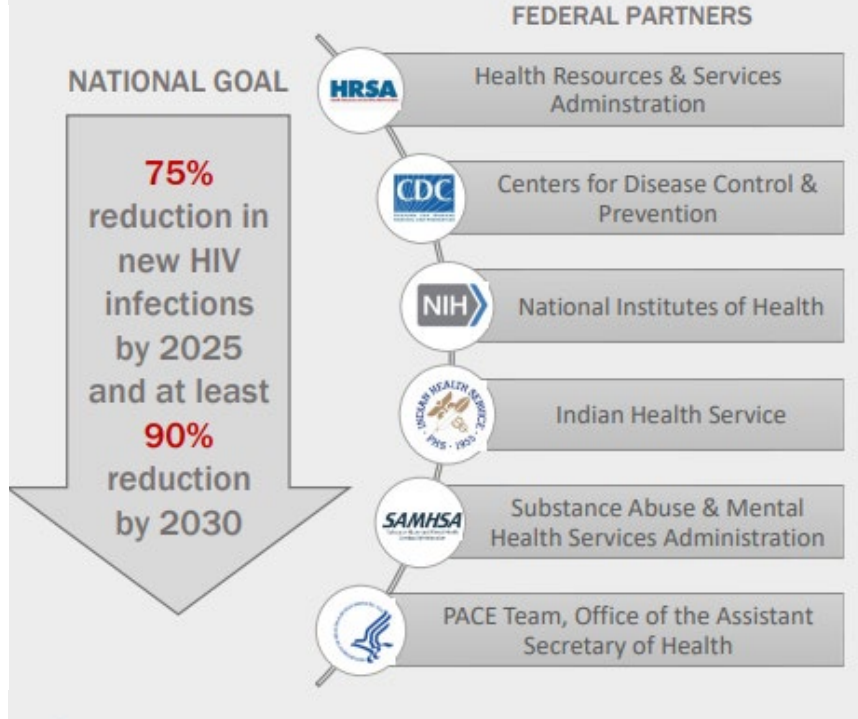
- Expand partner services to facilitate rapid ART and linkage to care
- Increase knowledge of and access to HIV services
- Assess mental health services to identify gaps in care
- Improve client experience by working with clinical staff
- Increase opportunities for telehealth
- Develop programming that provides services related to housing and emergency financial assistance

Respond

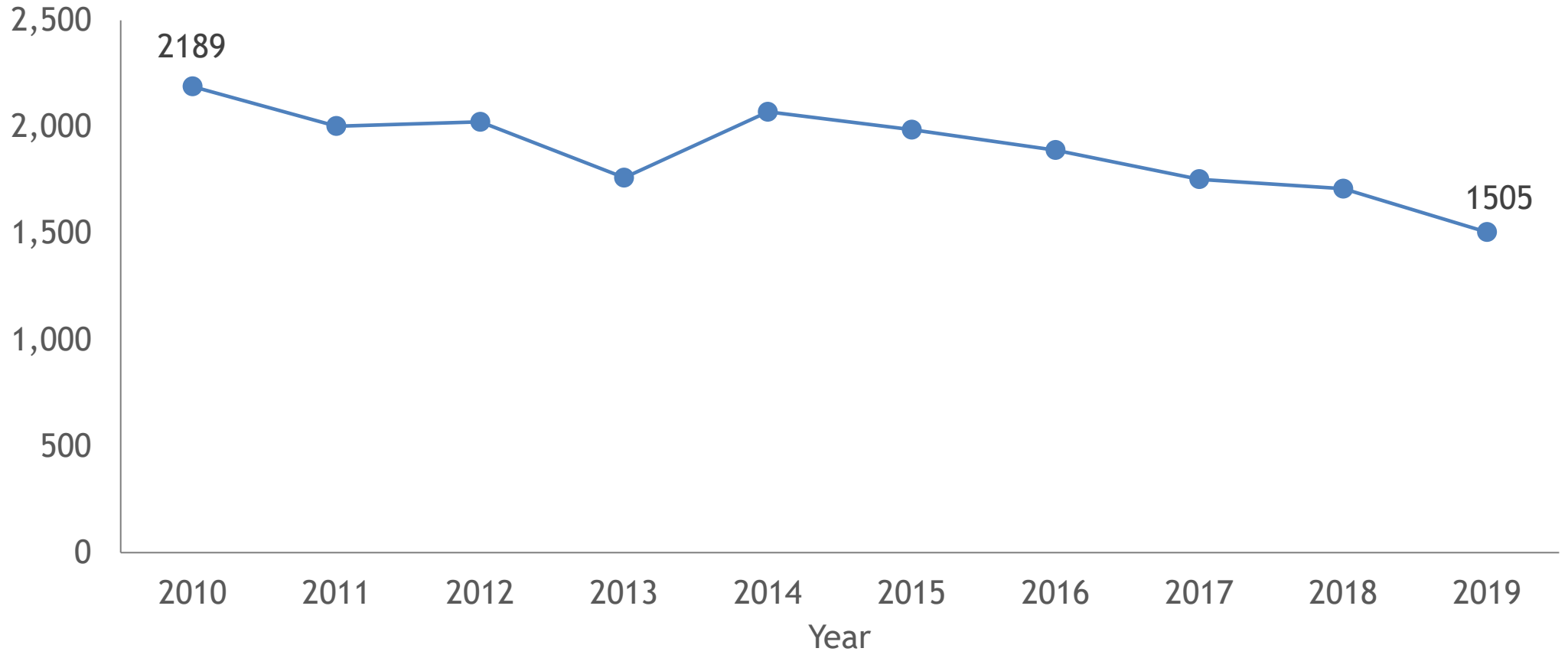
- Facilitate real-time cluster detection and response through protocol development and trainings
- Implement routine epidemiological analysis of new infections in hot spots and subpopulations
- Monitor and assess clusters identified through recency testing
- Continue to build surveillance infrastructure at the public health department

Federal Funding in LA County

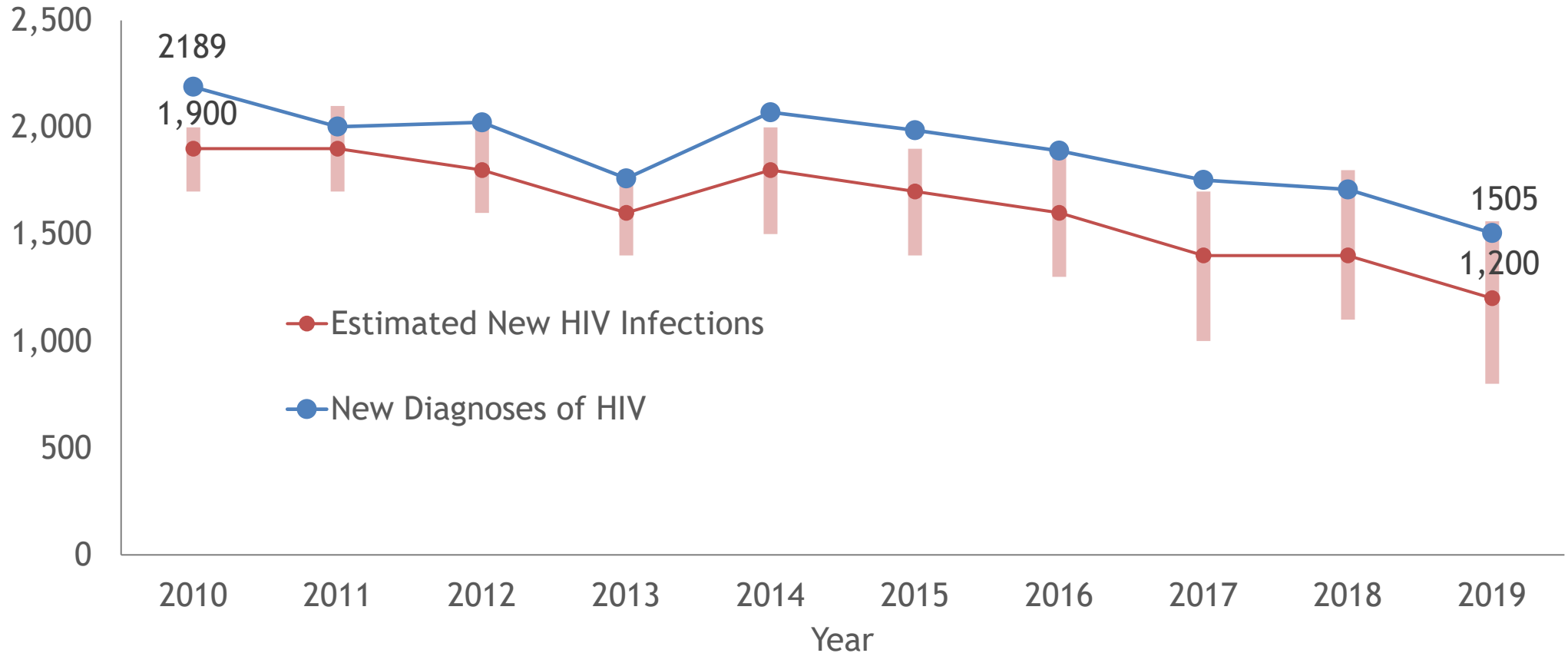
Various entities have received federal funding from HRSA, CDC & NIH to support ending the HIV epidemic goals and strategies, including the public health department, federally qualified health centers, AIDS Education Training Centers, and research partners.



A Declining Epidemic: Trends in the number of new HIV diagnoses and estimated number of new infections among persons aged 13+ years, LAC 2010-2019[1]



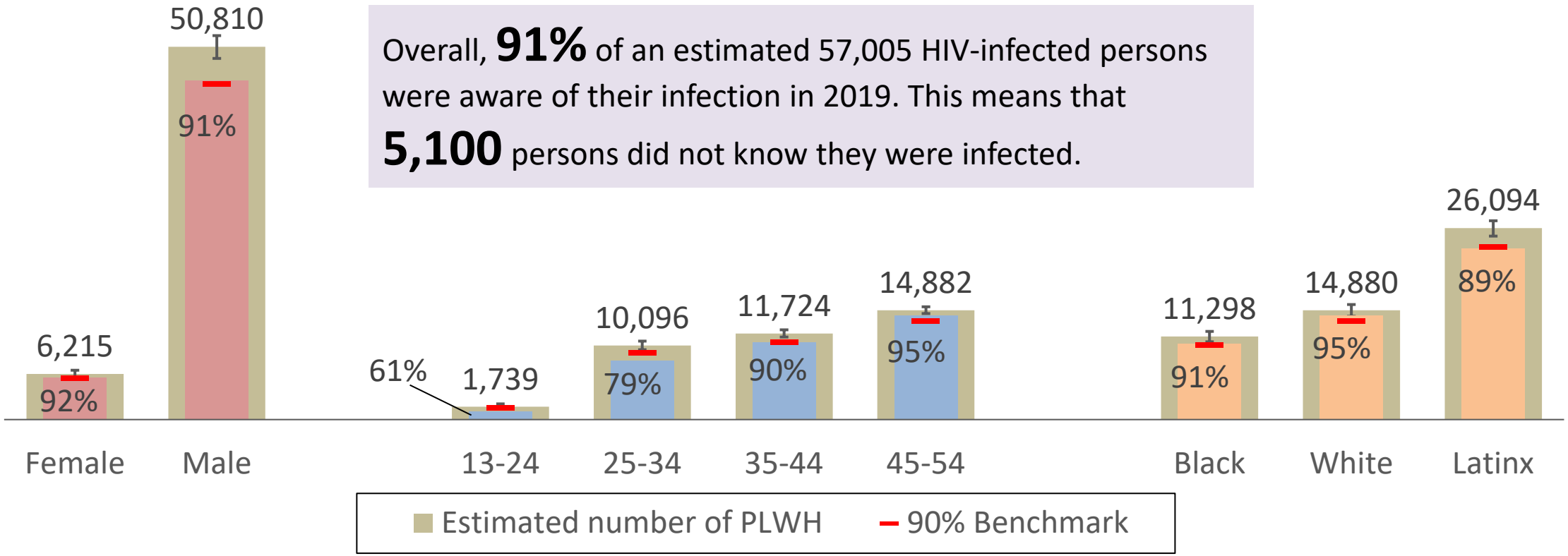
A Declining Epidemic: Trends in the number of new HIV diagnoses and estimated number of new infections among persons aged 13+ years, LAC 2010-2019[1]



[1]Using the CD4-based model developed by the Centers for Disease Control and Prevention, modified for use by Los Angeles County. 2019 incidence estimates are preliminary

Awareness of HIV-positive serostatus among PLWH aged 13 years and older by gender, age group, and race/ethnicity, LAC 2019[1]

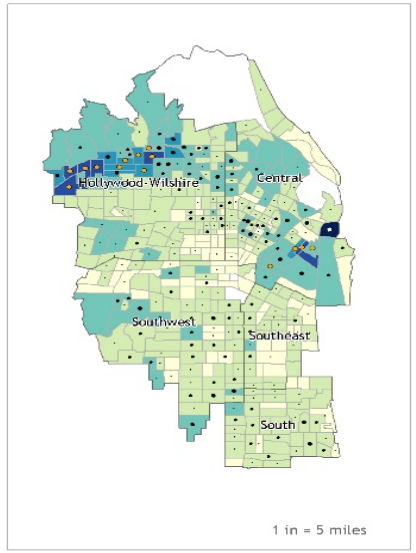
Overall, **91%** of an estimated 57,005 HIV-infected persons were aware of their infection in 2019. This means that **5,100** persons did not know they were infected.

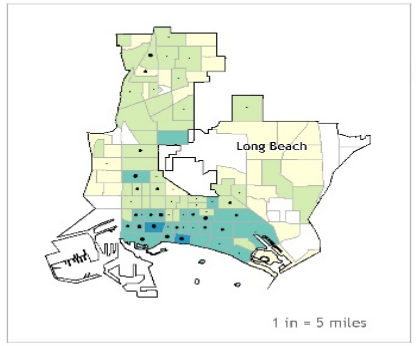


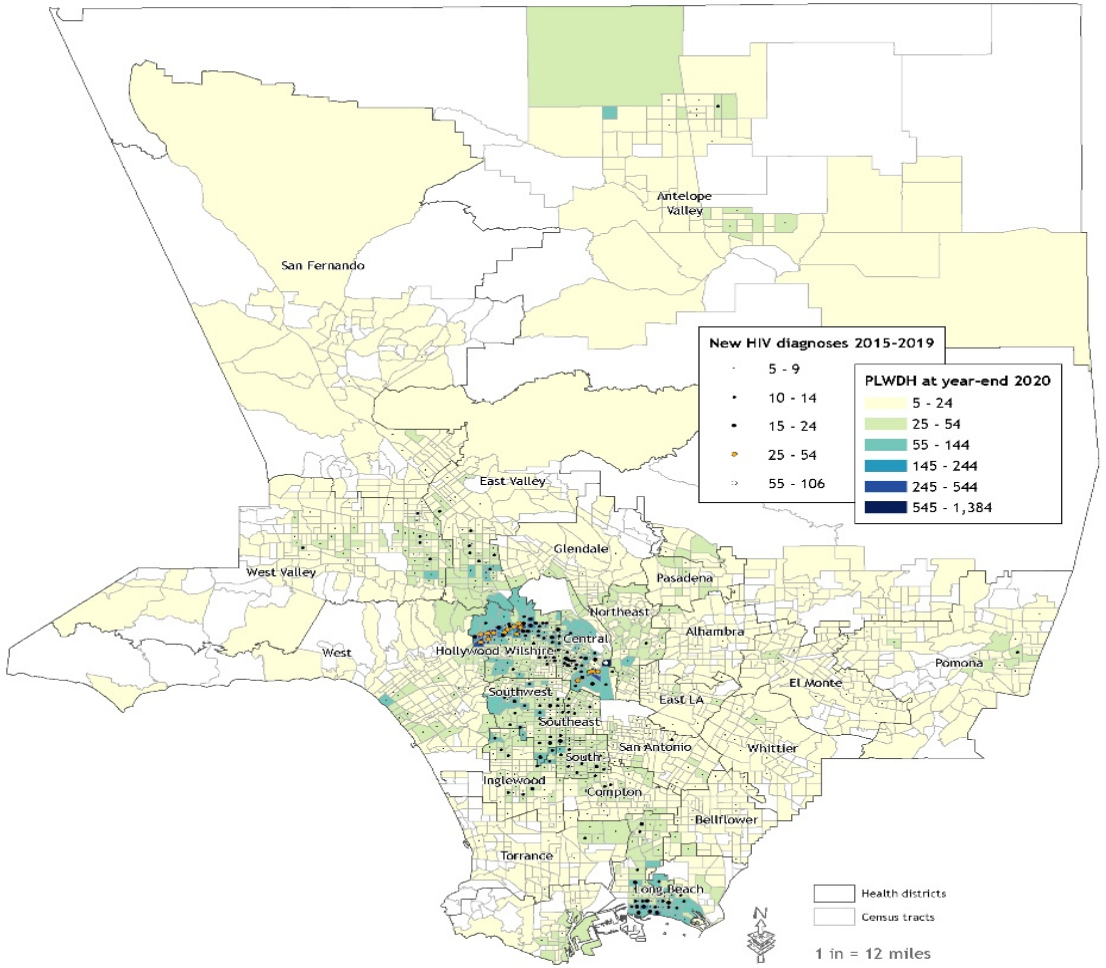
[1]Using the CD4-based model developed by the Centers for Disease Control and Prevention, modified for use by Los Angeles County. 2019 incidence estimates are preliminary. Transgender persons, Asian/Pacific Islanders, American Indians, Alaskan Natives and persons of multiple race/ethnicities were not included in the analysis because of unstable results due to small numbers.

Where are new HIV diagnoses being identified in Los Angeles County?[1]

The 3 HIV epicenters in Los Angeles County are Hollywood-Wilshire Health District, Central Health District, and Long Beach Health District

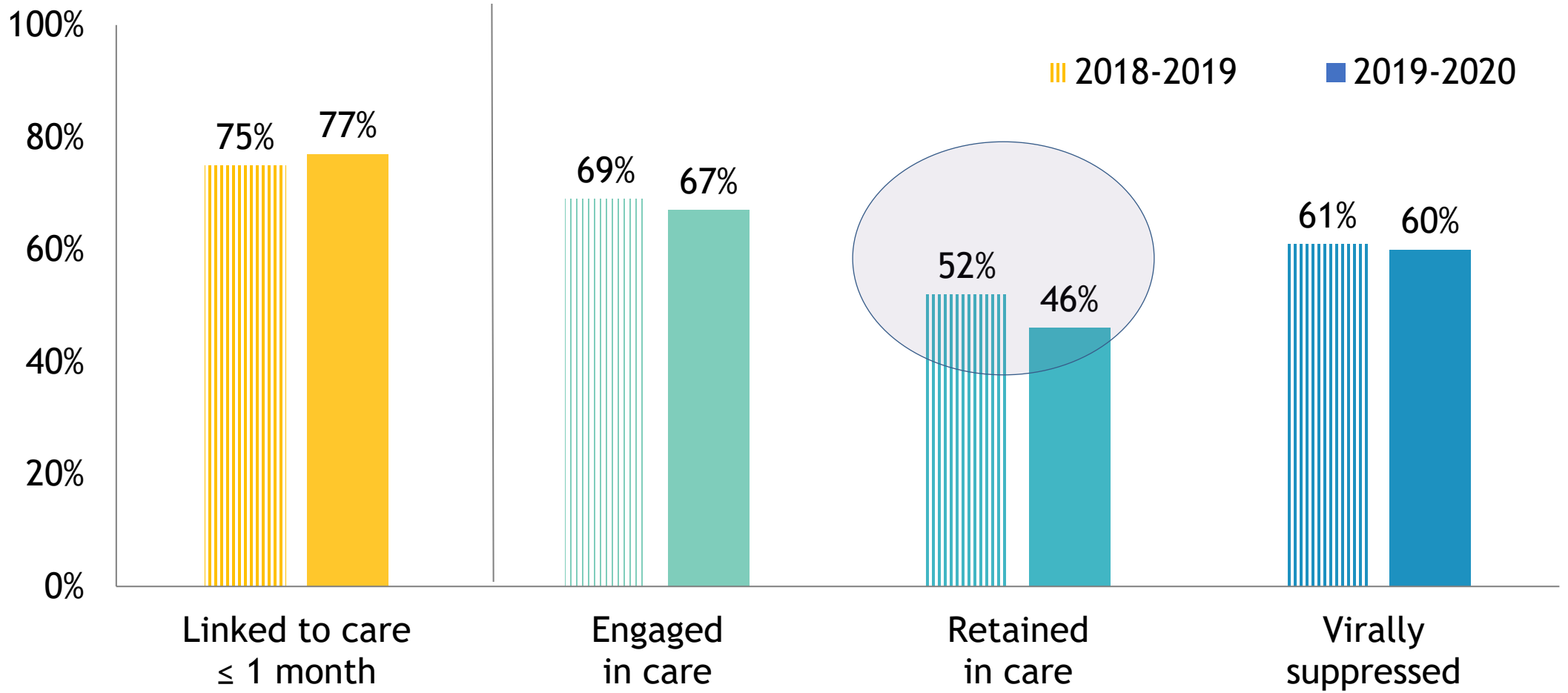






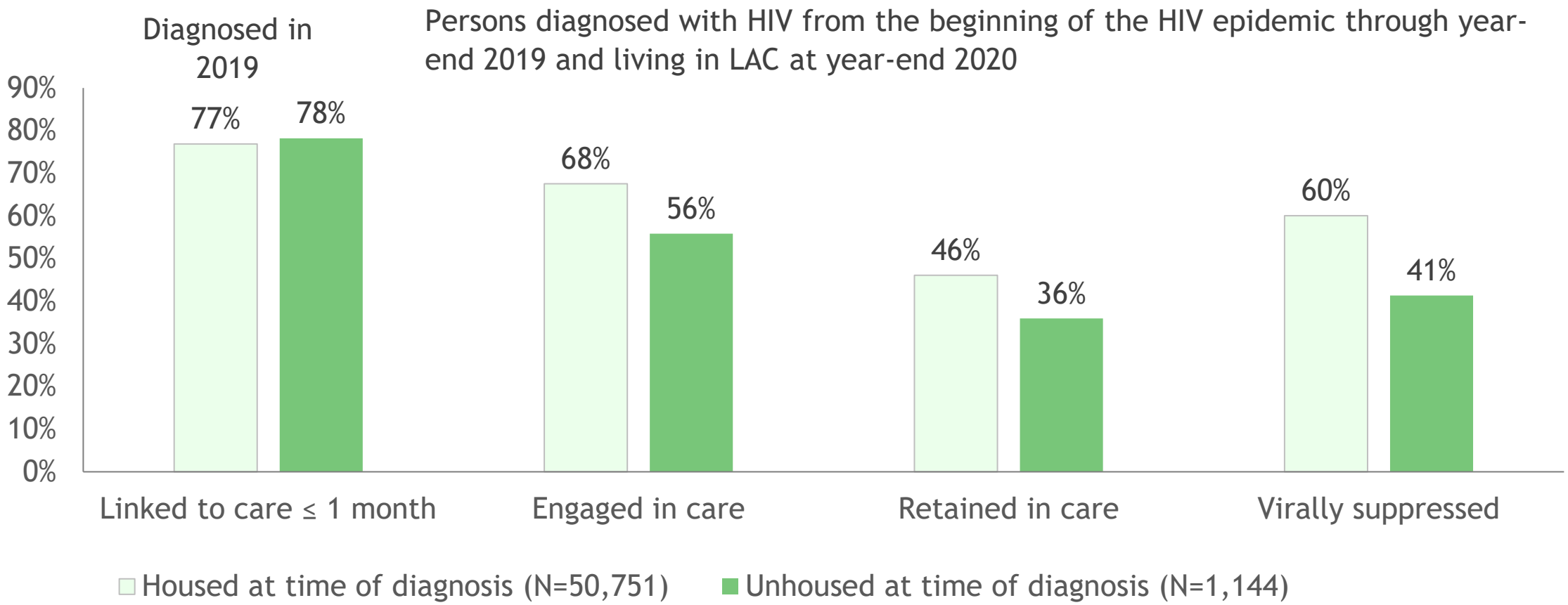
[1]Census tract and health district information was based on most recently reported residential addresses. Person with no reported street address information were aggregated to the census tract or health district level data based on available ZIP code information. Source: HIV Surveillance data as of December 31, 2020; U.S. Department of Commerce, 2010 U.S. Census Tract; U.S. Department of Housing and Urban Development, HUD USPS ZIP Code – Census Tract Crosswalk Files, 2nd quarter 2017 was used for HIV diagnoses 2015-2019 and 4th quarter 2020 was used for PLWDH at year-end 2020.

HIV care continuum[1] among persons aged 13+ years, LAC 2018-2020



[1]Linkage to care: numerator includes persons newly diagnosed with HIV in 2019 with ≥1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis; denominator includes persons who were diagnosed with HIV in 2019.
Engaged in care: numerator includes PLWDH with ≥1 CD4/VL/Genotype test in 2020; denominator includes PLWDH diagnosed through 2019 and living in LAC at year-end 2020 based on most recent residence.
Retained in care: numerator includes PLWDH with ≥2 CD4/VL/Genotype tests at least 3 months apart in 2020; denominator includes PLWDH diagnosed through 2019 and living in LAC at year-end 2020 based on most recent residence.
Virally suppressed: numerator includes PLWDH whose last VL test in 2019 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2019 and living in LAC at year-end 2020 based on most recent residence. For the purposes of this analysis, PLWDH without a VL test in 2020 were categorized as having unsuppressed viral load.

Unhoused persons have worse outcomes than housed persons across the HIV care continuum



Engaged in care: numerator includes PLWDH with ≥1 CD4/VL/Genotype test in 2020; denominator includes PLWDH diagnosed through 2019 and living in LAC at year-end 2020 based on most recent residence.
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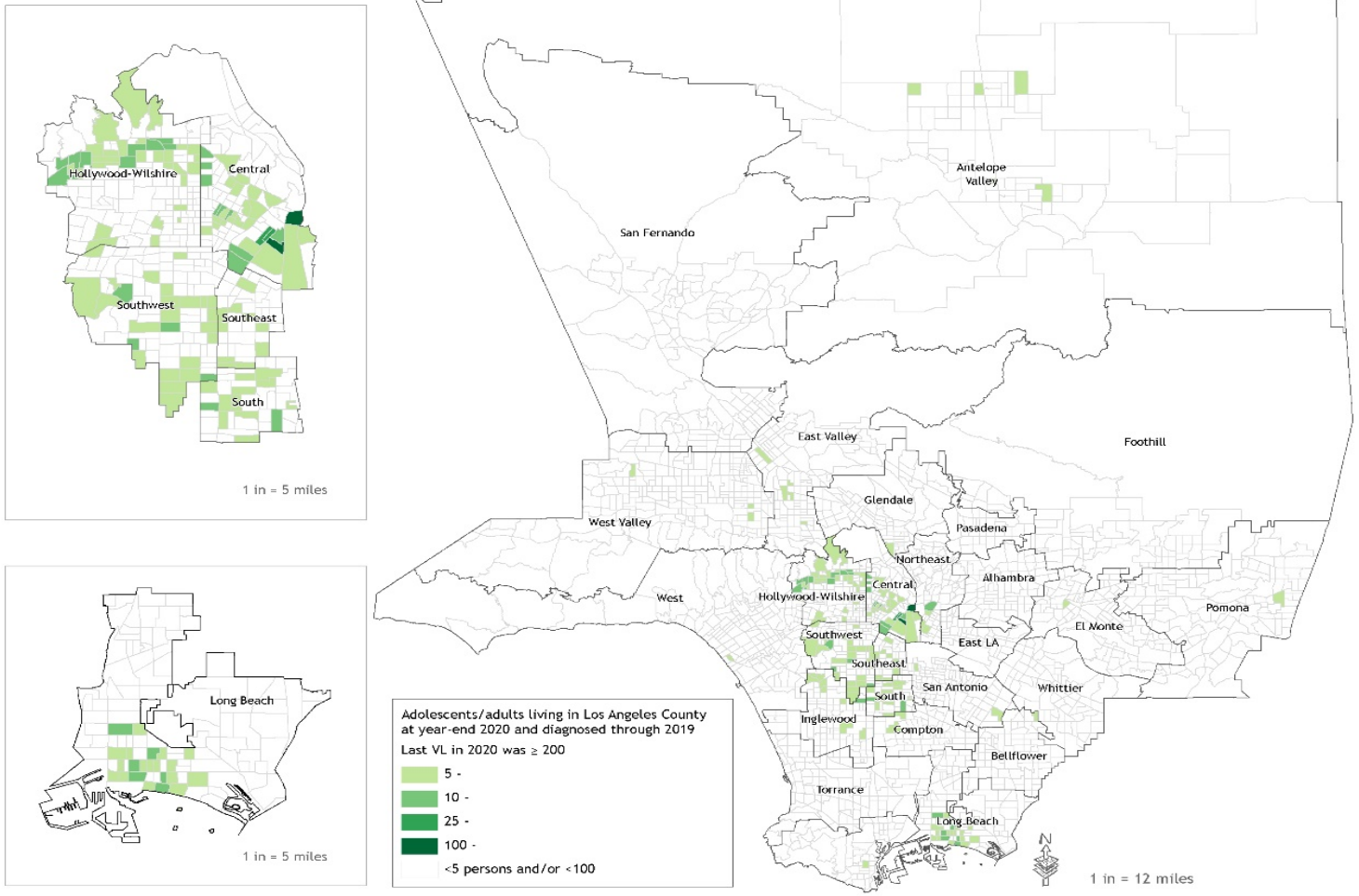
Virally suppressed: numerator includes PLWDH whose last VL test in 2020 was suppressed (HIV-1 RNA < 200 copies/mL); denominator includes PLWDH diagnosed through 2019 and living in LAC at year-end 2020 based on most recent residence. For the purposes of this analysis, PLWDH without a VL test in 2020 were categorized as having unsuppressed viral load.
Other transmission risk includes perinatal, hemophilia, coagulation disorder, blood transfusion, and risk factor not reported/identified. Persons without an identified risk factor were assigned a risk factor using CDC-recommended multiple imputation methods.

Where is HIV transmission occurring?

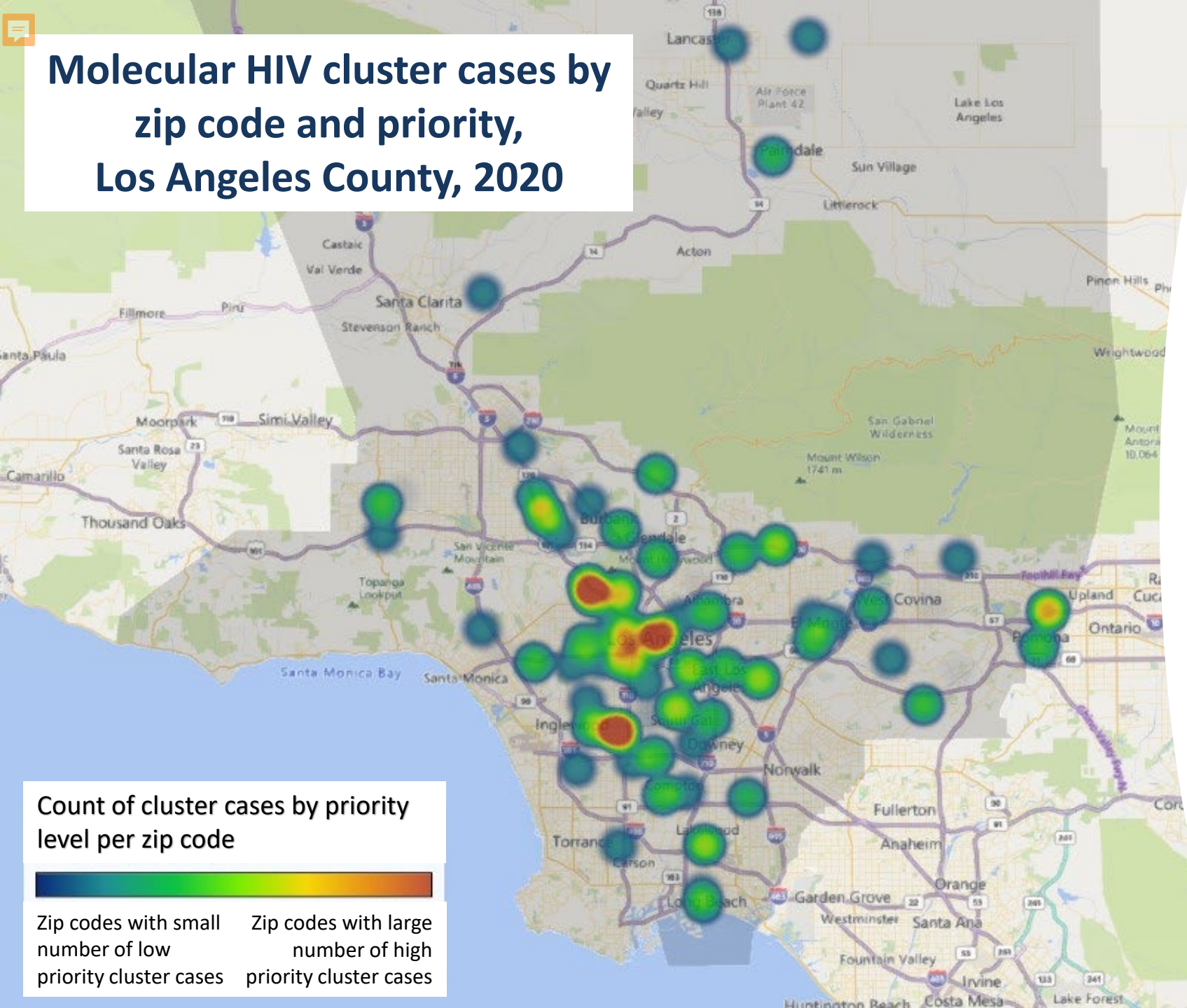
Unsuppressed viral load[1] among persons living with diagnosed HIV in Los Angeles County, 2020



Central, Hollywood-Wilshire, South, Southwest, Southeast, and Long Beach Health Districts have the highest levels of unsuppressed viral load. These areas represent the locations with highest potential for fueling onward HIV transmission.

[1]Unsuppressed viral load: numerator includes PLWDH whose last VL test in 2020 was unsuppressed (HIV-1 RNA ≥ 200 copies/mL); denominator includes PLWDH diagnosed through 2019 and living in LAC at year-end 2020 based on most recent residence. PLWDH without a VL test in 2020 were considered virally unsuppressed. Analysis excludes PLWDH diagnosed through 2019 and living at year-end 2020 who (1) had missing census tract information, (2) were engaged in care but never had a viral load test, (3) were not engaged in care for >12 months at year-end 2020, or (4) were in census tracts with small sample sizes (<5 persons with unsuppressed viral load or population size<100 persons). Exclusions represented 69% of PLWDH diagnosed through 2019 and living in 2020 whose last viral load was unsuppressed.

Molecular HIV cluster cases by zip code and priority, Los Angeles County, 2020



Count of cluster cases by priority level per zip code

Zip codes with small number of low priority cluster cases

Zip codes with large number of high priority cluster cases

Categorized HIV cluster priority as:

- Low <5 cases (**blue**)
- Medium ≥5 cases (**green**)
- High ≥5 cases (**orange/red**)

Findings:

- Highest number of high priority cluster cases in **West Hollywood, Downtown, and South LA**
- Risk profiles of persons in high priority cluster:
  - ~One in five have a history of meth use
  - ~10% have a history of homelessness
  - ~70% had anonymous sex partners
  - Nearly half have co-infection with syphilis

Progress towards Ending the HIV Epidemic Targets

	EHE Targets for 2025	EHE Targets for 2030	LAC current
Number of new infections[1]	380	150	1,200 (2019)
Number of new HIV diagnoses[2]	450	180	1,505 (2019)
Knowledge of HIV-status among HIV-infected persons[1]	95%	95%	91% (2019)
Linkage to HIV care among PLWDH[2]	95%	95%	77% (2019)
Viral Suppression among PLWDH[2]	95%	95%	60% (2020)
Percentage of persons in priority populations prescribed PrEP[3]	50%	50%	39%

1. Using Los Angeles County HIV surveillance data in the CDC Enhanced HIV/AIDS Reporting system (eHARS).
2. Using the CD4-based model developed by the Centers for Disease Control and Prevention, modified for use by Los Angeles County.
3. Using Los Angeles County data from the National HIV Behavioral Surveillance system, STD clinic data, online Apps survey, COE program data, and AHEAD dashboard.

The case for HIV recency testing to accelerate towards our EHE goals

"If you can describe the most recent 100 persons infected with HIV, you have the key to the epidemic"

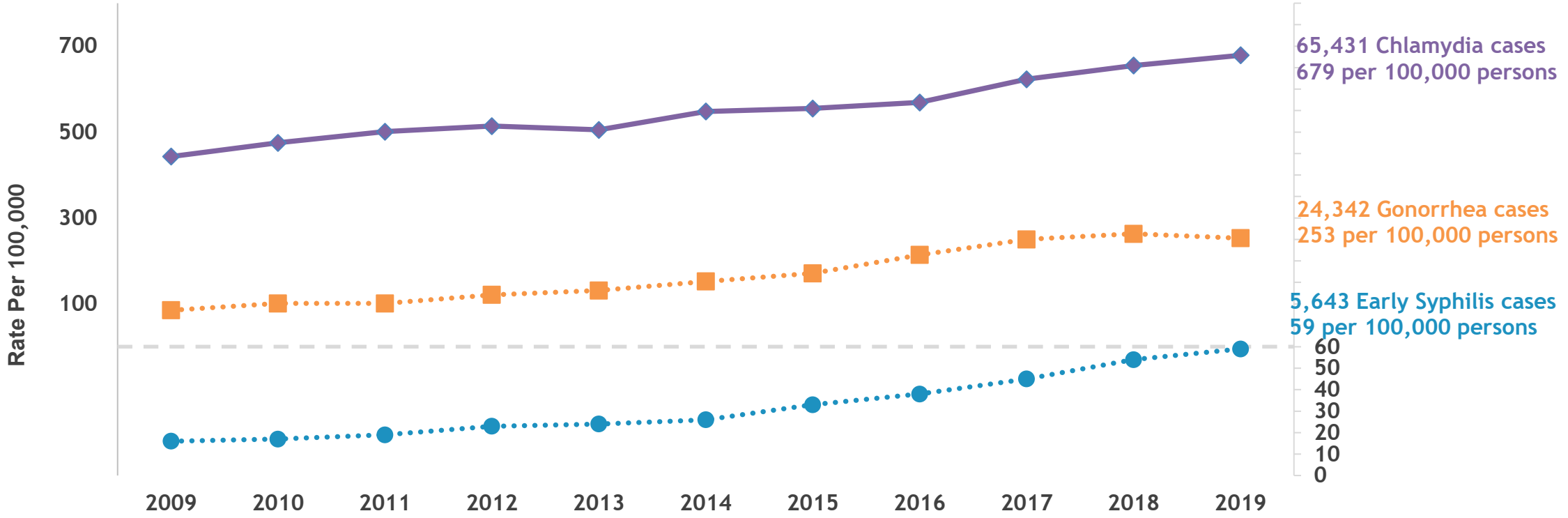
Updates in Sexually Transmitted Disease Surveillance

SEXUALLY TRANSMITTED DISEASE SURVEILLANCE, 2019

Reported STDs in the U.S. reach all-time high for 6th consecutive year

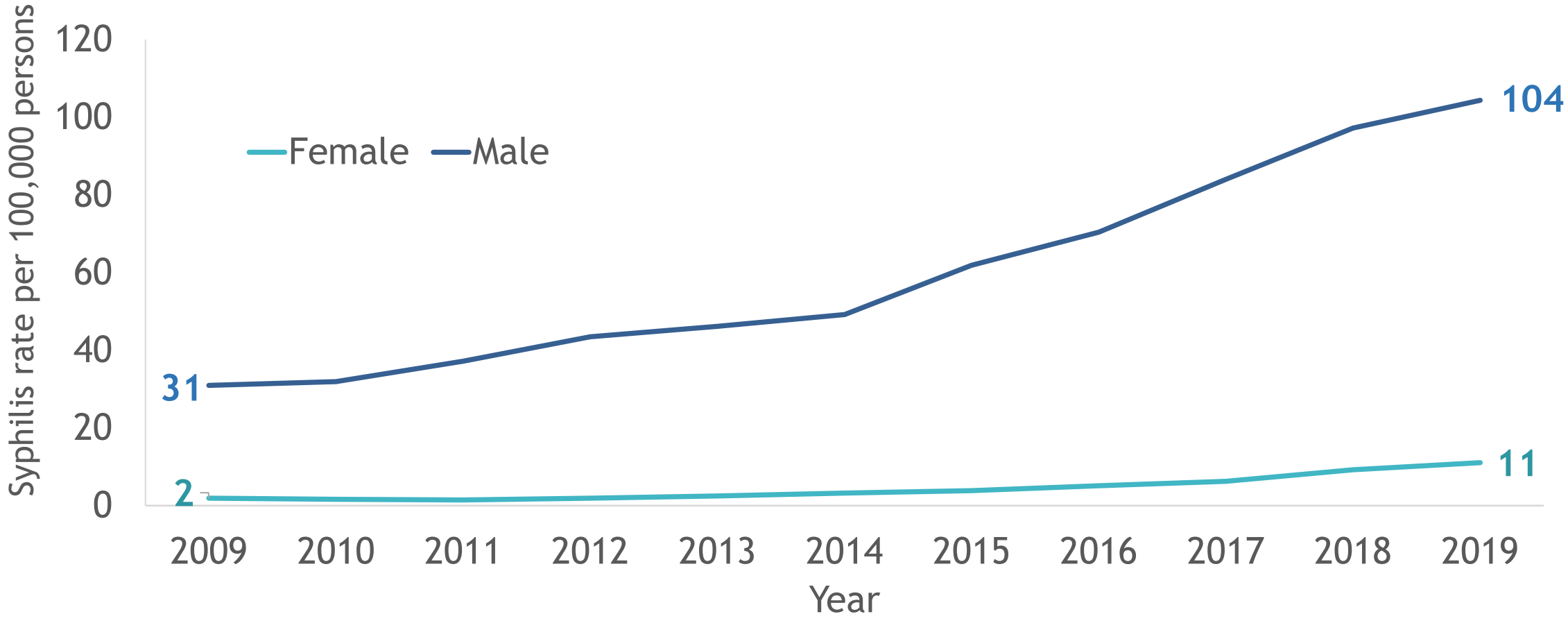
More than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported in 2019

Trends in Sexually Transmitted Diseases, Los Angeles County, 2009-20191



[1] Data as of 03/14/2021. Early syphilis includes all cases staged as primary, secondary, or early non-primary non-secondary (previously early latent);. cases from Long Beach and Pasadena are excluded. 2018 and 2019 data are provisional due to reporting delay.

Since 2009, early syphilis rates have increased **450%** among females and **235%** among males[1]



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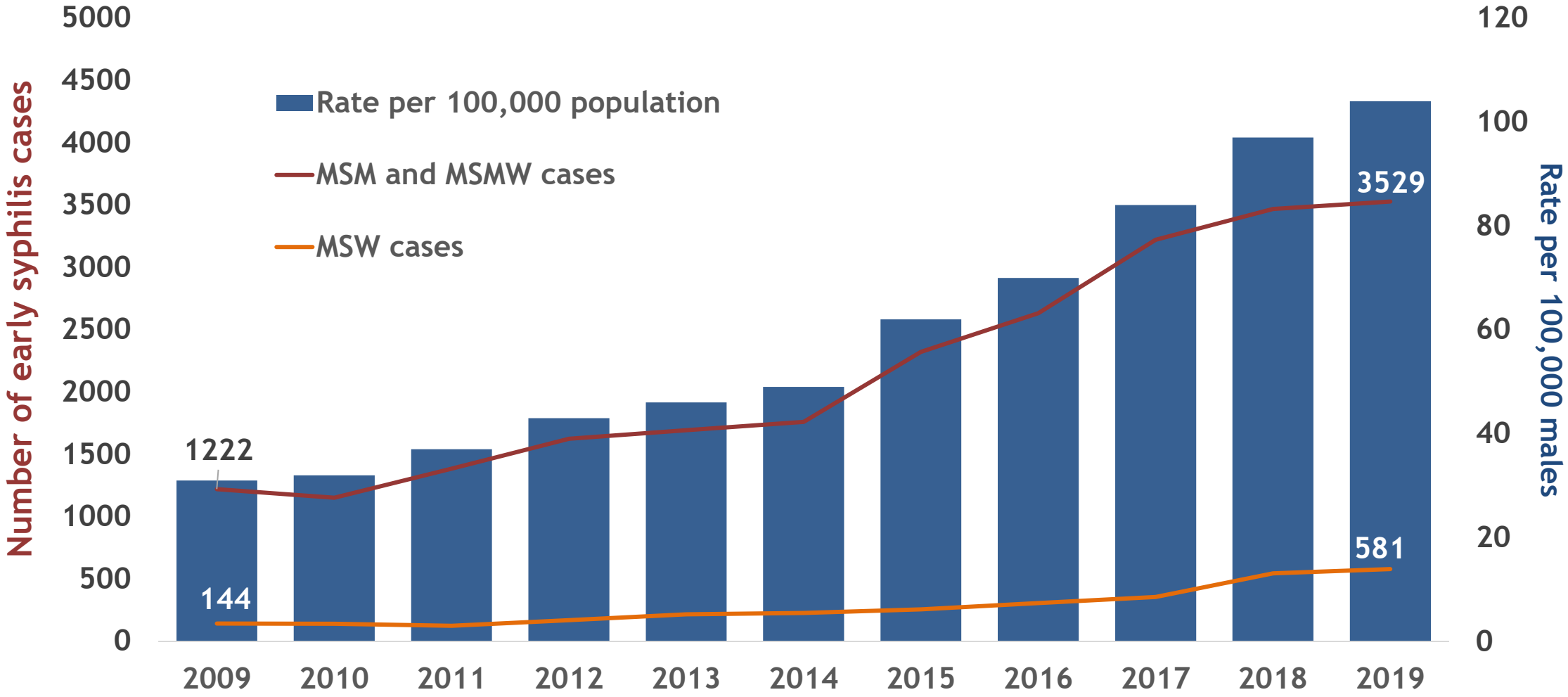
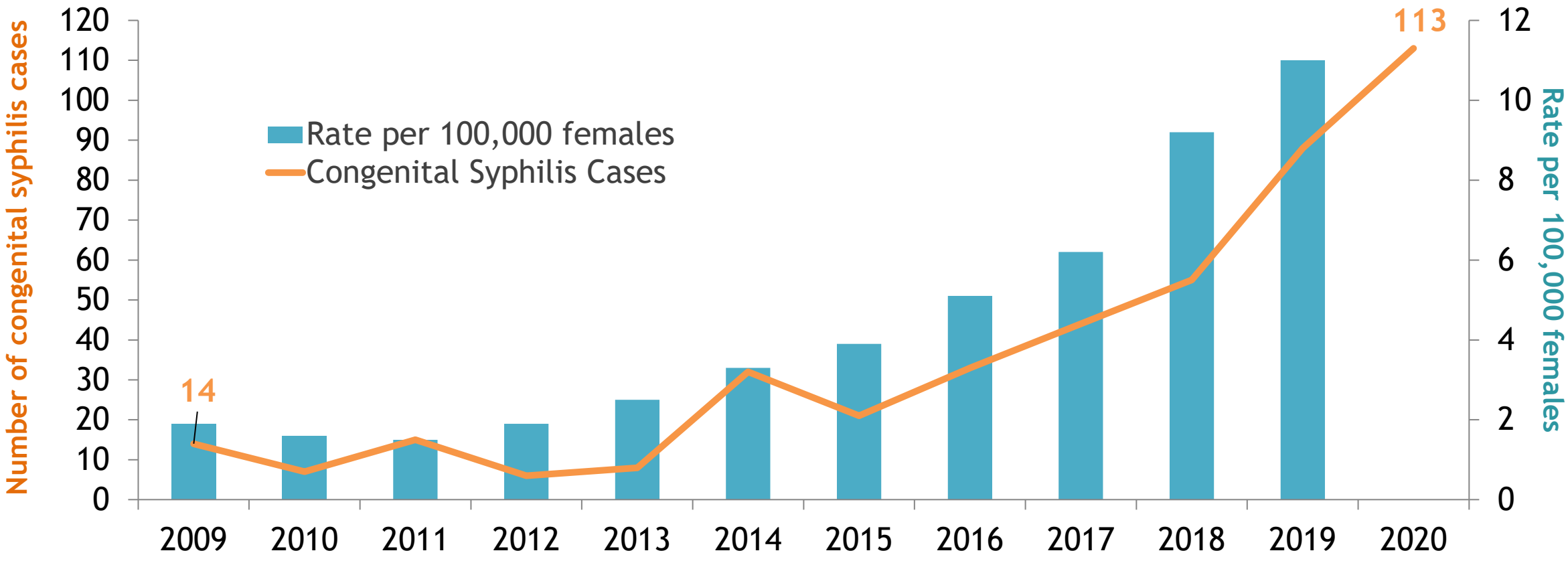
Early syphilis in males, Los Angeles County, 2009-2019[1]



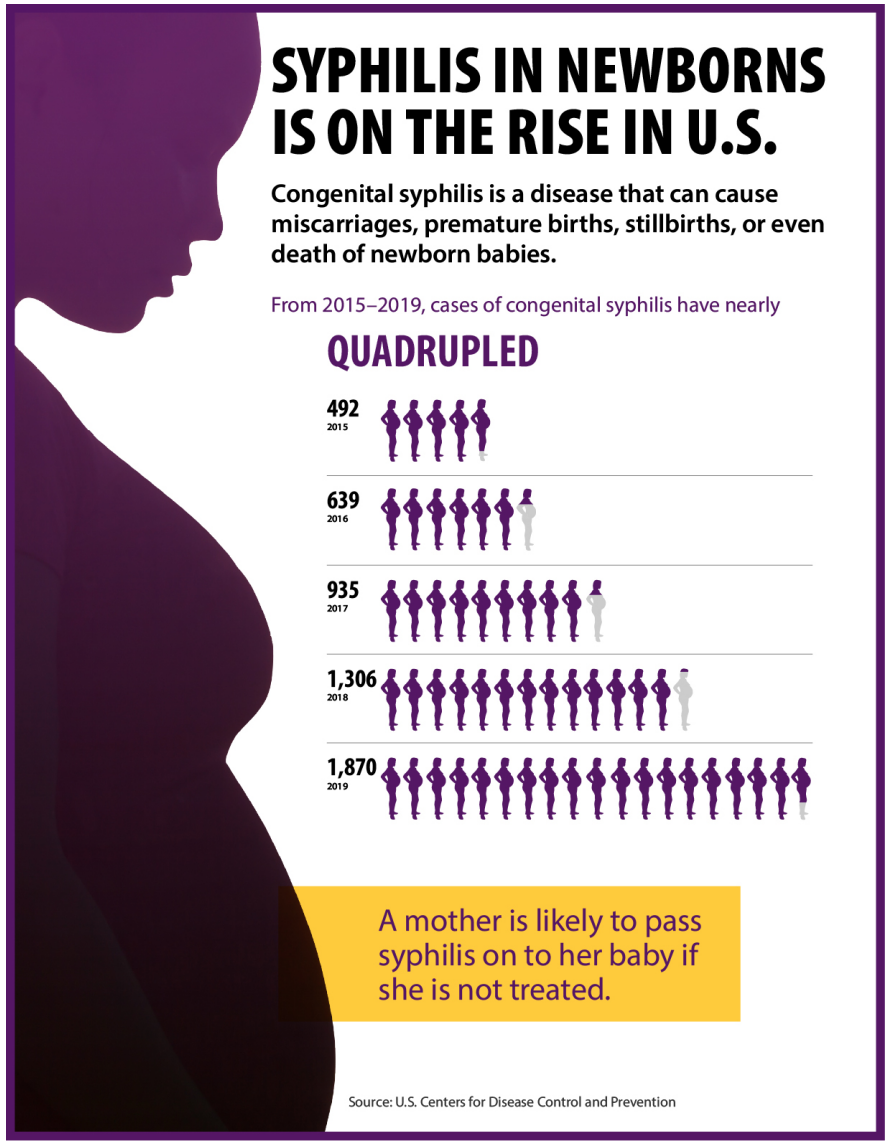
[1] Data as of 03/14/2021. Early syphilis includes all cases staged as primary, secondary, or early non-primary non-secondary (previously early latent); cases from Long Beach and Pasadena are excluded. 2018 and 2019 data are provisional due to reporting delay

MSM = men who have sex with men; MSMW = men who have sex with men and women; MSW = men who have sex with women

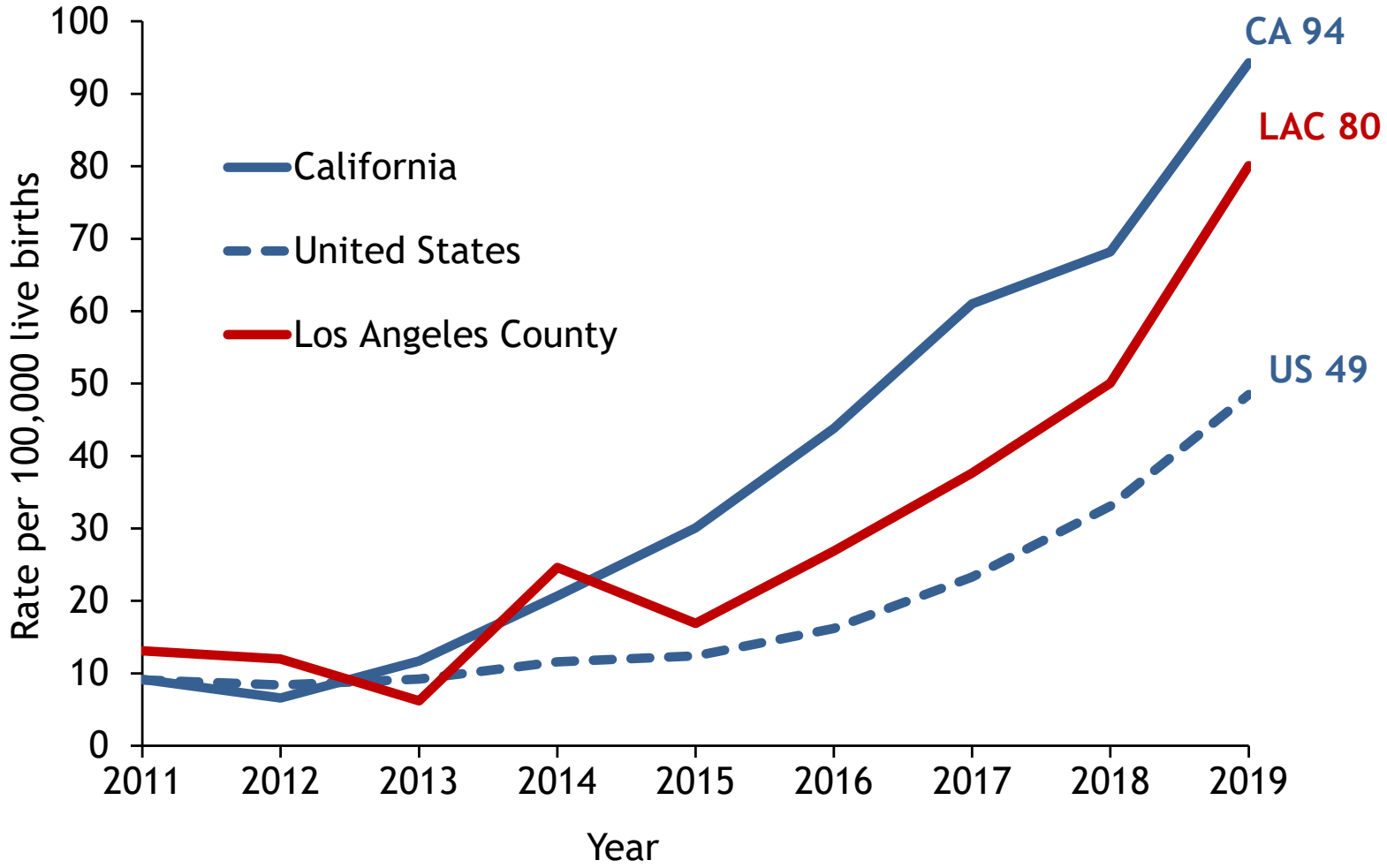
Early syphilis in females and babies, Los Angeles County, 2009-2019[1]



[1] Data as of 03/14/2021. Early syphilis includes all cases staged as primary, secondary, or early non-primary non-secondary (previously early latent); cases from Long Beach and Pasadena are excluded. 2018, 2019, and 2020 data are provisional due to reporting delay



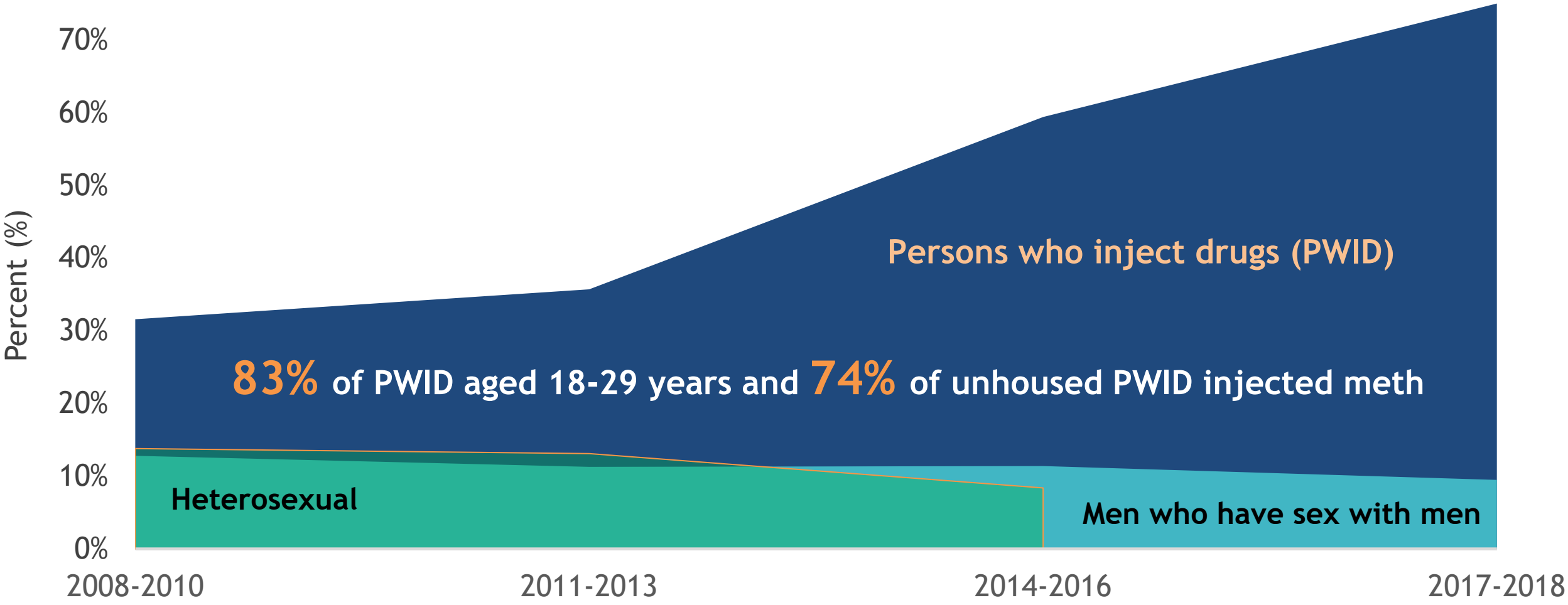
Congenital Syphilis: How does Los Angeles County compare with California and the US?[1]



[1] Los Angeles County data as of 03/14/2021. Cases from Long Beach and Pasadena are excluded. 2018 and 2019 data are provisional due to reporting delay. US and California data accessed from the Centers for Disease Control and Prevention 2019 STD Surveillance Report.

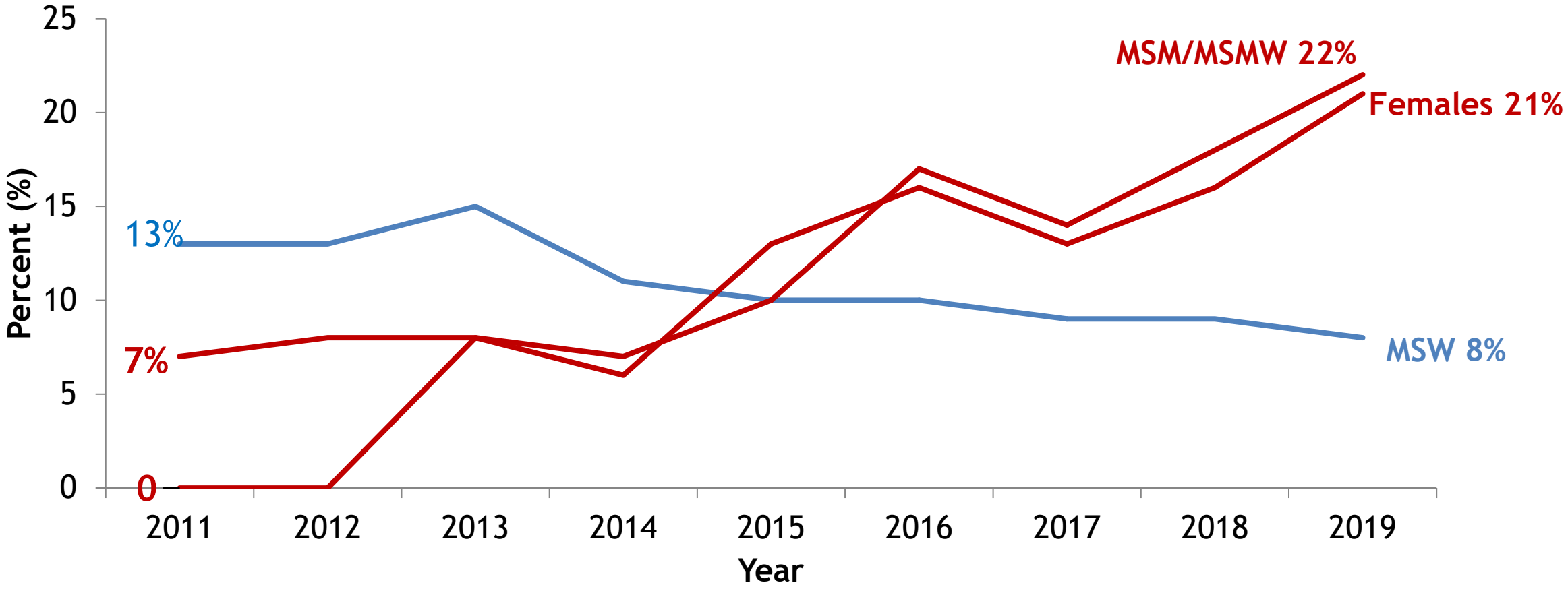
What is driving the increases in syphilis and congenital syphilis in Los Angeles County?

Methamphetamine Use in Los Angeles County, 2008 to 2018[1]



[1]Data abstracted from the National HIV Behavioral Surveillance (NHBS). NHBS is a national behavioral surveillance system designed to generate nationally representative estimates of HIV prevalence and behaviors among groups at highest risk for HIV infection. NHBS has been implemented in 20 local health jurisdictions, including LAC, since 2004. In LAC, the most recent cycles of NHBS was conducted in 2016 for heterosexuals, 2017 for MSM and 2018 for PWID.

Methamphetamine Use among Persons with Early Syphilis by Gender of Sex Partners, Los Angeles County, 2011-2019[1,2,3]



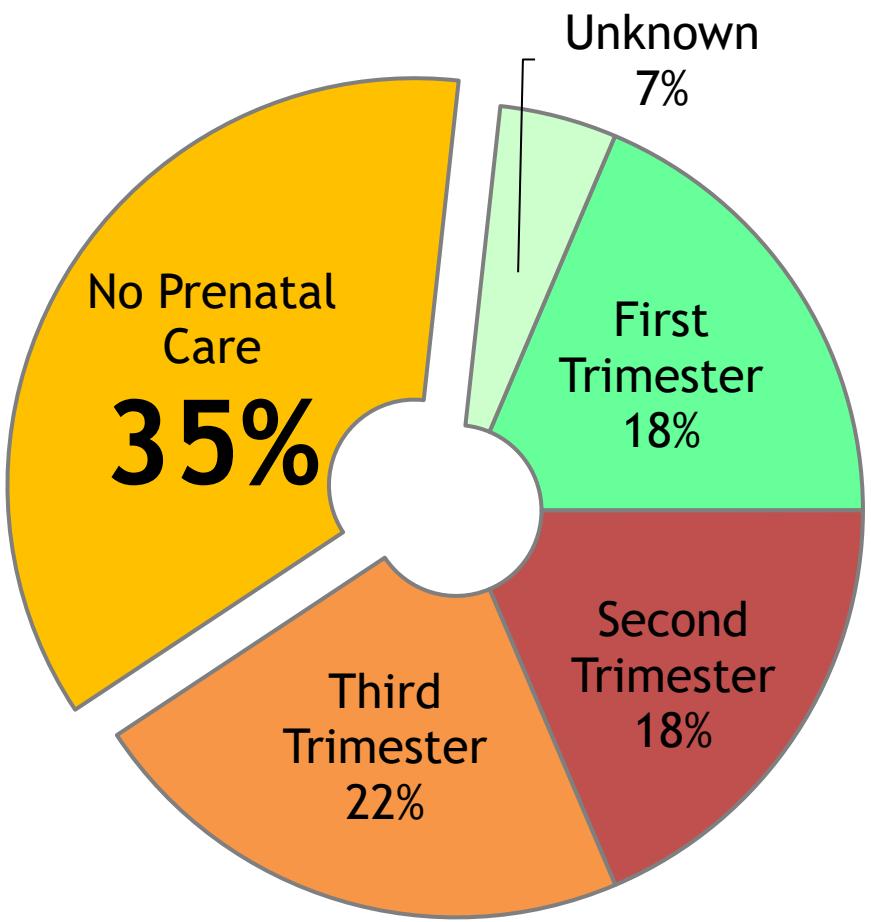
[1] Early Syphilis includes Primary, Secondary and Early Latent Syphilis. Data as of 3/12/2021.

[2] MSM = men who have sex with men; MSMW = men who have sex with men and women; MSW = men who have sex with women only. Men who have sex with transgendered are included in the MSM/MSMSW category.

[3] Data based on syphilis cases who received partner services (N=25,937). Methamphetamine use reflects the number of individuals reporting methamphetamine use in the past 12 months.

Maternal Characteristics of 88 Congenital Syphilis Cases, Los Angeles County, 2019

Entry into Prenatal Care



36% had a history of incarceration

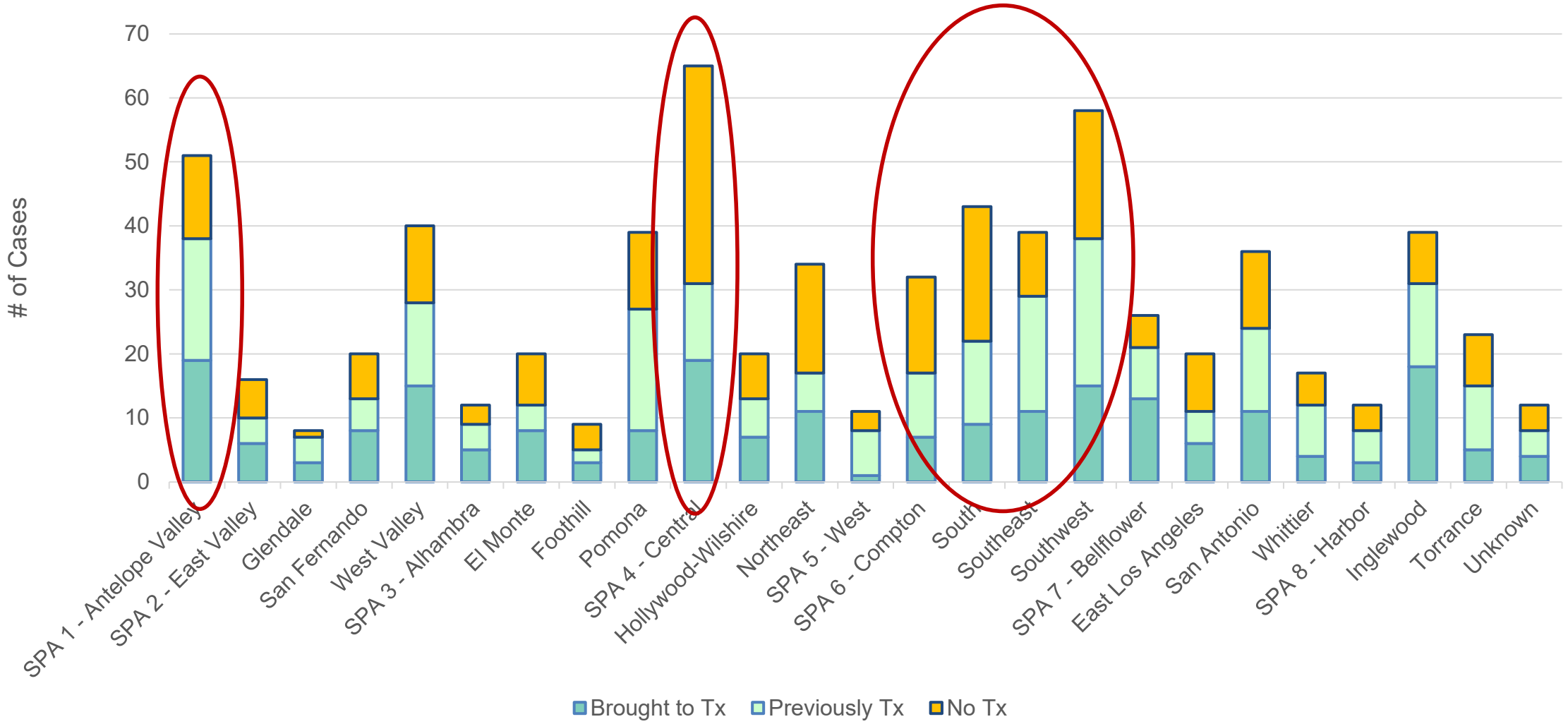
40% had unstable housing

68% had a substance use disorder

49% were using meth or some drug combination with meth

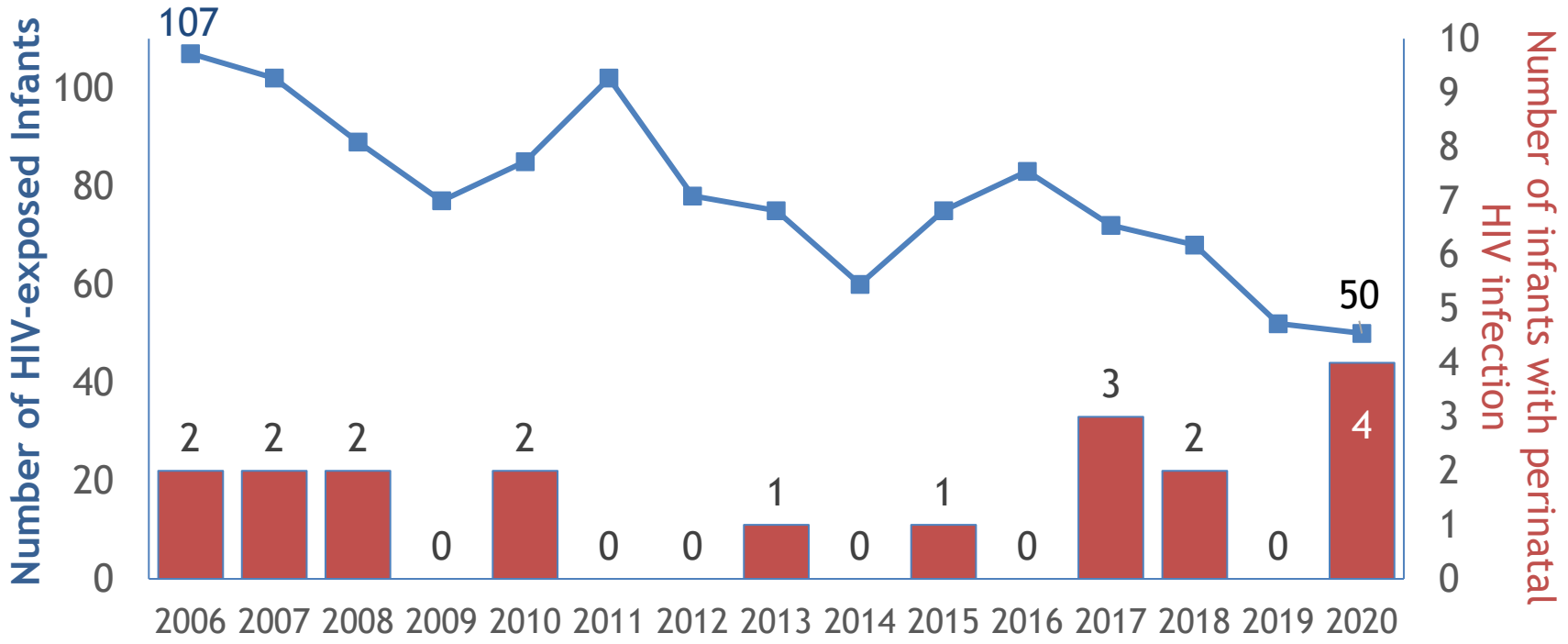
80% of deliveries resulted in DCFS/Foster Care Referral

Female syphilis cases by geographic area and treatment status, Los Angeles County, January – August 2020[1]



[1] YTD 2020 data are preliminary and as of 11/01/20. Data exclude Long Beach and Pasadena. Treatment data are based on disposition. Syphilis among females of reproductive age (aged 15-44) including all cases staged as primary, secondary, early non-primary non-secondary (previously early latent) and unknown duration/late (previously late latent).

Trends in HIV-exposed infants and perinatal HIV transmission, 2006 to 2020[1]



In 2020, LAC had **4** perinatal HIV transmissions

Common maternal risk factors

- Meth use (N=3)
- Unhoused (N=3)
- Mental illness (N=3)
- STDs (N=4)
  - **Syphilis** (N=3), GC (N=1)
- History of incarceration (N=2) and partner incarceration (N=1)

Neonate information

Congenital syphilis (N=3)

[1]The number of infants with perinatal HIV infection (Red bars) includes perinatal transmissions that occurred in LAC for a given birth year. The number of HIV-exposed infants was derived from 7 pediatric HIV-specialty sites which serve over 90% of HIV-positive pregnant women who seek care in Los Angeles County and is an underestimate of the total number of HIV-exposed infants in the County. Data for 2019 and 2020 are provisional due to reporting delay.

What do our surveillance data show?

HIV

- Although HIV diagnoses is declining, Los Angeles County is far from reaching our local EHE goals.
- An estimated 1,200 persons are infected with HIV annually and ~5,100 persons living with HIV are not aware of their infection.
- As HIV incidence declines, the potential for HIV outbreaks has grown.
  - Viral suppression is lagging due to gaps in the case cascade and will contribute to onward transmission.
  - Meth use among persons who inject drugs (PWID) is increasing, especially young PWID and unhoused PWID.
  - In 2020 hotspots of rapid and recent transmission were identified in West Hollywood, Downtown, and South LA.
- Perinatal transmission is on the rise and fueled by syndemics of syphilis co-infection, meth use, homelessness, and mental health.

What do our surveillance data show?

STDs

- Syphilis cases have increased 450% among females and 235% among males since 2009.
- Meth use has increased among females and men who have sex with men (MSM) and MSM who have sex with women.
- Increases in syphilis among females has led to a historic high in congenital syphilis cases.
- Maternal risk factors for congenital syphilis include meth use, unstable housing, mental illness, and lack of prenatal care.
- Syphilis co-infection is common among persons with diagnosed HIV residing in high priority HIV cluster locations and among infants with perinatal HIV infection.

Intersecting epidemics and opportunities

HIV

Substance abuse

Mental illness

Unstable housing

Low access to care

Lack of integrated services

Syphilis

Opportunities

- Leverage EHE funds to increase collaboration between STD, HIV, substance abuse prevention and control, and housing programs
  - Work with providers for substance abuse services and homeless programs to provide pregnancy screening for women, HIV and syphilis testing for patients, and facilitate prompt linkage to care and prevention programs.
  - Target harm reduction outreach in homeless encampments to prevent outbreaks.
  - Integrate HIV recency testing in STD and HIV screening programs to identify and rapidly respond to clusters of recent transmission.
  - Expand active surveillance for perinatal HIV and syphilis exposure to improve identification and reporting of HIV-exposed and syphilis-exposed babies
  - Improve integration of data systems across HIV, STD, and substance abuse programs
  - Continue to strengthen the data to care continuum through real-time use of surveillance data to accelerate rapid intervention to stop transmission.

Thank you

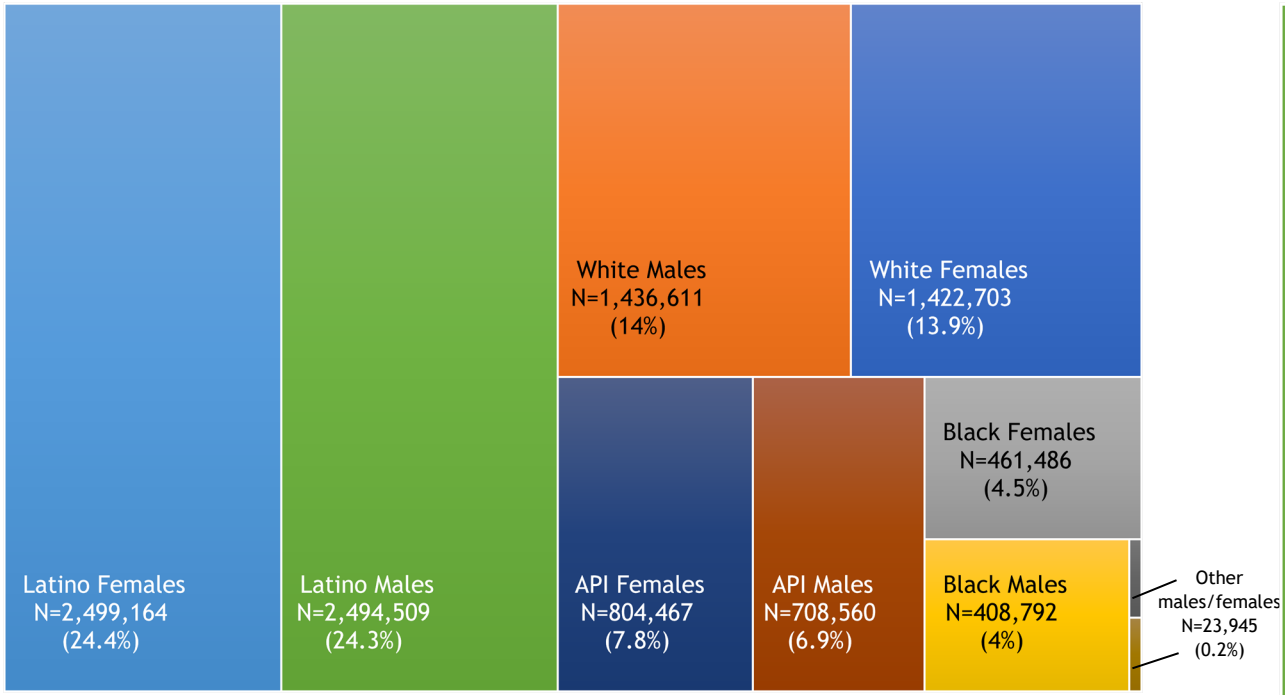
For more information, please visit
http://www.publichealth.lacounty.gov/dhsp/Reports/

Additional slides

Population dynamics, Los Angeles County, 2019-2020

County of Los Angeles Public Health

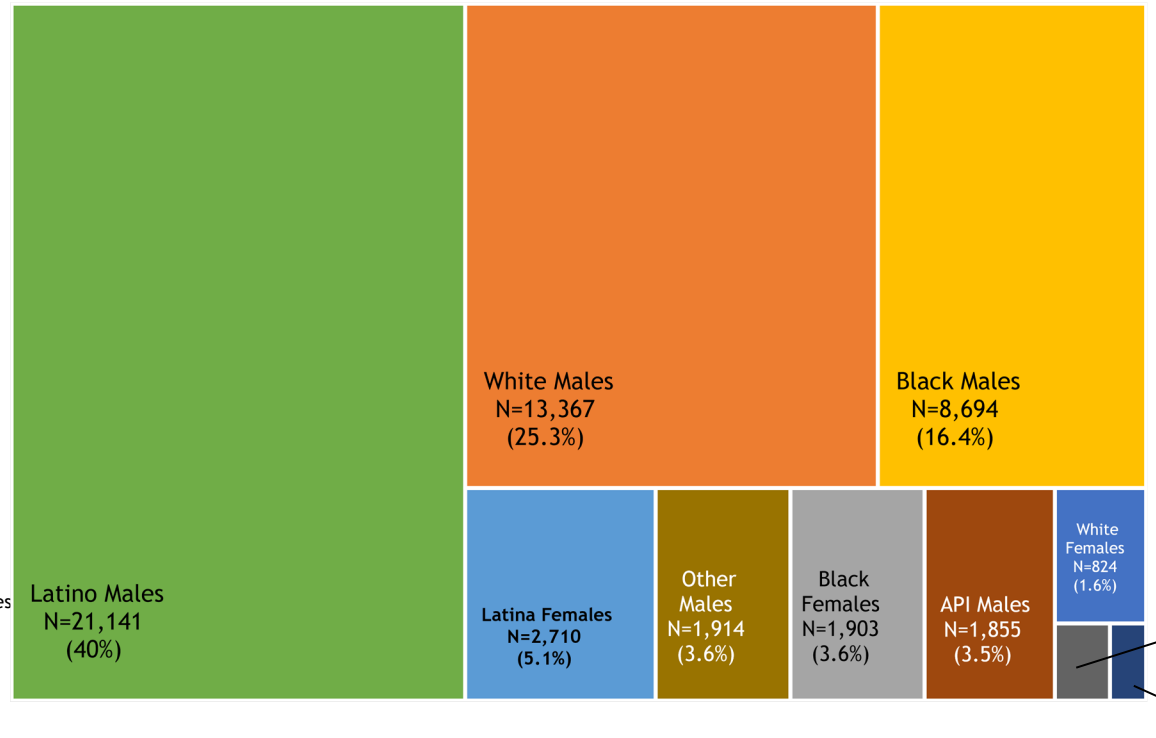
Distribution of sex[1] and race/ethnicity among Los Angeles County (LAC) residents in 2019 (N=10,260,237)[2]



[1] Population estimates are not currently available for transgender persons.
[2] Based on the 2019 population estimates provided by LAC internal Services Department and contracted through Hedderson Demographic Services.

~10.3 million people reside in LAC. The Latinx population represents the largest group, followed by the White population. Black men and women represent 8% of the total LAC population.

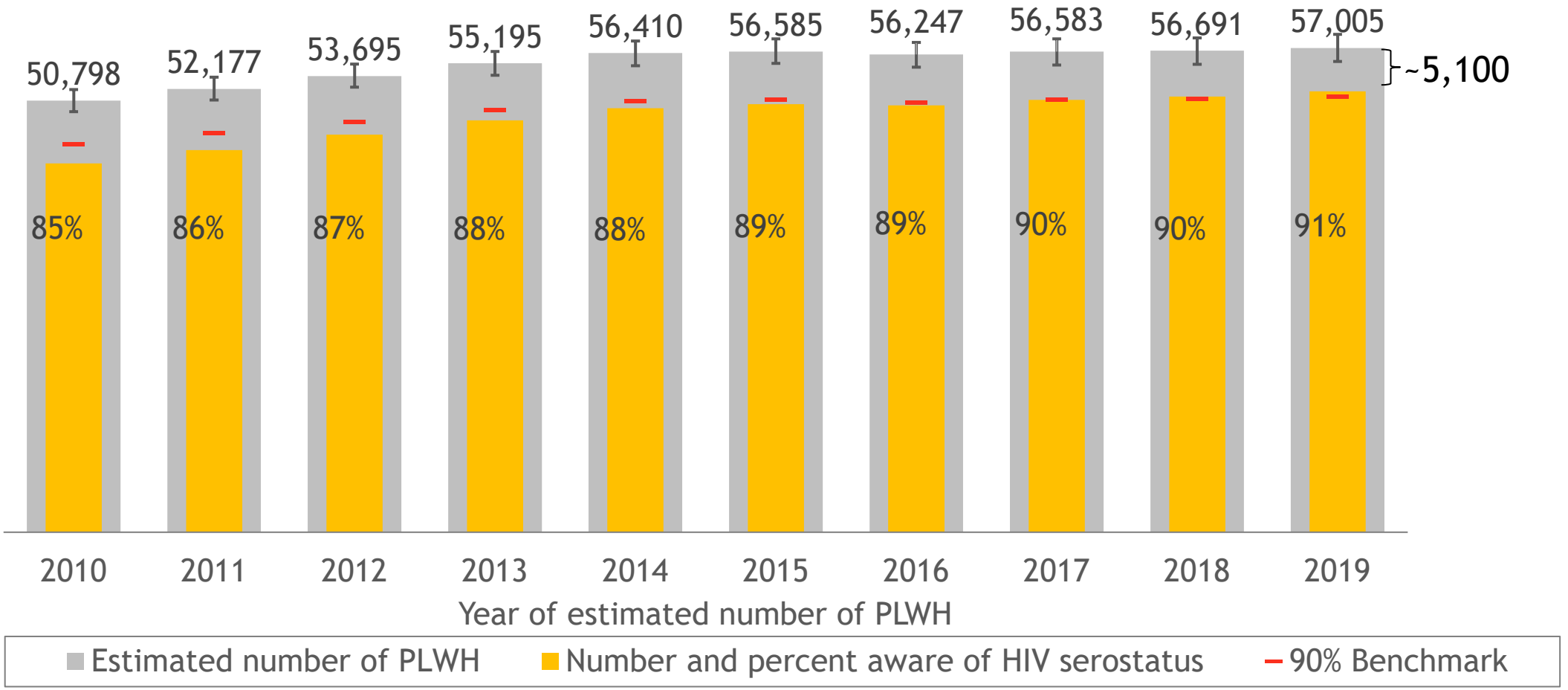
Distribution of sex[1] and race/ethnicity among persons living with diagnosed HIV at year-end 2020, LAC (N=52,878)



1. Population estimates are not currently available for transgender persons, therefore male and female categories are based on biological sex at birth.

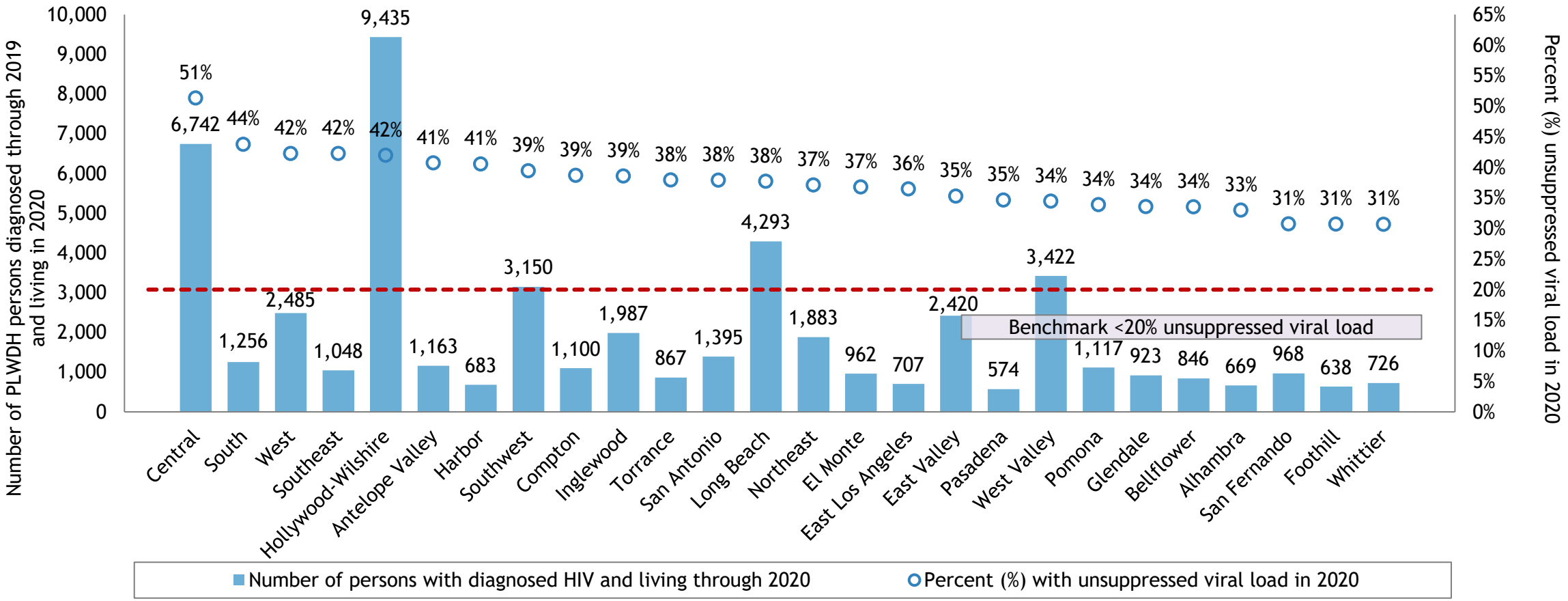
Latinos represent 40% of persons living with diagnosed HIV (PLWDH) followed by White (25%) and Black males (16%). These groups represent >80% of PLWDH in LA County.

Awareness of HIV-positive serostatus among PLWH aged 13 years and older, LAC 2010-2019[1]



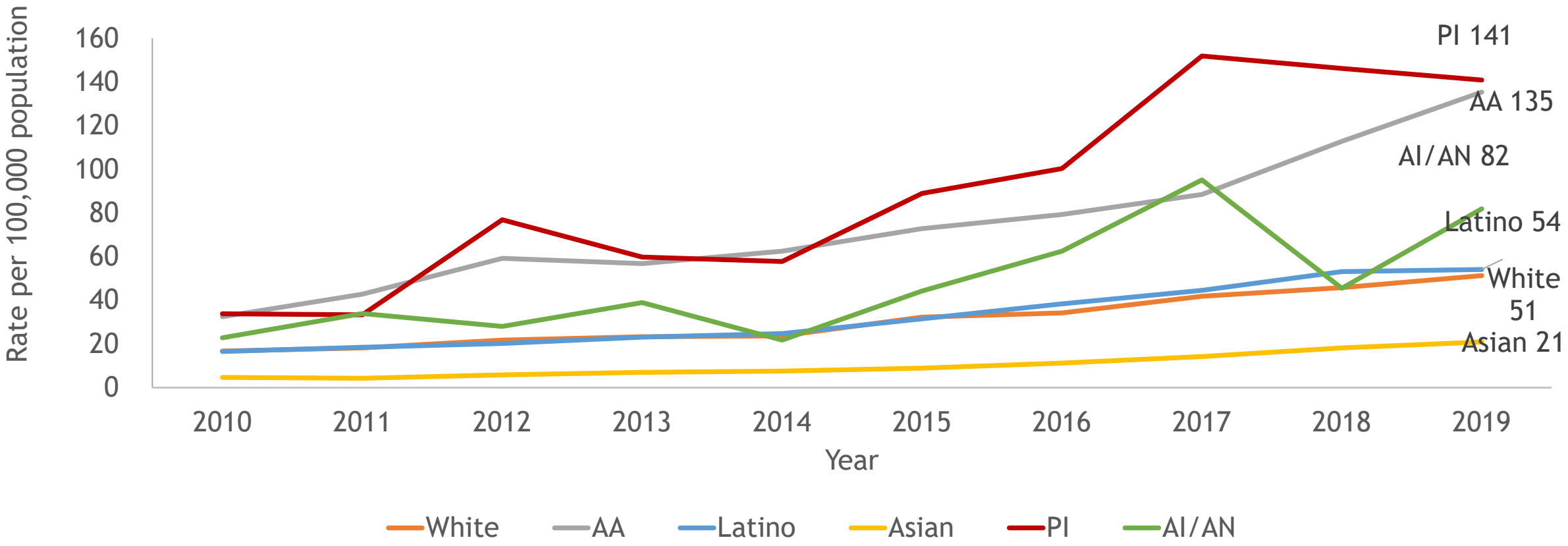
[1]Using the CD4-based model developed by the Centers for Disease Control and Prevention, modified for use by Los Angeles County. 2019 incidence estimates are preliminary

Unsuppressed viral load by Health District among persons aged ≥ 13 years diagnosed through 2019 and living in LAC at year-end 2020

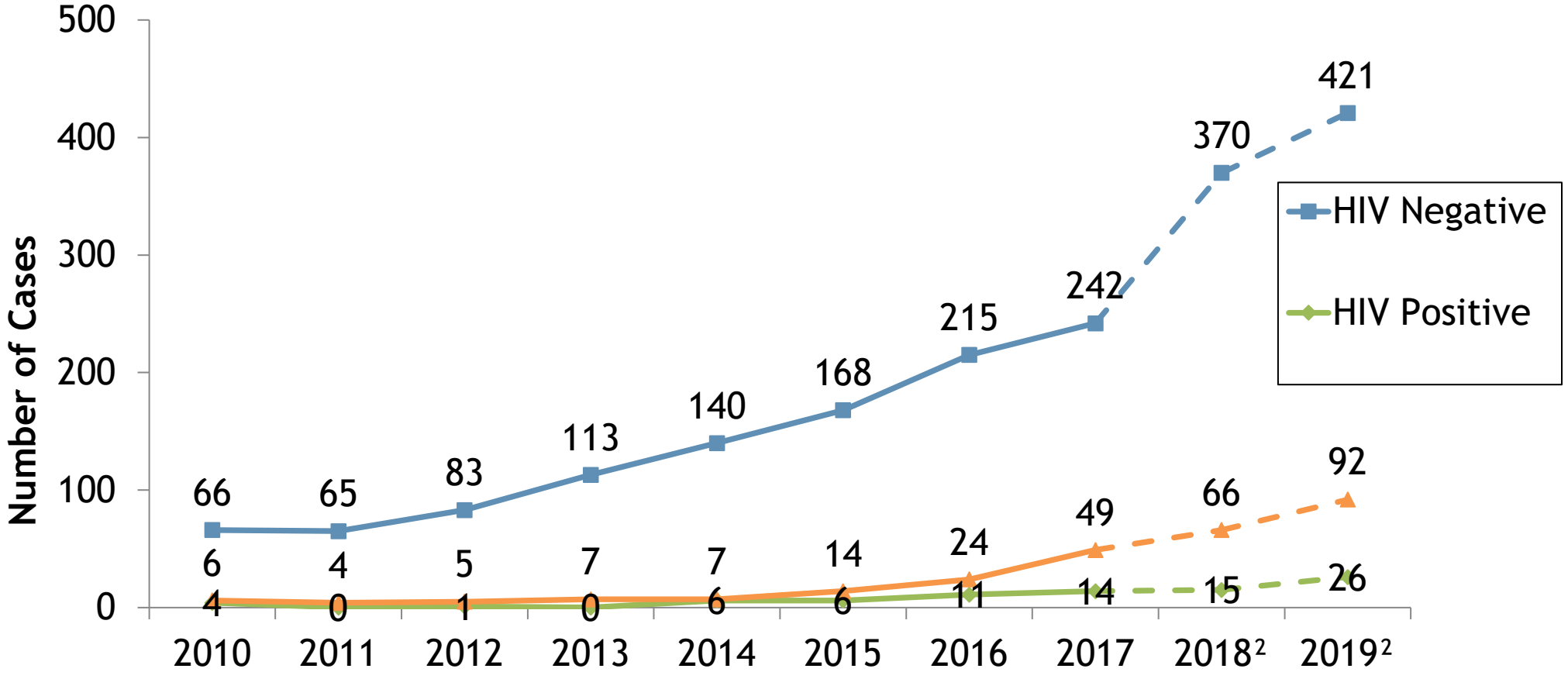


Unsuppressed viral load varies widely across LAC Health Districts. In 2020, no Health District achieved the national target for viral suppression, and lowest achievements were seen in Central, South, West, Southeast, and Hollywood-Wilshire Health Districts where unsuppressed viral load levels were ≥ 40%.

Syphilis Rates by Race/Ethnicity, 2010-2019

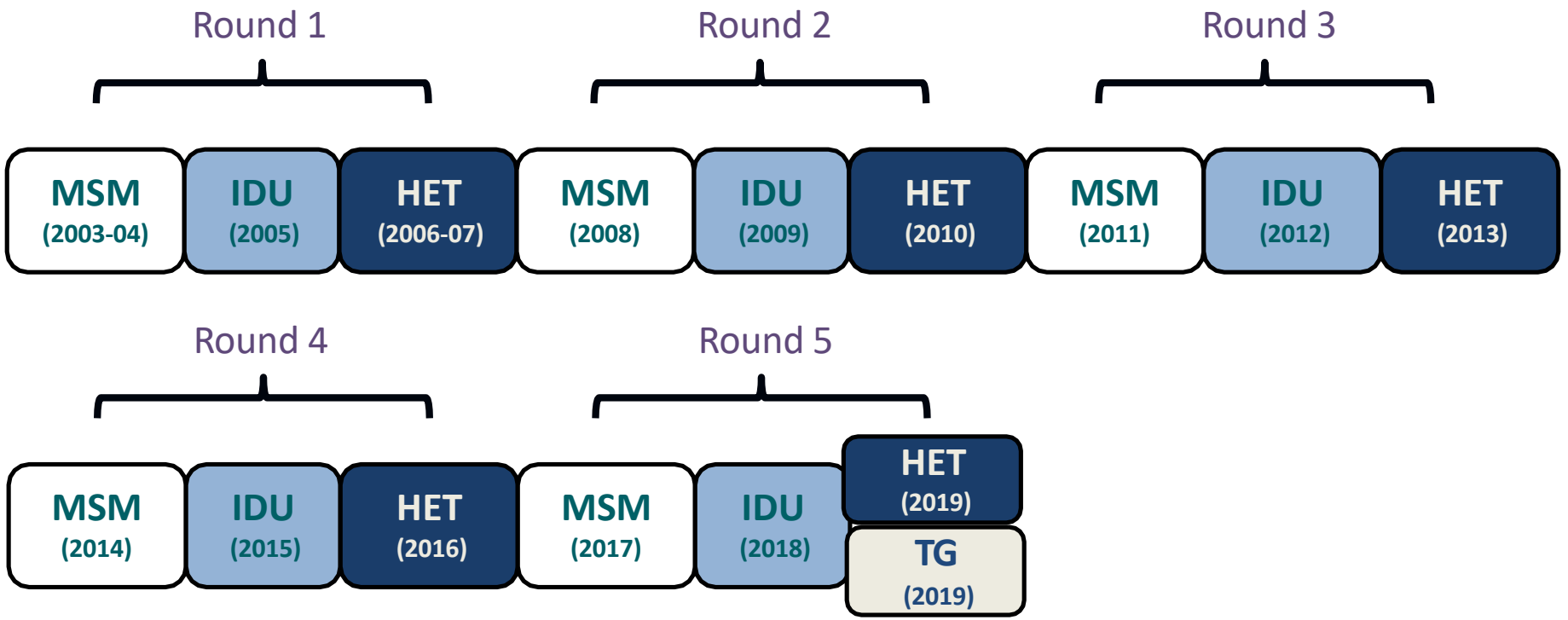


Number of Early Syphilis Cases among Females by HIV Status, Los Angeles County, 2013-2019[1]



[1] HIV positive status includes cases that were either self-reported and/or laboratory confirmed. Data as of March 14, 2021.
[2] 2018-2019 data are provisional due to reporting delay.

NHBS annual rotating cycles



NHBS is implemented in annual rotating cycles such that each population is surveyed once every 3 years.

***MSM: Men who have sex with men *IDU: Injection drug users *HET: Heterosexuals at increased risk for HIV infection (HET). Transgender (TG) will be piloted in 2019 as part of Round 5**

DHSP Provider Survey: Background

- In an effort to better understand the needs of community members and support the services being offered by Ryan White providers, DHSP distributed a short online survey regarding the **childcare, interpretation** and **translation** needs of clients
- The survey consisted of 7-10 questions and was estimated to take 5-10 minutes
- The link was emailed to 42 Ryan White agencies on 12/16/2020
- 16 of the 42 agencies responded (38%) at this time
- The link was emailed again to agencies on 3/02/2021 to ask for participation
- An additional 8 agencies responded
- **Overall response rate was a total of 24/42 (57%)**

Top 5 RW Agencies with Highest Proportion of Non-English Speaking Clients

Agency	Total Non English Speakers (%) - March 2019-February 2020
Bienestar	69 (87.3%)
El Proyecto Del Barrio	146 (68.2%)
AltaMed	750 (59.3%)
Rand Schrader	1030 (55.7%)
MCA Clinic	251 (54.1%)

*Highlighted color denotes agencies that completed and submitted the Provider Survey

Provider Survey: Childcare and Translation Needs

24 out of 42 RW agencies responded (57%)

- AIDS Health Care Foundation
- APLA
- Bienestar
- Children's Hospital Los Angeles
- City of Long Beach
- DHS Harbor UCLA Medical Center
- DHS High Desert Health
- DHS Hubert Humphrey – Main Street Clinic
- DHS Long Beach Comprehensive Health Center
- DHS Olive View, UCLA
- DHS Rand Schrader Clinic
- East Valley Community Health Center
- El Proyecto del Barrio
- JWCH
- Oasis Clinic
- Northeast Valley Community Clinic
- Saban Community Clinic
- St. John's Well Child and Family Center
- St. Mary's Care Center
- Tarzana
- T.H.E. Clinic Inc
- UCLA Care Clinic
- UCLA Peds/LAFAN
- Watts Health Care Corporation

Top 5 RW Agencies with Highest Proportion of Female Clients of Childbearing Age

Agency	Total RW Females Served, Aged 15-44 (%) - March 2019-February 2020
Salvation Army Alegria	17 (60.7%)
MCA Clinic	230 (49.6%)
Center for Health Justice	18 (18.8%)
Children's Hospital, LA	8 (16.7%)
Watts HealthCare Corporation	19 (9.1%)

*Highlighted color denotes agencies that completed and submitted the Provider Survey

Provider Survey: Childcare Needs

- None of the agencies who responded to the survey currently provide childcare services
- 11/24 (46%) identified a need for childcare
  - 9/11 (82%) said 25% or less of their clients needed childcare about 2 days/week

Would you consider applying for childcare if DHSP offered it?

- YES: 11/24 (46%)
  - 5 agencies who did NOT identify a need for childcare would apply anyway
- NO: 13/24 (54%)
  - 4 agencies who stated they needed childcare would NOT apply for funding
  - Main reasons: Don't have the client need, **lack of space**, no females of childbearing age served

Provider Survey: Childcare Needs

County of Los Angeles Public Health

Agency	Need Childcare? Yes/No	Consider Childcare if DHSP funded?	Total RW Females Served, Aged 15-44 (%) - March 2019-February 2020
AIDS Healthcare Foundation	No	No	163 (4.3%)
APLA	No	Yes	61 (2.3%)
Bienestar	No	Yes	2 (2.5%)
Children's Hospital	No	Yes	8 (16.7%)
DHS Harbor UCLA	No	No	56 (6.7%)
DHS High Desert	No	Yes	7 (4.8%)
DHS Long Beach	No	No	4 (2.5%)
East Valley Community Clinic	No	No	21 (4.8%)
JWCH	No	Yes	34 (3.7%)
Saban Community Clinic	No	No	---
St. Mary's Care Center	No	No	41 (3.9%)
T.H.E. Clinic	No	No	13 (6.3%)
UCLA CARE Clinic	No	No	16 (2.4%)

Provider Survey: Childcare Needs

Agency	Need Childcare? Yes/No	Consider Childcare if DHSP funded?	Total RW Females Served, Aged 15-44 (%) - March 2019-February 2020
City of Long Beach	Yes	No	10 (4.9%)
DHS Hubert Humphrey – Main Clinic	Yes	Yes	18 (5.0%)
DHS Rand Schrader	Yes	Yes	147 (7.9%)
DHS Olive View UCLA	Yes	Yes	46 (8.5%)
El Proyecto Del Barrio	Yes	Yes	10 (4.7%)
UCLA (LAFAN)	Yes	No	---
Northeast Valley Health Corp	Yes	No	42 (5.9%)
OASIS Clinic	Yes	No	27 (7.6%)
St John's	Yes	Yes	6 (6.9%)
Tarzana	Yes	Yes	19 (3.3%)
Watts Health Care Corporation	Yes	Yes	19 (9.1%)

Provider Survey: Translation Needs

- **21/24 (88%) <u>currently</u> offer translation/interpretation service**
- Those that offered translation/interpretation services noted they use:
  - *"A translation/interpretation service is used for the whole company. When we had PALS it was more convenient."*
  - *"Staff are bilingual and so can meet most language needs on their own."*
  - *"We use a telephone translation service or staff members when needed. Providers are never really sure that patients are understanding medication instructions or are able to answer all patient questions. Medical interpretation would also be a plus for deaf clients. In the past, GLAAD Case Managers would meet clients for appointments and were able to explain medication regimens, ask questions and assist with other client needs."*
  - *"We have traditionally used PALS for languages other than Spanish."*
  - *"We utilize facility resources for on site and telephonic interpretation or I-pad for sign language."*
- **Only 9/24 (38%) identified a need for translation services among 25-50% (avg) of their clients**
  - Languages requested: Spanish, Cantonese, Mandarin, Farsi, Tagalog, French

Provider Survey: Interpretation/Translation

County of Los Angeles Public Health

Agency	Need Interpretation?	Need Translation?	Total Non English Speakers (%) - March 2019-February 2020
AIDS Healthcare Foundation	No	No	1495 (22.8%)
APLA	No	No	579 (22.5%)
Bienestar	No	Yes	69 (87.3%)
Children's Hospital	No	No	3 (6.3%)
DHS Harbor UCLA	No	No	342 (40.6%)
DHS High Desert	No	Yes	20 (13.7%)
DHS Hubert Humphrey – Main Clinic	No	No	130 (36.6%)
DHS Long Beach	No	No	38 (23.3%)
DHS Olive View UCLA	No	No	249 (46.2%)
Northeast Valley Health Corp	No	No	313 (43.9%)
Saban Community Clinic	No	Yes	---
St John's	No	No	46 (52.9%)
St. Mary's Care Center	No	Yes	197 (19.1%)
Tarzana	No	No	53 (9.2%)
UCLA Care Clinic	No	Yes	79 (11.9%)

Provider Survey: Interpretation/Translation

Agency	Need Interpretation?	Need Translation?	Total Non English Speakers (%) - March 2019-February 2020
UCLA (LAFAN)	Yes	Yes	---
OASIS Clinic	Yes	Yes	83 (23.3%)
City of Long Beach	Yes	Yes	36 (17.7%)
DHS Rand Schrader	Yes	No	1030 (55.6%)
East Valley Community Clinic	Yes	Yes	136 (30.9%)
El Proyecto Del Barrio	Yes	Yes	146 (68.2%)
JWCH	Yes	No	242 (25.9%)
T.H.E. Clinic	Yes	Yes	64 (31.4%)
Watts Health Care Corporation	Yes	Yes	91 (43.8%)

Summary/Key Take Aways

- Fewer than half of the 24 providers who responded to the survey stated they needed childcare services and just over half indicated they would not apply for additional funding if available (58%). Most also indicated it was a need only 1-2 days a week.
- Most providers offer interpretation/translation services (88%) and only 33% indicated an additional need for these services. However, the comments implied that while these services may be available, they could be improved especially for languages other than Spanish (e.g. Cantonese, Mandarin, Farsi, Tagalog, French).
- Three of out four of the providers (75%) reported no huge disruptions to their services from COVID-19. The main barrier or change noted was that services have moved to tele-health.
- Only 57% of the 42 DHSP-funded agencies responded to the survey so results may not represent the experience of all contracted agencies.

NMAC leads with race ENDING THE EPIDEMIC

Who Benefits from Minority AIDS Initiative (MAI) Funding?

In 1998 African Americans surpassed White people as the population with the largest number of new cases of HIV. After the data was released, 30 Black leaders met with the Centers for Disease Control and Prevention (CDC) to demand action. The effort was led by Dr. Beny Primm, then board chair of NMAC. He had NMAC's Director of Government Relations, Miguelina Maldonado, work with the Congressional Black Caucus, the Congressional Hispanic Caucus, and the Congressional A/PI Caucus to create the Minority AIDS Initiative (MAI). The goal for the MAI was to build the infrastructure of minority-led community-based nonprofits to minimize the racial divide in HIV health outcomes for African Americans and all people of color.

Table 24. Estimated persons living with AIDS, by race/ethnicity and year, 1993 through 1999, United States[1]

	Year						
Race/ethnicity	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
White, not Hispanic	80,480	86,703	91,756	98,615	107,273	114,895	122,880
Black, not Hispanic	60,678	71,863	81,287	92,274	105,306	117,426	129,943
Hispanic	31,245	36,524	41,072	46,194	52,121	57,443	62,995
Asian/Pacific Islander	1,295	1,460	1,617	1,859	2,094	2,318	2,609
American Indian/Alaska Native	569	662	718	803	888	969	1,085
Total[2]	**174,475**	**197,471**	**216,796**	**240,184**	**268,242**	**293,702**	**320,282**

[1]These numbers do not represent actual cases of persons living with AIDS. Rather, these numbers are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases and estimated deaths are adjusted for reporting delays, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available. See Technical Notes.
[2]Totals include estimates of persons whose race/ethnicity is unknown. Because column totals were calculated independently of the values for the sub-populations, the values in each column may not sum to the column total.

After 20 years of MAI funding, which communities benefited the most?

Race/ethnicity	% of People with HIV, 2018	% of U.S. Population, 2018
Black	41%	13%
White	29%	60%
Latino	23%	18%
Asian	1.5%	6%
American Indian/Alaska Native	0.3%	1.3%
Native Hawaiians and Other Pacific Islanders	0.09%	0.2%

Source: CDC, Estimated HIV incidence and prevalence in the United States, 2014–2018, and US Census Bureau, Quick Facts —United States.

From 1998 to 2018, African Americans with HIV went from 39 percent of the cases in 1998 to 41 percent of the cases in 2018. White people went from 40 percent of the cases in 1998 to 29 percent of the cases in 2018. The Latinx community went from 19.5 percent of the cases to 23 percent in 2018. Asians went from 0.78 percent to 1.5 percent of the cases. American Indians/Alaska Natives stayed level at 0.3 percent. After 20 years of MAI and other funding, only the White community saw a significant decrease in HIV cases.

That outcome speaks directly to the question the Biden/Harris administration is trying to unpack with the Executive Order looking at racial equity across all government programs: to not just look at how race impacts access and funding, but also how to make the system fair. They are seeking community input on how to make this happen.

Per an email from the White House:

“Through the Office of Management and Budget, the Biden-Harris administration is soliciting input from stakeholders in the public, private, advocacy, not-for-profit, and philanthropic sectors, including State, local, Tribal, and territorial areas. This request for information (RFI) seeks answers to dozens of questions critical to the administration’s efforts to advance equity, including how agencies can address known burdens or barriers to accessing benefits programs in their assessments of benefits delivery, and what practices agencies should put in place to reach rural areas and communities that might not be able to visit Washington, D.C., to engage directly with policymakers.

"A link to the RFI can be found at: https://www.federalregister.gov/documents/2021/05/05/2021-09109/methods-and-leading-practices-for-advancing-equity-and-support-for-underserved-communities-through

"Responses are due: Tuesday, July 6, 2021"

I believe the White House understands the system is unfair. The challenge is how to fix it. NMAC hopes you will respond to this RFI and write about your solutions. As we get ready to prepare our response, I will share our journey. This question is core to NMAC's mission. How do we change the structural racism that is baked into the federal government?

Yours in the struggle,

Paul Kawata
NMAC

DONATE

Our mailing address is:
1000 Vermont Avenue, NW, Suite 200
Washington DC 20005-4903