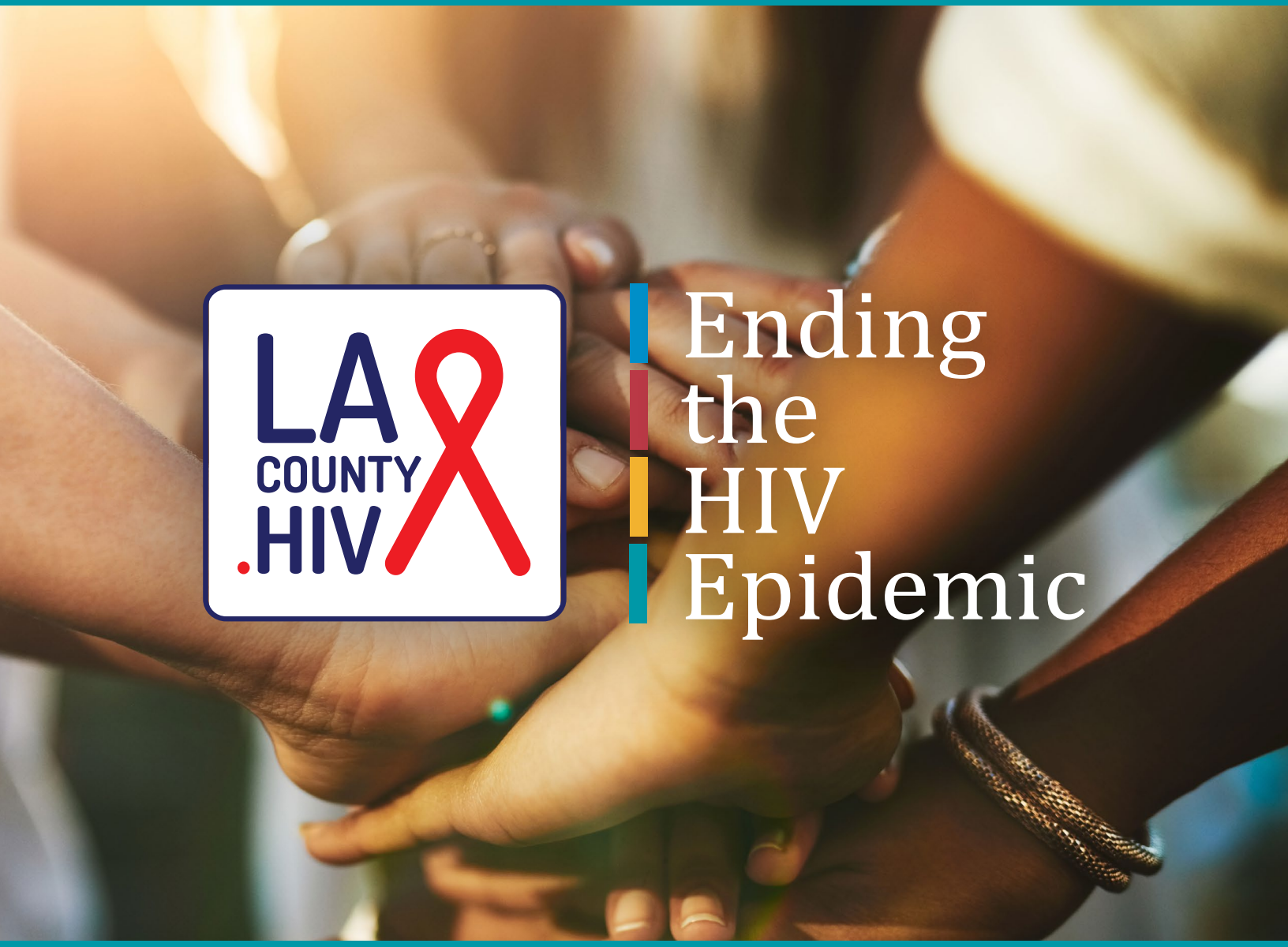

ENDING THE HIV EPIDEMIC IN LOS ANGELES COUNTY

2020-2025

County of Los Angeles
Public Health
DIVISION OF HIV AND STD PROGRAMS

COUNTY OF LOS ANGELES
Public Health

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January 7, 2021

Dear EHE Colleague:

SUBJECT: ENDING THE HIV EPIDEMIC (EHE) IN LOS ANGELES COUNTY

On behalf of the Los Angeles County (LAC) Department of Public Health, its Division of HIV and STD Programs and many critical contributors, partners and stakeholders, I am pleased to announce the release of the ***Ending the HIV Epidemic Plan for Los Angeles County***.

In full alignment with the national initiative, ***Ending the HIV Epidemic: A Plan for America***, our EHE Plan focuses on four key pillars designed to help us reach the goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years (by 2025) and by 90 percent in ten years (by 2030.)

The four EHE Pillars are:

1) **Diagnose** people living with HIV as early as possible;
2) **Treat** people living with HIV rapidly and effectively to achieve viral suppression;
3) **Prevent** new HIV transmissions using proven interventions, and;
4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them.

Please know that while we continue to implement interventions to address these pillars, we are also guided by an overarching strategy to ensure that the interventions address and eliminate health inequities, that considers long-standing racial inequities that contribute to HIV-related disparities, that focuses on the communities and sub-populations most impacted by HIV, and prioritizes a client-centered, people first approach to this endeavor. To reach the goals outlined in the EHE Plan for Los Angeles County, significant scale up and expanded reach of both new and proven interventions is needed. We are hopeful that the plan, guided by the four pillars and undergirded by the most effective strategies and interventions will allow us to collectively meet our shared goals.

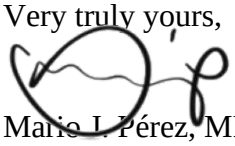
As we launch this EHE plan and with a renewed commitment and deeper understanding of the importance of public health, we remind ourselves that there are approximately 58,000 people living with HIV (PLWH) in our County in 2021, the majority of these persons are male (90%), a smaller fraction are female (9%) and an even smaller fraction yet are transgender (but remain among the most disproportionately impacted sub-populations in our County). We are encouraged that the majority of PLWH in LAC are treating their HIV infection with highly active antiretroviral therapy (ART) and effectively managing HIV as evidenced by their achievement of sustained viral suppression – that is, reducing the level of HIV in the bloodstream to a level that is so low that it is undetectable.

While we remain encouraged by areas of HIV progress, we recognize that this progress is uneven. Not only must we confront HIV-related health disparities fueled by structural racism, social inequity and economic inequality, we must also recognize that other threats to our HIV progress have persisted or have worsened in recent years, including those related to syphilis (and congenital syphilis), homelessness, and substance use disorders.

We are aware that we are releasing this EHE Plan during the devastating COVID-19 pandemic, an acute economic crisis, and a time of heightened political, social, and racial tensions. We have been reminded of the fragile nature of our lives and the complex set of issues that impact our charge, our progress and the health and vitality of our communities. As we take this moment to launch our EHE Plan for Los Angeles County, we do this in the context of the realities surrounding our community, our County, California, the United States and the globe.

Thank you all in advance for your commitment and action to operationalize this EHE Plan and for joining us as we remain undeterred to keep our promise to end to HIV, once and for all.

Very truly yours,



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

MJP:JT

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Introduction

Ending the HIV Epidemic: A Plan for America (EHE) is a national initiative which focuses on four key pillars of interventions designed to help us reach the goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years (by 2025) and by 90 percent in ten years (by 2030).[1] The four EHE Pillars are: (1) **Diagnose** people living with HIV as early as possible, (2) **Treat** people living with HIV rapidly and effectively to achieve viral suppression, (3) **Prevent** new HIV transmissions using proven interventions, and (4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them.

Through collaboration with key stakeholders and community partners, the Los Angeles County Department of Public Health (LAC DPH), Division of HIV and STD Programs (DHSP), plans to guide, implement and evaluate activities that enhance the current Los Angeles County HIV portfolio; align our efforts with the four pillars of EHE, and further advance efforts to both prevent new HIV infections and improve HIV-related health outcomes among persons living with HIV. EHE is built on the premise that the right data, the right tools, and the right leadership will be the drivers in achieving a generation not impacted by HIV/AIDS; this will require commitment, accountability, and transformational leadership across sectors.

Today in Los Angeles County (LAC), there are approximately 58,000 people living with HIV (PLWH), the majority of these persons are male (90%), a smaller fraction are female (9%) and a smaller number (but highly disproportionate compared to their share of the LAC population) are transgender (either male to female or female to male). The majority of PLWH in LAC are treating their infection with highly active antiretroviral therapy (ART) and effectively managing HIV as evidenced by their achievement of sustained viral suppression – a level of HIV in the bloodstream that is so low that it is undetectable. While some people living with HIV can achieve viral suppression through the routine and consistent access to their health care delivery system, many other persons living with HIV depend on access to a broader menu of medical and support services to achieve viral suppression. These services include but are not limited to medical care coordination services that improve health system navigation, housing support, mental health, oral health, food and nutrition services, substance use treatment, and transportation services.

In addition to the 58,000 persons living with HIV in LAC, there are nearly 1,700 new HIV infections each year and separately there are more than 6,000 undiagnosed persons living with HIV. For persons living with HIV, adherence to ART and achieving viral suppression is critical to promoting health and to ensuring that HIV is not sexually transmitted to others.[2] For persons who have HIV but are not yet diagnosed (e.g. unaware of their infection) or for persons who have been diagnosed but are experiencing challenges with both adherence to ART and maintaining viral load suppression, the scale up of existing effective interventions and the adoption of new interventions are necessary to achieve our Ending the HIV Epidemic goals. It has been well established that broad scale testing that allows persons with HIV to be diagnosed as close to the period of infection as possible and promptly linking newly HIV diagnosed persons to care and treatment services will not only improve overall individual health outcomes but will also have broad public health benefits. The support and access of new biomedical HIV prevention tools like PrEP (pre-exposure prophylaxis or a daily pill that prevents HIV transmission) for HIV-negative persons at elevated risk for HIV continues to be uneven across Los Angeles County. The underutilization of these low-cost or no-cost prevention tools in the most impacted areas of our County will require a renewed commitment of education, awareness, and mobilization if we are to realize the full potential of this science, and end the HIV epidemic, once and for all.

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[1] https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview

[2] https://www.cdc.gov/hiv/risk/art/index.html

Please note that the following EHE Plan for Los Angeles County is written and structured in accordance with the Centers for Disease Control and Prevention (CDC) requirements and guidelines for *Notice of Funding Opportunity (NOFO) PS19-1906: Strategic Partnerships and Planning to Support Ending the HIV Epidemic in the United States Component B*: *Accelerating State and Local HIV Planning to End the HIV Epidemic* and does not include descriptions of the entire existing LAC HIV portfolio. A list of acronyms utilized throughout the Plan are included in Appendix A.

Section I: Engagement Process

Community engagement has been and will continue to be invaluable to the planning and development process for HIV prevention, care and treatment services throughout Los Angeles County (LAC). Prior to the launch of *Ending the HIV Epidemic: A Plan for America* (EHE), LAC developed and released its own jurisdictional plan in November 2017, the *Los Angeles County HIV/AIDS Strategy for 2020 and Beyond* (LACHAS), which offered a framework of policies, recommended strategies, and numerical targets that collectively we sought to achieve.

In February 2019, fifteen months after the release of LACHAS, the federal administration announced its plan to launch EHE, providing LAC with the opportunity to adapt and expand the goals and activities described in LACHAS and requiring LAC to align its current efforts with the national EHE initiative. LAC DPH elicited and secured input and guidance on services and activities critical to LACHAS and necessary for EHE implementation through a series of listening sessions and planning meetings with community stakeholders including the Los Angeles County Commission on HIV (local Ryan White Program (RWP) planning body), the California Department of Public Health Office of AIDS (California OA), the University of California at Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), the local EHE Steering Committee, people living with HIV/AIDS (PLWH) and a broad network of community-based service providers. LAC DPH also engaged in meetings and site visits with multiple federal partners to inform local EHE efforts. Los Angeles County will continue to work to engage communities, especially those that are hardly reached, as we jointly implement the EHE Plan and are prepared to adapt our strategies, activities, and portfolio as EHE needs evolve throughout the years.

Local Prevention and Care Integrated Planning Body

The Los Angeles County Commission on HIV (Commission) is the local, federally mandated Ryan White Program community planning body that sets program priorities and funding allocations for HIV prevention, care and treatment services throughout the County. The Commission is comprised of 51 members (all appointed by the Board of Supervisors) who represent the diversity of LAC and communities impacted by HIV. LAC DPH has a long-standing partnership with the Commission and will rely on this and other partnerships as key community engagement efforts tied to EHE move forward.

After the release of the Los Angeles County HIV/AIDS Strategy (LACHAS), LAC DPH continued to collaborate with the Commission to disseminate, promote, and engage a broader set of community stakeholders to build knowledge and awareness of LACHAS strategies and goals, and to recruit new partners and voices into this effort. The Commission helped spearhead over a dozen call-to-action meetings, held in various communities and jurisdictions across the County to inform, engage, and empower community stakeholders and residents to participate in LACHAS implementation. As a result of outreach and promotion to the existing network of HIV planning, program and service partners, including special invites to key stakeholders and elected officials not traditionally engaged in HIV efforts, over 750 community stakeholders were reached through the call-to-action meetings. Summary reports from the call-to-action meetings, including health district demographics, key takeaways, and top insights

from the group discussions were developed and distributed to the community.[3] The Commission was integral in promoting LACHAS, encouraging the community to get involved, and identifying new non-traditional partners to join the movement to end the HIV epidemic. The ongoing community engagement and input conducted for LACHAS provided valuable perspectives on needed services and activities and helped drive the development of the EHE Plan.

In response to the announcement of EHE, the Commission held an all-day community meeting in November 2019 with over 190 participants to 1) directly hear from community partners on an EHE Plan for LAC, 2) determine the best way to engage the community moving forward as we transition from LACHAS to the EHE Plan, and 3) garner input on the leadership necessary to achieve EHE goals. The meeting included a panel of representatives from the California OA; LAC DPH leadership; the Office of Assistant Secretary of Health's Region IX Prevention through Active Community Engagement (PACE) Team; UCLA CHIPTS, among other important HIV stakeholders. Key takeaways included the importance of multi-sector commitment to achieve EHE goals, a commitment to being disruptively innovative with new and expanded interventions and policies, ensuring transparency and accountability from all partners, and lifting voices of communities most impacted by HIV. The meeting agenda is included in Appendix B.

In January 2020, the Commission reinforced its commitment to EHE efforts by providing dedicated space for Commissioners and members of the public to participate in small group breakout sessions to discuss additional ideas related to community engagement and mobilization for EHE. With an understanding that LAC needs to be even more intentional, has to be disruptively innovative and must bring new voices to the table to end the HIV epidemic, participants broke out into small groups to discuss and address several key questions, including: 1) How can community members take individual action in EHE efforts, 2) Which sectors should partners for prioritize for new or increased mobilization around EHE, and 3) How can the development of a new LAC EHE Steering Committee be used to support efforts to recruit new perspectives, enlist change agents and spur more action. As a follow up to these community-driven discussions, the Commission is also working to increase membership on its planning body with persons representing pharmaceutical companies, commercial health plans, and California's Medicaid program.

In September 2020, LAC DPH released the draft EHE plan to community stakeholders as part of a 30-day public comment period and partnered with the Commission to ensure individuals and communities were aware of the input opportunity. In addition, Commissioners were provided an opportunity to submit written feedback as a complement to the listening sessions facilitated by Commission staff. The Commission submitted 13 pages of public comments including recommendations from the Black/African American Community Taskforce to be considered for inclusion in the EHE Plan. Separately, Commission leaders continue to provide feedback on the content, strategies, and activities included in the EHE Plan.

Local Community Partners

In September 2020, LAC DPH formed an Ending the HIV Epidemic (EHE) Steering Committee as a strategy to identify new partners that could support the local implementation of new EHE strategies as well as serve as catalyst for collective action to end the HIV epidemic (Appendix C). To maximize the pool of potential Steering Committee candidates, LAC DPH launched an application process via an online survey platform, distributed the application across 11 distinct HIV and non-HIV specific listservs, and reached out to mission-aligned partners such as the Region IX PACE Program, the LAC DPH Center for Health Equity, and the LAC DPH Regional Health Offices to further amplify the application opportunity. A review team from LAC DPH and the Executive Director of the Commission on HIV reviewed and scored

[3] https://tinyurl.com/LACHASmeetings

over 85 applications that were received over a two-week period, and selected Committee members who reflect a broad range of disciplines and perspectives beyond HIV including health equity, social justice, substance use disorder, housing, and mental health. LAC DPH notified candidates in early September 2020 and announced Committee Members to the public at the Ending the HIV Epidemic Townhall on September 16, 2020. The first Steering Committee meeting was held on October 1, 2020 and a subsequent meeting was held on November 10, 2020. The EHE Steering Committee members will be integral in the development and implementation of the EHE Plan and have been tasked to not only provide their input on the proposed strategies and activities, but also assume roles as EHE ambassadors and help advance specific EHE projects in their organizations and/or communities.

Local community partners have also been engaged through recurring EHE updates at monthly Commission meetings and subcommittee meetings. In addition, the Commission currently has three official caucuses (Consumer Caucus, Women's Caucus, and Transgender Caucus) and two taskforces (Aging Taskforce and the Black/African American Communities Taskforce) that focus on specific populations disproportionately and/or highly impacted by HIV. After the COVID-19 pandemic forced the closure of most County offices in March 2020, the Commission switched all meetings to a virtual platform, allowing community partners to continue to participate in critical Commission deliberations. During that period, there has been a notable increase in community participation in these meetings, including an estimated 25% increase in new participants in the monthly meetings and a 50% increase in new participants at the Commission's recently-launched Virtual Lunch and Learn Series which reviews and promotes HIV services available across the County. The Commission's virtual platform has allowed participation from individuals who had not been able to attend meetings in the past due to competing priorities, logistical challenges, or other barriers.

On September 16, 2020, LAC DPH hosted a virtual Ending the HIV Epidemic (EHE) Townhall to provide an overview of EHE efforts, describe how COVID-19 is impacting progress on EHE, and formally open a 30-day community public comment period on the EHE plan. The public comment opportunity was promoted both at the Townhall and through the same vehicles used to promote the EHE Steering Committee application and recruitment process. As a follow up to the EHE Townhall, LAC DPH hosted a virtual EHE Townhall in Spanish on October 28, 2020 in collaboration with the Commission and the Region IX PACE Program to provide space for the Spanish-speaking community to learn about EHE and provide input on the proposed plan. Through this exercise, LAC DPH gathered input from a diverse group of local community partners, service providers, and new voices which resulted in the submission of 26 public comments via the online feedback form (17 pages), six pages of comments from the EHE Steering Committee, and two pages of comments from the EHE Spanish-language event. The key themes that emerged from the Spanish-language event included the need to focus on communities most impacted by HIV; the need for increased educational opportunities for non-HIV-sector providers and community partners on implicit bias, trauma informed care, medical mistrust, sexual health, and Pre-exposure Prophylaxis (PrEP); and the need to implement rapid/same day ART and same day PrEP.

To further expand the reach and engagement of new voices and local community partners, LAC DPH plans to conduct widespread and meaningful engagement on EHE efforts in communities across the County by partnering with organizations that will empower residents to affect change in their own communities through a community-led approach. Community residents will focus on advancing projects related to the Diagnose, Treat, and Prevent EHE Pillars.

Local Service Provider Partners

Local service providers are represented and engaged through various committees, coalitions, working groups, and networks across Los Angeles County. There is a strong network of LAC DPH funded community-based organizations that serve people living with and affected by HIV in diverse communities across the County. In addition, there are several public facing listservs that disseminate information for trainings, webinars, and events related to HIV and the social determinants of health that impact HIV. Service providers are also represented on the Commission, the EHE Steering Committee, and Service Provider Networks (SPNs) in specific jurisdictions across the County. There are strong coalitions and groups in LAC such as the LAC PrEP/PEP Working Group and the Ending the Epidemics Statewide Coalition that addresses policy and advocacy on the intersection between HIV, sexually transmitted infections (STIs), and viral hepatitis. By actively working with these groups and coalitions, LAC DPH has been able to gain input and guidance on HIV prevention, care and treatment efforts. Service providers were actively engaged in the various community listening sessions and health district discussions that were facilitated as part of the development and release of LACHAS; and most have remained active in the development and refinement of the EHE Plan. LAC DPH continues to partner and collaborate with two city health departments that exist within the County (Long Beach Department of Health and Human Services and the Pasadena Public Health Department) to advance EHE strategies. We hope to align the existing HIV plans and programs goals in these jurisdictions (e.g. the Long Beach HIV/STD 2019-2022 Strategy) with the LAC EHE Plan as well.

In addition to the existing service provider network, LAC DPH has been working to enlist its five Regional Health Offices that oversee all public health issues in specific geographic service planning areas throughout the County as well as the LAC Community Prevention and Population Health Task Force which focuses on the social determinants of health but has not yet identified HIV as a priority public health issue. New potential EHE partners were also identified through the UCLA CHIPTS Regional EHE Coordination meeting held January 2020. In addition, LAC DPH will continue to work with the Los Angeles County Departments of Mental Health and Health Services to develop systems and processes that more effectively align goals, strategies, and programming to optimize HIV-related services for clients and communities. The PACE Program has been an important resource to help advance local EHE community engagement efforts. Separately, the LAC DPH HIV Medical Advisory Committee (which includes medical leadership from Ryan White Program-funded HIV Clinics across the County) and the Medical Care Coordination (MCC) Learning Collaborative (which provides feedback on all HIV prevention and treatment activities for high acuity clients in the MCC program) have also provided valuable feedback and perspectives tied to the EHE Plan.

Concurrence with Local Planning Council

The development of the EHE Plan was an iterative process designed to fully vet and refine the strategies and activities necessary to end the HIV epidemic in LA County (LAC). The approach for achieving concurrence included presenting drafts of the EHE Plan for review and input to the leadership of the Commission as well as providing the opportunity for Commissioners to submit feedback outside of the online public comment form to allow for flexibility in providing robust and overarching comments given the long-standing commitment and expertise of Commissioners. In addition, LAC DPH continues to provide space for Commissioners to provide ongoing EHE feedback at several monthly Commission committee and caucus meetings (i.e. Executive Committee which includes Commission leadership and Consumer Caucus meetings which includes consumers of HIV prevention and treatment services) and at the larger full Commission body monthly meetings. Consistent with the national and other jurisdictional

plans, the LAC EHE Plan is a living document and will continue to be updated based on progress as well as ongoing community engagement and guidance from key EHE stakeholders.

LAC DPH worked closely with the Commission to not only reach concurrence on the final plan, but to further engage the community and monitor progress of EHE strategies (Appendix D). LAC DPH values community voices as part of the planning, development, implementation, and evaluation of LAC HIV prevention, care and treatment efforts and is fortunate and grateful to the Commission for offering guidance and engaging community stakeholders in the development of the EHE Plan despite the COVID-19 impact on individuals and organizations across the County.

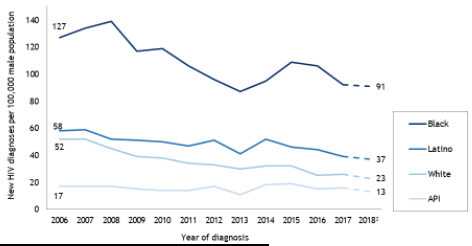
Section II: Epidemiologic Profile

Los Angeles County (LAC) spans over 4,000 square miles and includes 88 cities, 26 health districts, and a mix of urban, suburban, and rural areas. In 2018, there were an estimated 10.3 million people that resided in LAC with the Latinx population representing the largest population group (49%) followed by the White population (28%). The Black/African American (Black/AA) community represents 8% of the total LAC population. In contrast, the populations most impacted by the HIV epidemic are Latinx cisgender[4] men who have sex with men (cis MSM), who represent nearly 40% of all people living with HIV (PLWH) followed by White cis MSM (26%) and Black/AA cis MSM (16%). Combined, these three groups represent more than 80% of PLWH in LAC.

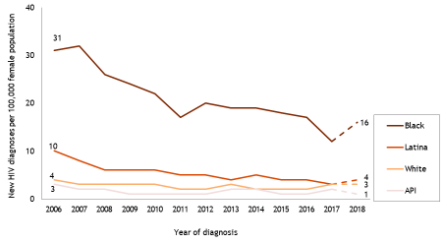
Epidemiological Profile – Pillar 1: Diagnose

In Los Angeles County (LAC), reducing new HIV infections and improving health outcomes for people living with HIV (PLWH) remains a challenge and a priority. In 2018, 1,660 persons aged 13 years and older were newly diagnosed with HIV infection with cisgender MSM representing 87% of those new HIV diagnoses (N=1,445). Cisgender women (cis women) (N=180; 11%) and transgender persons (N=35; 2%) represented a much lower number and proportion of persons newly diagnosed with HIV.[5] Again, the primary mode of HIV transmission for newly diagnosed cis men was having sex with other men (MSM; 92%), followed by combination of MSM and injection drug use (IDU; 4%), and IDU alone (3%). Among cis women newly diagnosed with HIV the primary modes of transmission were having sex with men (75%) and IDU (25%). The percentage of persons newly diagnosed with HIV who were unhoused at the time of diagnosis has more than doubled in recent years from 3.1% in 2010 to 7.5% in 2018. HIV diagnoses rates have also increased among persons experiencing homelessness in the past three years from 19 per 100,000 in 2015 to 24 per 100,000 in 2018. While HIV diagnoses rates have declined in general and across all racial and gender groups, key inequities persist. Black/AA cis men and cis women continue to have the highest rates of new diagnoses.[6]

HIV diagnoses rates among males aged ≥ 13 years by race/ethnicity, LAC 2006-2018



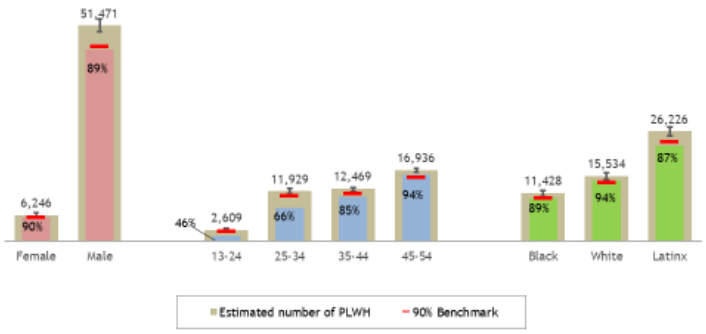
HIV diagnoses rates among females aged ≥ 13 years by race/ethnicity[1], LAC 2006-2018



[4] Defined as individuals whose current gender identity is the same as the sex they were assigned at birth.
[5] Transgender-specific data collected has been required by CDC since May 2013, however accurate information on gender identity may not be consistently documented or reported by providers which may result in an underrepresentation or lower count of persons identifying as transgender including transgender women, transgender men, non-binary persons, and people with other gender identities.
[6] Rates for transgender persons cannot be reported due to unreliable estimates of the total population.

In 2017, there were 57,717 PLWH of whom 51,317 (89%) were diagnosed and an estimated 6,400 (11%) were unaware of their HIV infection. The greatest disparities in awareness of HIV-positive serostatus were among young PLWH. Only 48% of PLWH aged 13-24 years and 66% of PLWH aged 25-34 years were aware of their HIV status, falling very short of the 95% target. Sero-status awareness disparities also existed for persons who inject drugs (PWID), with over one-third of PWID with HIV unaware of their HIV-positive status and only 55% of surveyed PWID having been tested for HIV in the past 12 months.

Awareness of HIV serostatus[1] among PLWH aged ≥ 13 years by gender, age group, and race/ethnicity, LAC 2017



It is well understood that diagnosis and treatment of PLWH needs to occur soon after HIV acquisition to ensure that viral suppression is achieved and sustained, and the forward transmission of HIV is interrupted. While the percentage of persons presenting with AIDS (the latest stage of HIV infection), at the time of diagnosis in LAC has been slowly decreasing, it has persisted at around 20% most recently. Almost half of Latinx cisgender men (48%) and 17% of Black/AA cis men were diagnosed with AIDS at the time of HIV diagnosis; compared to only 2% of White cis men, and 4% of Latinx and Black/AA cisgender women.

Meeting timely diagnosis benchmarks requires that people at ongoing and elevated risk of HIV test regularly. Across the three Centers for Disease Control and Prevention (CDC) National HIV Behavioral Surveillance (NHBS) survey populations, the highest levels of recent HIV testing (in the past 12 months) were reported among transgender (85%) and MSM (84%) participants. Among transgender participants, the highest levels of recent HIV testing were among Latinx (89%) and those aged 30 and younger (90%). Among MSM, 83% of Latinx, 83% Black/AA, and 90% of White MSM reported recent HIV testing. Among PWID, 55% reported recent HIV testing, with lowest levels reported among White PWID (47%). Among at-risk heterosexuals[7], the overall level of recent HIV testing was 30% and was lowest among Latinx (27%) and cis men (28%).

Data in Action: More work is needed to diagnose people living with HIV (PLWH) earlier or soon after HIV acquisition. Testing programs need to be scaled for groups with highest levels of undiagnosed HIV infection including youth between the ages of 13-34 and PWID. Latinx cis men are more likely to wait until they are sick to seek HIV testing services, highlighting the need to focus on improving early HIV diagnosis in this population. *Note: Data in Action sections serve to contextualize programmatic and policy implications for the local response to HIV.*

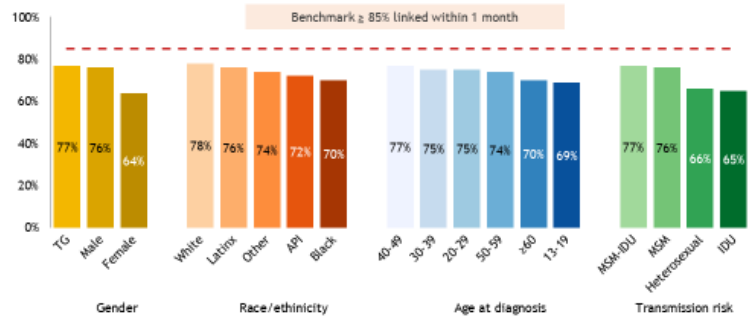
[7] Defined as persons who were born and identify as male or born as and identify as female, younger than 60 years of age, and reported vaginal or oral sex with a partner of the opposite sex in the past 12 months.

Epidemiological Profile – Pillar 2: Treat

The Ending the HIV Epidemic (EHE) Treatment Pillar focuses on treating people rapidly and effectively and includes two primary indicators to measure progress: (1) Increasing the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95% and (2) Increasing the proportion of diagnosed PLWH who are virally suppressed to 95%.

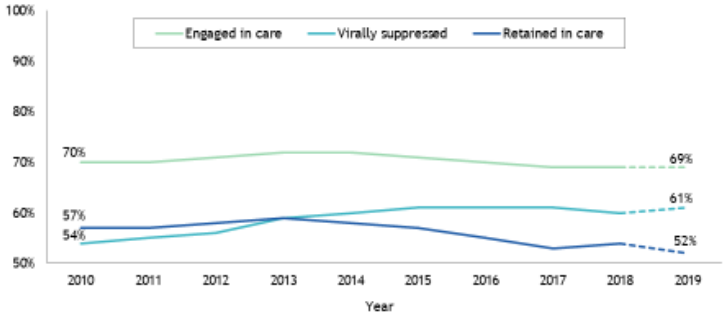
Linkage to Care: Ideally, linkage to care should occur within days of diagnosis to ensure optimal treatment for the individual and reduce transmission. In 2018, 75% of people aged 13 and older newly diagnosed with HIV in LAC were linked to care within one month of diagnosis. Populations with the lowest levels of linkage include cis women, Black/African American persons, youth ages 13-19, people over age 60, and individuals whose mode of HIV transmission was heterosexual sex or IDU.

Linkage to care[1] within 1 month of HIV diagnosis among persons aged ≥ 13 years newly diagnosed with HIV by selected demographic[2] and risk characteristics, LAC 2018



HIV Care Continuum: Despite increased programming to improve HIV Care Continuum outcomes, there has been only modest improvement in engagement, retention, and viral suppression among PLWH in LAC since 2010. At the end of 2019, only 7 in 10 PLWH were engaged in HIV care (at least one HIV medical visit/year), 5 in 10 were retained in care (two or more HIV medical visits/year separated by 90 days) and 6 in 10 were virally suppressed (most recent viral load test <200 copies/ml). While 9 in 10 PLWH in HIV care achieved viral suppression, individuals not in care were unlikely to remain virally suppressed.

Trends in engagement, retention and viral suppression for persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019[1]

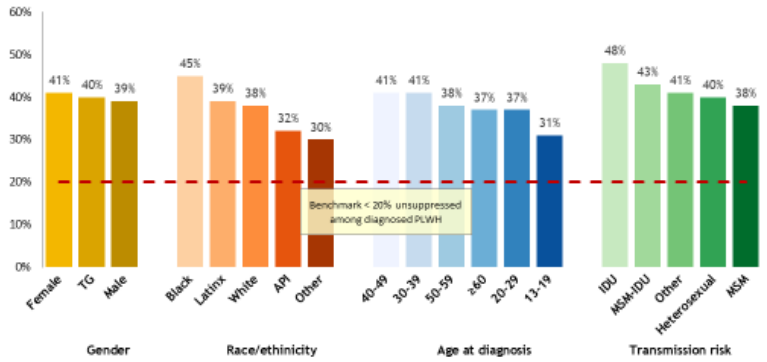


People whose mode of HIV transmission was IDU had the lowest levels of engagement in care (61%), retention in care (47%), and viral suppression (52%) compared with persons who report other modes of

HIV transmission. Compared to PLWH of other race/ethnicity groups, Black/African American persons have experienced the poorest care outcomes with the lowest levels of engagement (66%), retention in care (48%), and viral suppression (55%). Poor outcomes persist throughout the HIV care continuum for unhoused persons compared with housed persons, with greatest disparities observed in viral suppression at 45% and 61%, respectively.

Data in Action: Groups with greatest disparities in the HIV care continuum are people who are unhoused at the time of HIV diagnosis, cis women, those with IDU transmission risk, and Black/AA PLWH. Client-centered interventions tailored to individual needs and that respond directly to the diverse challenges and needs of these populations are urgently needed for these groups.

Unsuppressed viral load[1] by selected demographic and risk characteristics among persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019

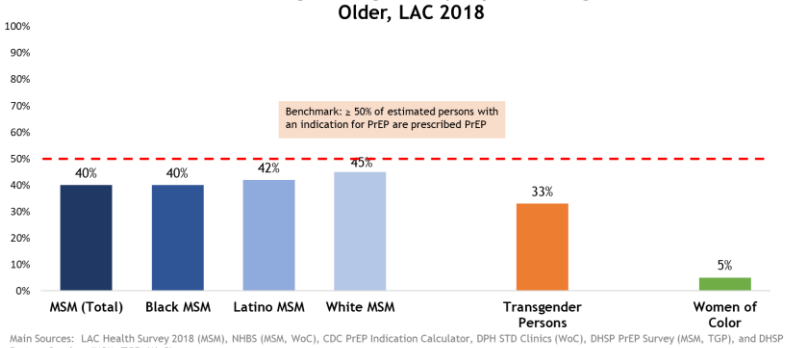


Epidemiological Profile – Pillar 3: Prevent

The Ending the HIV Epidemic (EHE) Prevent Pillar focuses on preventing new HIV transmissions through proven interventions with the primary performance indicator to increase the proportion of persons prescribed pre-exposure Prophylaxis (PrEP) in priority populations from 35% to at least 50% by 2025.

Pre-exposure Prophylaxis : "PrEP coverage" is defined as the number of people aged 16 years and older prescribed PrEP divided by the number of people with an indication for PrEP, meaning that they were at elevated risk for HIV acquisition. Based on multiple data sources, an estimated 72,700 LAC residents had an indication for PrEP and approximately 25,500 had been prescribed PrEP in 2018, representing a 35% PrEP coverage level. In LAC, approximately 24% of MSM (42% of Latinx, 60% of Black/AA, and 12% White MSM), 21% of transgender persons, and 8% of cis women of color had an indication for PrEP. PrEP coverage among MSM was 40% with highest coverage among White MSM (45%) followed by Latinx (42%) and Black/AA MSM (40%). PrEP coverage among transgender persons was 33% while PrEP coverage for cisgender heterosexual Latinx and African-American women with an indication for PrEP was 5%.

Estimated PrEP Coverage among Priority Populations Aged 18 Years and Older, LAC 2018



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)

Syringe Support Service Programs (SSP): Drug-using related risk behaviors and access to and use of prevention services among people who inject drugs (PWID) in LAC is monitored every three years through CDC's National HIV Behavioral Surveillance (NHBS) project. Recent cycles of NHBS among PWID have focused on recruiting younger PWID as they have more recently started injecting drugs and may better represent current trends in drug use and injection behaviors compared to older PWID. In 2018, 36% of the 511 PWID participants reported receptive sharing of syringes while 60% reported receptive sharing of other injection equipment (e.g., cookers, cotton, or water). Those who reported sharing syringes had an average of 4 sharing partners. Compared with PWID aged 30 and older, more PWID participants aged 18–29 years reported receptive syringe sharing (50% compared to 32%) and injection equipment sharing (74% compared to 56%).

Sixty-nine (69%) percent of PWID participants had obtained sterile syringes from LAC syringe exchange programs in the past 12 months. Other syringe sources included pharmacies (47%) and friends (32%). Approximately 26% of participants reported always disposing of used syringes safely. During the past 12 months, 75% had received clean injection equipment, 52% had received free condoms, and 27% had participated in an HIV behavioral intervention. Approximately 55% had taken medicines including methadone, buprenorphine, Suboxone or Subutex, to treat opioid use disorder.

Heroin was the most commonly injected drug among PWID, with 84% of participants reporting IDU in the past 12 months and 70% reported injecting heroin daily. While heroin use has remained relatively consistent over time, IDU of methamphetamine in the past 12 months among PWID participants increased from 29% in 2009 to 68% in 2018. This trend was observed specifically among younger PWID (aged 30 and younger), White PWID, unhoused PWID, and cis men who inject drugs.

Data in Action: Interventions to address suboptimal PrEP coverage, particularly among Black/AA MSM and cis women of color, are critically needed. Without broader and sustained interventions in this area, increased use of injection methamphetamine and higher risk injection behaviors represent a critical and emerging HIV and other infection outbreak risk among PWID in LAC.

Epidemiological Profile - Pillar 4: Respond

The use of individual-level information reported to LAC DPH to identify and target individuals for communicable disease contact tracing and linkage to services has a long precedent that continues during the current COVID-19 pandemic. All people newly diagnosed with HIV should receive a *Partner Services* interview to help them engage in HIV care and ensure that any sex or needle-sharing partner is tested for HIV and linked to PrEP and/or SSPs to prevent forward transmission. Unfortunately, in 2019, more than a quarter of newly diagnosed HIV-positive persons in LAC did not receive a Partner Services interview due to workload capacity of existing staff or refusal by the client. Among all the named sex or needle-sharing partners of persons diagnosed with HIV, Partner Services staff referred over 50% to PrEP services, but only confirmed subsequent HIV testing for 1 in 5 named partners.

Data-to-Care is a data-driven approach that uses HIV surveillance and other data sources to identify PLWH who are not in care, link those not in care to appropriate medical and social services, and ultimately move clients along the HIV care continuum to sustained viral suppression.[8] Despite increased focus on direct public health interventions to improve the HIV care continuum since 2013, linkage to and engagement in HIV medical care remain suboptimal. The lowest levels of linkage to care within one month of diagnosis was among cis women, Black/African Americans, and PWID newly diagnosed with HIV in 2018. At the end of 2019, approximate 1 in 3 PLWH had no evidence of HIV medical care in the

[8] https://tinyurl.com/DataToCare

past 12 months with the lowest levels of engagement in care among PWID (39%), Black/African American persons (34%), heterosexual persons (33%), persons aged 40-49 years (33%), and cis women (32%).

To further identify and prioritize individuals for public health interventions, the CDC has advanced two new approaches, HIV Molecular Cluster Detection and time-space cluster analyses to complement Data-to-Care activities. In 2018, LAC adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention). Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their status but are not virally suppressed. LAC staff perform molecular cluster analysis of available surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams. A total of 16 priority molecular clusters are currently being monitored and prioritized for public health action including five clusters identified by California OA and CDC that involve LAC cases. Upon investigation, approximately 25% of all cluster members were not virally suppressed and 35% had never received Partner Services. Direct intervention at the cluster-level resulted in 75% of all cluster members being contacted and offered partner services.

Time-space cluster analysis has been conducted monthly in LAC since January 2019 to monitor changes in the number of diagnoses by health district. No transmission clusters have been identified to date. This approach requires complete reporting of new diagnoses to LAC DPH which is estimated at 65% and currently limits the potential utility of this approach.

Data in Action: Groups with greatest disparities across the HIV care continuum are persons who are unhoused at the time of HIV diagnosis, those who report injection drug use transmission risk, cis women, and Black/AA PLWH. More work is needed to understand the structural and individual-level barriers to staying in care and how LAC DPH can address these barriers. Improvements in HIV case reporting completeness and timeliness are needed to effectively identify and respond to potential transmission clusters.

Section III: Situational Analysis & Needs Assessment

Situational Analysis & Needs Assessment - Pillar 1: Diagnose

An HIV diagnosis as close to the period of infection as possible is a crucial first step to achieving good HIV-related health outcomes and reducing the likelihood of HIV transmission to others. As mentioned previously, only 89% of PLWH in LAC are aware of their HIV status, meaning that approximately 6,400 people in LAC who are HIV-positive are unaware of their infection. To increase the proportion of people living with HIV who are diagnosed to at least 95%, LAC DPH, community health clinics, non-traditional community-based HIV testing partners, and other private and public entities must jointly support a robust and widespread HIV testing strategy, including testing in new and innovative ways. LAC DPH supports a cross-section of organizations to conduct HIV testing in a variety of settings, including non-clinical venues that serve the priority populations, community-based HIV/sexually transmitted diseases (STD) clinics, social and sexual network testing programs, and commercial sex venues. Overall, LAC DPH supports 42 HIV testing providers with annual goals to provide over 80,000 HIV tests and with the goal of diagnosing more than 800 individuals with HIV each year. In addition, LAC DPH staff directly provides

HIV testing in the LAC jails and County STD Clinics. These public-sector supported HIV testing and diagnosis efforts are an important complement to private sector HIV testing efforts supported by commercial health plans.

The Los Angeles County (LAC) Department of Public Health (DPH) has had a long-standing partnership with the LAC Department of Health Services and the Los Angeles County Sheriff's Department to ensure that clients have access to HIV testing and other sexual health related services, including those delivered in County correctional and juvenile detention centers. LAC DPH continues to strive to ensure that the HIV-related health needs of gay and bisexual men as well as transgender persons are also met. Notwithstanding our commitment to promoting the public's health, LAC DPH recognizes that there is necessary reform related to the criminal justice system, patterns of systemic racism and the treatment of communities of color. In that spirit, we understand the nature of the recent political and civil unrest witnessed and experienced in LAC and communities across the Nation. We pledge to do our part to confront harmful and racist practices perpetuated by racist systems as we continue to commit to ensuring that programs and services provided in these settings are client-centered and best support the client needs.

Routine HIV Testing

Expanding routine HIV testing within emergency departments, hospitals in highly HIV impacted geographic areas, federally qualified health centers (FQHCs), and other clinical settings is crucial to meet the HIV testing goals tied to EHE. While targeted testing often provides the highest positivity rate, implementing routine testing in health care settings is an important component to not only move towards destigmatizing HIV, but also allowing individuals who do not recognize their HIV risk to be tested for HIV. Opportunities to include HIV testing as a part of routine STD screenings and at substance use disorder treatment facilities persist. Routine testing in a subset of clinical settings can have an acceptable yield while leveraging multiple revenue streams, including public and private health plans, to cover testing costs. Despite these opportunities and benefits, launching new routine HIV testing programs in healthcare settings in LAC has been difficult. To catalyze routine HIV testing, a variety of policy changes are needed including changes that require low barrier reimbursement for HIV screening and strong annual screening mandates. In addition, we must address several non-financial routine HIV testing barriers, including broad scale training and technical assistance of routine HIV testing staff, broad scale adaptation of electronic medical records to incorporate HIV testing prompts and export critical HIV testing data, the development of protocols to ensure the immediate linkage of newly-diagnosed HIV-positive persons to care, and incentives to recruit and maintain a county-wide cadre of health care settings based routine HIV testing "champions." In LAC, fourteen FQHCs, all part of the local Community Clinic Association of Los Angeles County (CCALAC) network, received EHE funding to cover start-up costs and reduce barriers to adopting routine HIV testing, PrEP, and other HIV prevention services within their clinics.

In the past, LAC DPH has conducted Public Health Detailing (a method of targeting and reaching providers who will benefit from a short, focused key public health message) related to *HIV*, *PrEP*, and *Syphilis among Women* to influence practice patterns for established community medical providers. This effective intervention, however, remains both resource and time intensive for a jurisdiction the size of LAC. A more targeted approach of connecting with medical schools and training programs, including residency programs, nurse practitioner and physician assistant training programs, may be a more cost-effective way to support sustained clinical practices with public health benefit. By reaching clinicians at the beginning of their healthcare training and careers, the importance of HIV prevention and HIV testing can be included as a fundamental element of routine clinical practice that spans the life of medical careers, and can be used to identify and development HIV champions.

Rescreening individuals with elevated HIV risk
Both national and local data indicate that many people at higher risk for HIV infection are not screened according to clinical guidelines. Among CDC's National HIV Behavioral Surveillance (NHBS) participants, 16% of MSM and 45% of PWID had not had a test in the past 12 months; and a lower proportion of persons with ongoing HIV risk received an HIV test every three or six months as recommended by the CDC.

The link between sexually transmitted diseases (STDs) and elevated HIV risk is clear, and we must ensure that health care providers are not missing opportunities to conduct HIV testing with clients who are seeking STD screening, diagnosis and treatment services. The wide-scale adoption of technology to allow HIV testing providers to track and communicate with clients via text or a secure portal when they are due for repeat testing in an automated fashion and could accelerate efforts to ensure that clients who are newly diagnosed are promptly linked to care. The adoption of this technology and the use of digital forms of communications is congruent with how younger individuals prefer to exchange information, particularly given their ease and the higher levels of confidentiality they provide.

Home Test Kits
Due to the COVID-19 pandemic, the use of preventive and diagnostic health care services have been negatively impacted, as evidenced by a steady decrease in the number of HIV tests provided in local healthcare settings. Alternative HIV testing approaches are necessary to ensure that HIV diagnoses continue among individuals who may be HIV-positive but who may be less inclined to seek in-person services. The U.S. Food and Drug Administration (FDA) has approved home HIV test kits, that while less sensitive than other rapid tests, provide an important low barrier option for individuals to confirm their HIV status. In response to this alternate testing strategy, LAC DPH has partnered with the National Association of AIDS Directors (NASTAD) and Building Healthy Online Communities and joined the multi-jurisdictional Take Me Home initiative. Take Me Home is a timely and innovative HIV home test kit ordering program that centralizes advertising, data collection, and test kit distribution to clients, relieving health departments from coordinating and hiring staff during the COVID crisis. As a strategy to promote linkage to care efforts, LAC DPH will also make available home HIV test kits to community-based partners who also offer video or phone assistance and support by trained test counselors and who prioritize providing linkage to care services to persons testing HIV-positive.

Additional HIV Testing Modalities
Although mobile HIV testing is often cited as an important HIV testing strategy for some individuals and communities, after years of supporting this modality, LAC DPH has noted a low positivity rate, lower than average linkage to care rates, and poor PrEP referral rates from mobile testing programs compared to health center or community-based organization-based testing programs. The average linkage to HIV medical care from these programs has been as low as 23% and no higher than 70% -- far below the goal of 95% linkage to care rates expected for newly diagnosed HIV positive persons. As a result of these performance disparities, the resources that have been used to support mobile testing programs have been repurposed to expand the number of programs that target high HIV impacted sexual and social networks throughout LAC. These testing modalities have reported a higher HIV positivity rate among testers as well as a higher linkage to care rate.

LAC looks forward to working with partners to further explore HIV testing opportunities that allows for the highest impact in increased testing access points, reduced barriers for clients, and integration of routine testing across syndemics such as viral hepatitis and sexually transmitted infections. LAC DPH will continue to expand or support the existing HIV testing portfolio especially for populations where HIV rates are rising and is committed to partnering with agencies such as homeless service providers

conducting street outreach to further increase HIV testing opportunities, given their expertise of the communities and clients they serve.

Situational Analysis & Needs Assessment - Pillar 2: Treat

By leveraging a combination of federal, State, and local prevention, care and treatment funds, LAC DPH supports a network of HIV prevention providers and more than 30 LAC DPH funded HIV medical homes, where referrals, linkage assistance, medical care, and medications are available regardless of insurance status. Since the advent of "treatment as prevention," LAC DPH has worked with the Commission and its network of providers to reduce barriers to care so that PLWH can be readily linked to and retained in HIV medical care. Despite these efforts, at the end of 2019, linkage to care, engagement in care, and viral suppression rates remain far below targets for a significant subset of patients, as described in the Epidemiological Profile Section.

Linkage to care

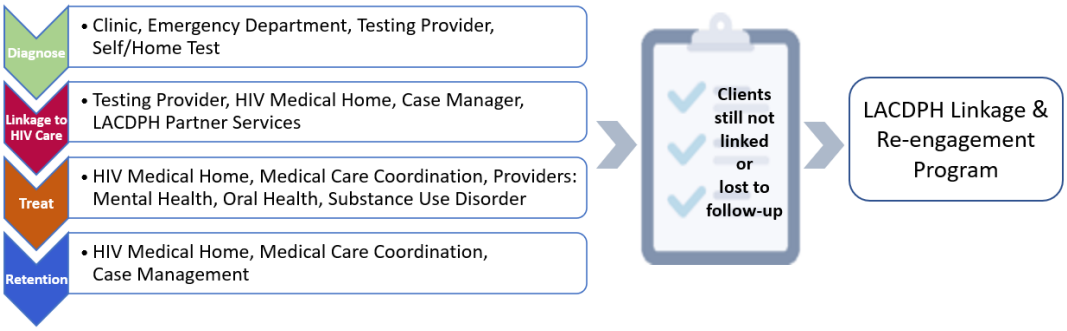
Since 2011, LAC DPH has incentivized timely linkage to HIV medical care for its network of community-based HIV testing providers. HIV testing providers assume primary responsibility for linking a newly diagnosed person to HIV care by setting up appointments and following up with the client until the first appointment is completed. While this incentive structure initially produced significant improvements in initial linkage to care, more recently performance has generally plateaued. This is likely due to a combination of factors, such as denial or competing life demands, and structural barriers, such as lengthy financial screening requirements and administrative paperwork. The current system must evolve to make rapid initiation of antiretroviral therapy (ART) the easiest choice for both the provider and the patient. LAC DPH, together with HIV prevention and medical providers, must restructure its approach to linkage to care, must treat new HIV diagnoses with more urgency, and must ensure that providers receive technical assistance to make same day linkage referrals a standard practice. In addition, LAC DPH will utilize its position as funder to provide technical assistance to clinics to reduce unnecessary administrative barriers for patients and improve the client experience (Appendix E).

Engagement and Retention in Care

In 2013, LAC DPH implemented the *Medical Care Coordination (MCC)* program in Ryan White Program-funded HIV medical homes with the goal of addressing the unmet psychosocial and medical needs of patients at risk for or already experiencing poor health outcomes. Comprised of a Registered Nurse, a Social Worker, a Case Manager, and a Retention Outreach Specialist, the MCC teams help patients with a range of psychosocial, behavioral, and medical issues that may impact their treatment adherence. A robust evaluation of the MCC program demonstrated that PLWH who utilize MCC services experience significantly improved health outcomes after 12 months. In 2016, DHSP established the *Linkage and Re-engagement Program (LRP)* as a complement to the MCC program to identify, reach, and re-engage patients who have fallen out of care. Based on these findings and experiences, LAC DPH expanded MCC to additional HIV clinics in 2017. Given that the path to consistent, ongoing HIV care and reaching viral suppression is not always a linear experience for clients (for multiple reasons), the Linkage and Re-engagement Program was developed as a specialty linkage program to work with clients who have had challenges linking to care or have fallen out of care and cannot be reached. LRP utilizes experienced DPH-based health navigators, who have access to a wide-range of LAC DPH and County data systems in order to locate and follow-up with clients who are often not well served by traditional medical and support service models, including those without a cell phone or who are unstably housed, or who have not been located or responsive to service providers' attempts to engage them in care. While the engagement and retention in care of clients remains a primary responsibility of the clinic, the LRP

program is intended to serve as a complementary option of last resort to focus efforts on locating and connecting with clients and subsequently facilitating a warm hand-off to clinics and MCC teams.

Figure 1. *Visual model of the comprehensive provider network available to link and re-engage clients in LAC, including the separate Linkage and Re-engagement Program that is available as a service of last resort for clients who are not in care despite efforts across the full network of provider services.*



LAC DPH understands that despite the availability of these programs, many PLWH struggling with financial concerns, housing instability, mental health diagnoses, and substance use disorders (SUD), also struggle to not only access care, but remain in care and achieve viral suppression over long periods of time.

In Los Angeles County, the LAC DPH Substance Abuse and Prevention Control (SAPC) Program leads and facilitates the delivery of prevention, treatment, and recovery support services intended to reduce the impact of substance use, abuse, and addiction county-wide. The LAC DPH Division of HIV and STD Programs collaborates with SAPC to connect clients to HIV and STD-related services. From 2008 to 2017, methamphetamine (meth) related hospitalizations and emergency department visits in LAC increased by 604% and 290%, respectively.[9] Among SAPC-funded programs, methamphetamine is the primary drug of use for over 20% of clients admitted for SUD treatment; and only 47% of these clients successfully completed treatment.[10] Given the consistent increase in methamphetamine use over time and its well-established intersection with HIV, syphilis, and poor HIV-related health outcomes, it is imperative that LAC facilitates greater integration and synergy of HIV and substance use disorder services. Stronger partnerships among HIV service providers and SUD providers must include strategies that address meth use and its role with sexual HIV risk behavior, must promote adherence to PrEP or ART, and must prioritize the expansion of contingency management services coupled with these biomedical HIV prevention tools. More broadly across the substance using spectrum, programs that promote harm reduction, mitigate the sharing of injection equipment and promote syringe services programs must be prioritized, including geographic areas with high rates of HIV transmission but devoid of SSPs. The LA-based Act Now Against Meth Coalition, a long-standing community mobilization and awareness effort launched to address the alarming increase in meth use among gay and bisexual men has recently been re-energized. Separately, SAPC has launched a Countywide Meth Task Force to inform meth prevention and treatment strategies and address both the upstream drivers of meth use and abuse. DHSP has been invited to participate in both the Prevention and Treatment Committees of the Meth Task Force.

The current safety net in LAC to address the needs of multiply-diagnosed (e.g., substance use disorder, homeless, mentally ill, other co-morbidities, and chronic health conditions) persons living with HIV is fraught and complex. Navigating the healthcare system and identifying accessible and quality mental health and SUD services, particularly for low-income persons, can be difficult; at the same time, mental

[9] Methamphetamine in Los Angeles County by Gary Tsai, MD; July 2020
[10] Unpublished data, LAC DPH Substance Abuse Prevention and Control.

health services specifically designed for PLWH remain underutilized in parts of LAC. To ensure that we improve the health outcomes of PLWH who have not achieved viral suppression, disruptive programming that provides supportive services with an emphasis on emotional support, trauma informed care, stigma reduction and improves the lives of people experiencing financial hardship, homelessness, mental illness, and SUD are greatly needed. New and unconventional programming, such as conditional financial incentives, also known as contingency management, must be expanded, as well as advances in antiretroviral therapy such as long acting injectables, particularly for individuals facing the most complex life circumstances. For communities most impacted by HIV, the importance of addressing barriers to care and ensuring PLWH are informed and able to easily access various programs and resources will be important.

Situational Analysis & Needs Assessment - Pillar 3: Prevent

Pre-exposure Prophylaxis (PrEP)

Increasing the number of people who take advantage of and have access to clinical preventive services, such as PrEP, continues to be a major public health challenge. Despite widely available PrEP resources and providers in LAC, fewer than a third of persons with an indication for PrEP report taking it. In California, significant progress has been made to limit PrEP associated costs as a barrier to uptake; most health insurance plans now cover most PrEP associated health care costs, with public and private programs available to cover out-of-pocket costs based on income.[11] Unfortunately, assistance programs require eligibility screening and paperwork, which can deter some clients. Clear and direct messaging about PrEP from the appropriate community stakeholders is greatly needed to address mistrust and combat misleading information. Health care systems must adapt to make PrEP initiation and its continued use as easy as possible so that individuals with a continued indication are retained in care.

Mistrust of new pharmacologic interventions and medical providers in communities of color are understandable and justifiable given the history of Black Americans mistreatment as unwilling subjects of medical research and continued racial biases in access to and the delivery of health care services. Unsurprisingly, the uptake of PrEP among Black and Latinx MSM has consistently been lower compared to Whites. Unfortunately, this underutilization is compounded by the fact that potential side effects of PrEP have received undue and misdirected attention due to advertising by those seeking product liability lawsuits against the drug manufacturer. In addition, many individuals incorrectly believe that PrEP will be too expensive and therefore inaccessible. While federal, State, and local programs that support PrEP at low to no-cost remain in place; community-based organizations, medical providers, and public health departments all have a role to play to help address misinformation and mistrust as a step towards deconstructing institutional racism and improving healthcare access patterns. The Commission's *Black/African American (AA) Community Task Force* has recommended increasing culturally sensitive PrEP advertising designed with input from the very communities it is attempting to reach, including Black/AA youth, cis women, transgender individuals, and gender nonconforming populations. In addition, voices of influential individuals through social media and marketing may help destigmatize both HIV and PrEP use and could potentially activate some individuals to take action. Lastly, PrEP support groups have the potential to create social support to promote PrEP initiation and retention and may be a particularly promising strategy for younger men who do not have much experience navigating the healthcare system.

For PrEP to reach the individuals who would most benefit from this prevention tool, health care partners across all sectors and disciplines must not only understand its clinical use, but, more importantly, be mindful and comfortable in their approach discussing sexual behaviors with patients, ideally in an open

[11] www.PleasePrEPMe.org/payment

non-judgmental manner. The network of LAC PrEP Centers of Excellence was launched in 2016 with the goal of creating culturally competent access points where patients can also receive assistance navigating PrEP-related cost and health insurance coverage issues. Since the FDA approval of PrEP, the number of medical providers in LAC who report being a PrEP provider has steadily increased.[12] Unfortunately, certain geographic areas of LAC have a low number of PrEP providers relative to the number of individuals at risk for HIV: Eastern San Gabriel Valley near Pomona, High Desert, South Los Angeles, San Fernando Valley, and Long Beach. Recently, 14 Federally Qualified Health Centers (FQHCs) in LAC were funded directly through the federal Ending the HIV Epidemic initiative to expand their PrEP and HIV prevention efforts. Recent California legislation and policy changes have further expanded PrEP access points to include pharmacies and telemedicine providers.

An outstanding concern regarding PrEP uptake is its duration of use among individuals with continued risk. Discontinuation of PrEP is likely due to multiple factors, including pill fatigue, administrative barriers, and competing life demands. To ensure consistent, sustained access for clients at highest risk for HIV and other STDs in sexual health and prevention services and PrEP services, providers must develop more systematic and innovative ways of staying engaged with their clients. PrEP providers can reduce barriers to care for follow up appointments by offering telemedicine visits and allowing patients to come in only when laboratory work is needed. Expansion of technology to allow for accurate and sensitive home or self-collected HIV and STD tests will be a significant step toward further minimizing the frequency and length of time for medical visits and ensuring PrEP adherence. Many clients, especially younger individuals, prefer digital forms of communication and care, yet many community health centers still lack secure technology platforms to facilitate easier communication with patients. With the passing of California's Senate Bill 159, pharmacists are now allowed to directly provide PrEP and post exposure prophylaxis (PEP). LAC DPH and stakeholders must continue to promote all PrEP access points to further increase uptake. Recent studies have demonstrated that the "2-1-1" PrEP regimen (where an individual takes two pills 2 to 24 hours before sex, one pill 24 hours after the initial dose, and one final pill 24 hours later), as well as long acting injectable PrEP options, are important alternatives to oral daily PrEP. These alternate regimens have the added benefit of being attractive for individuals with pill fatigue or those struggling with adherence issues. Lastly, providers must be aware of clients who have or continue to utilize PEP, the use of antiretroviral drugs for people who are HIV-negative after a single high-risk exposure to stop HIV acquisition. Clients utilizing PEP should be connected to PrEP service providers to further prevent HIV transmission and acquisition. Although providers must acknowledge that for some clients, repeated use of PEP overtime may be the most beneficial form of biomedical prevention.

Syringe Services Programs

Historical data in LAC have shown injection drug use (IDU) to be a consistent, but less common risk factor for HIV transmission, accounting for less than 5% of HIV cases annually. However, across the United States, and more recently in Seattle-King County, IDU-based HIV outbreaks have occurred, even in areas where syringe support programs are available.[13] The rise of conditions that contribute to drug use, such as economic inequality, homelessness, untreated mental illness, and opioid and methamphetamine use are pervasive in LAC, increasing our susceptibility to an IDU outbreak. The most recent National Behavior Surveillance Survey (NHBS cycle among PWID in LAC, which surveyed more younger PWID than previous cycles, revealed higher levels of risky injection practices, methamphetamine use, exchange sex, and unstable housing.

[12] www.PleasePrEPMe.org/find-a-provider

[13] MMWR Feb 2019 Seattle. https://www.cdc.gov/mmwr/volumes/68/wr/mm6815a2.htm.

Fortunately, syringe services programs (SSPs are legal under California law, but programs in LAC experience fragmented or insufficient support from County and City of Los Angeles partners. In addition, LAC DPH funded SSPs continue to be small in scale, including only six agencies funded at modest levels through the LAC DPH Substance Abuse and Prevention Control Program (SAPC). Of the six currently funded SSP agencies, only three are funded to provide HIV, STD, and hepatitis C (HCV) testing. Unfortunately, there is limited data and an absence of an in-depth analysis to confirm the impact of the LAC DPH-supported SSP programs, including data tied to linking clients to testing, other HIV prevention and care resources as well as Hepatitis and substance use disorder services. As part of our EHE efforts, we aim to increase our investment in this area and enhance the SSP service portfolio to ensure clients are linked to HIV prevention and treatment services and allow for more robust data collection.

Given the increased number of IDU HIV outbreaks reported nationally, the need to assess and address gaps in HIV prevention services targeted to PWID has become important. In 2019, the California legislature, recognizing the importance of SSPs and the effectiveness of a comprehensive, integrated approach to care for people who inject drugs, allocated increased funding to SSPs for expanded service provision and HCV screening. As a result, the LAC DPH's Division of HIV and STD Programs (DHSP, Substance Use and Prevention Control (SAPC, and the Acute Communicable Disease Control Program (ACDC) began preliminary work to expand HCV, HIV, and syphilis screening among SSP users. Unfortunately, the COVID-19 pandemic has put tremendous strain on all three LAC DPH Divisions. We remain eager to expand the bandwidth of County-based and community-based partners to accelerate efforts to expand SSP programming and services.

Situational Analysis & Needs Assessment - Pillar 4: Respond

The use of client-level data reported to the public health department to identify and target HIV-positive individuals for contact tracing and linkage to services has a long precedent that continues during the current COVID pandemic. The use of this client data for expanded HIV prevention and outreach efforts, however, is relatively recent. For decades, national guidelines and state laws restricted access and use of client-level HIV surveillance data to traditional surveillance functions, such as generating aggregated reports to describe population-based trends among persons living with diagnosed HIV. While these limits on the use of surveillance data in the early days of the HIV epidemic as a way to protect privacy of PLWH were understandable, these laws severely limited the ability of public health staff to use available information to further advance outbreak investigation efforts.

Fortunately, we finds ourselves in a different era where data driven HIV public health strategies, such as data-to-care, the use of geospatial analysis, and molecular cluster analysis are available (and required) and can be leveraged to ensure that the HIV public health response is more timely, targeted and has the greatest impact. These activities require real-time access to client-level surveillance data and are expected to be carried out regularly as part of the Respond Pillar of the EHE strategy as a way to not only identify individuals who need enhanced services, but to also detect and rapidly respond to early clusters or outbreaks of HIV in the community. In addition, the development and growth of technology-based dating mechanisms has further complicated the issue of identifying and monitoring clusters and new HIV diagnoses. LAC DPH has three programmatic Respond activities: Partner Services, the Linkage Re-engagement Program, and HIV Molecular Cluster Detection, all described further below.

Partner Services

The CDC describes Partner Services as a public health activity of rigorously trained staff to "identify and locate the sexual contacts of infected people and other people at risk for behavioral or other risk factors

'contact tracing'- and then refer them for care and treatment, as appropriate."[14] While the Partner Services program in LAC has been successful in interviewing newly diagnosed clients, there is opportunity to further expand the program's capacity to ensure all newly diagnosed clients and their partners are being interviewed in a timely and more efficient manner. In LAC, improved data system integration, easier data access, and increased staffing will improve the ability of LAC DPH to reach all newly diagnosed persons with HIV. The latest estimate suggests that two-thirds of newly diagnosed persons with HIV in LAC receive an offer of Partner Services around the time of their diagnosis. There is an opportunity to build staff capacity within the Partner Services program as well as expand partnerships with providers at high volume HIV/STD clinical testing sites to 1) establish more on-site counseling and education for persons testing positive within clinics, 2) promote rapid linkage to care and treatment efforts, and 3) reinforce community driven service sites that support and empower clients to prioritize their wellness and connect identified partners with critical HIV testing and/or PrEP. In addition, Partner Services will need to adapt to new technologies in order to respond to the use of web-based platforms, mobile apps, and other internet-based modalities that facilitate identifying and connecting with partners to testing, prevention, or care.

Linkage Re-engagement Program

At LAC DPH, the Linkage Re-engagement Program (LRP) is staffed by a team of health navigators and supervised by a social worker. LRP provides intensive case management and longitudinal support to PLWH who are out of care, who are facing challenging life circumstances, and who have multiple co-morbid, mental health or SUD conditions. While linkage and re-engagement activities are the primary contracted responsibility of clinics and organizations that provide direct services to clients, LAC DPH offers LRP as a complementary service designed to locate and connect the hardest to reach clients to the health care system. The majority of clients served by LRP are referred by their medical provider after they have fallen out of care and have been lost to follow-up. Other clients in need of LRP services are identified through data-to-care analyses because they are high need for intensive case management such as pregnant women, individuals recently released from jail, and individuals who are identified as part of a growing HIV transmission cluster.

HIV Molecular Cluster Detection

In 2018, LAC adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention.) Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their status but are not virally suppressed. LAC staff perform molecular cluster analysis of available surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams. Given the novel nature of molecular cluster detection, in late 2019 LAC DPH launched an effort to engage community stakeholders regarding its use and assess potential unintended consequences. LAC DPH provided an overview of molecular surveillance to the Commission on HIV to provide background information, address community concerns, address misperceptions related to the use of data, and review the potential legal ramifications and privacy issues. Unfortunately, planned activities for further community dialogue have been put on hold due to the deployment of staff to the local COVID-19 response. As a part of continued community engagement and awareness on molecular cluster detection and the monitoring of cluster outbreaks, the development of a communication strategy for community members and organizations is important and will resume in 2021.

[14] https://www.cdc.gov/std/program/partners.htm

More recently, LAC DPH has begun to identify emerging HIV diagnosis trends using a complementary methodology called time-space cluster analysis using case surveillance data. Time-space alerts determine whether the number of new cases in the prior 12 months is greater than expected baseline levels across different geographic areas and sub-populations, providing insight into where and among whom to prioritize early investigation and interventions to prevent onward transmission.

Looking forward

As we continue to move forward with EHE and develop new or strengthen existing partnerships with community stakeholders and service providers, LAC DPH will continue to adopt common language and improve understanding of the Respond Pillar. This will be important to advance strategies designed to support the adoption of this new technology, more efficiently serve clients in need, and prevent outbreaks. Successful EHE efforts are strongly dependent on the extensive partnerships between LAC's HIV medical homes, Medical Care Coordination teams, vast network of HIV support services providers, leaders from the most impacted communities, and a broad-based coalition of non-traditional service partners. An integrated data management system for case management and surveillance data is foundational to future programmatic enhancements. LAC DPH's Informational Technology branch intends to add HIV and STDs to its new surveillance data system for all communicable diseases in July 2021; the new system will offer large-scale improvements to overall data management, facilitate data linkages across diseases, and improve timely access to surveillance data for staff working with clients. Prior to the COVID-19 pandemic, there was broad LAC DPH-wide support to expand surveillance and program staff to support full implementation and optimization of LAC DPH EHE Respond Pillar activities. Since March 2020, most surveillance and program staff are reassigned to COVID-19 response, hindering the capacity to fully plan and implement new EHE Respond Pillar activities. With no current timeline for changes in the COVID-19 staffing plan, LAC DPH may be forced to delay further changes and improvements. LAC DPH hopes the social acceptance of contact tracing for COVID-19, and the societal shift in understanding its importance in disease investigation will translate into improved HIV case-finding efforts under the Respond Pillar of EHE.

Priority Populations

Based on the epidemiologic profile, situational analysis, and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include: **Black/African American MSM, Latinx MSM, women of color, people who inject drugs, transgender persons, and youth under 30 years of age**. Although priority populations have been selected for EHE, the LAC HIV portfolio will continue to support all populations affected by HIV and will not diminish efforts to prevent, diagnose, and treat HIV for populations who remain a critical concern, including people over age 50 who account for over 51% of PLWH in LAC[15] and people experiencing unstable housing or homelessness, among others.

Capacity Building & HIV Workforce

At the November 2018 Commission meeting, there was a resounding call from frontline HIV service providers of the need for providing the HIV workforce with the tools, resources, and support to maintain their health and wellbeing while continuing to diligently serve people affected by and living with HIV. LAC DPH is committed to exploring additional opportunities to support frontline workers by addressing staff burnout, identifying and addressing training needs, and supporting continued professional development and advancement, all of which will improve the quality of services and strengthen the local

[15] DHSP HIV Surveillance. Persons aged ≥ 13 diagnosed with HIV in LAC through 2018 and living at year-end 2019

HIV response. LAC DPH will continue to work with the California Prevention Training Center to identify trainings to support the HIV workforce, with a particular focus on client-centered approaches to HIV care.

Prior to COVID-19, LAC was experiencing a massive affordable housing and homelessness crisis, which has continued to disproportionately impact Black/African American and Latinx communities. Coupled with the disproportionate impact of HIV rates in the Black/African American community, worsening economic injustice, racial and social injustice amplified by the Black Lives Matter movement, and the COVID-19 pandemic, the emotional and physical capacity of individuals, organizations, and the HIV workforce including LAC DPH continues to be strained and tested. LAC DPH recognizes the need to support programs and services that 1) address intersectional issues that go beyond HIV prevention, care and treatment needs, 2) support PLWH with meeting basic human needs and 3) better support the LAC HIV workforce. LAC DPH will continue to encourage organizations to diversify the HIV workforce by hiring diverse employees to promote cultural competency, mirror the HIV epidemic, and combat systemic racism as we operationalize all EHE Pillars.

In the COVID-19 era, it is imperative that the strategies and activities outlined in the EHE Plan are adopted by organizations and the workforce beyond LAC DPH. LAC DPH plans on leveraging existing and new partnerships and will work closely with both the Long Beach Department of Health and Human Services as well as the Pasadena Public Health Department to achieve the EHE goals.

Section IV: Ending the HIV Epidemic Plan

The EHE Plan for LAC is a living document and includes proposed strategies and activities to be implemented within the first year (2021) and further expanded over the course of the next five years. It is commonly understood that the unprecedented COVID-19 pandemic has affected the timeline and implementation of proposed EHE efforts. LAC DPH received guidance and input during the 30-day public comment period from key community stakeholders on how to best navigate the current climate. The proposed strategies are complementary to the existing LAC HIV portfolio and will further expand existing prevention and care services available to people affected by and living with HIV/AIDS throughout the County.

Overall Goal: Reduce the annual number of new HIV infections by 75% in five years (2025) and 90% in ten years (2030.)

Overall Strategy: Ensure strategies and activities of the Ending the HIV Epidemic Initiative in Los Angeles County address and improve health inequities, dismantle racism in all forms, and focus on the communities most impacted by HIV in a client-centered, people first approach.

EHE Plan - Pillar 1: Diagnose

Leading Indicators:

1) Increase the percentage of PLWH who are aware of their HIV status to 95%.
2) Reduce the number of undiagnosed persons living with HIV.

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other settings (such as emergency departments and community health centers) in high prevalence communities.

- Activity 1A.1: Assess and monitor the degree that HIV testing is occurring County-wide. Identify infrastructure and healthcare system issues to determine the feasibility of expanding routine opt-out testing.
- Activity 1A.2: Expand the number of emergency departments and community health centers in high prevalence communities performing routine opt-out HIV screening.
- Activity 1A.3: Identify additional opportunities in healthcare and non-healthcare settings where HIV testing can be included, such as routine STD screening sites and substance use treatment centers, among others.

Strategy 1B: Develop locally tailored HIV testing programs to reach persons in non-healthcare settings including home and/or self-testing.

- Activity 1B.1: Assess and monitor the degree that HIV testing is occurring County-wide (see Strategy 1A). Identify infrastructure and healthcare system issues to determine the feasibility of launching a county-wide rapid HIV self-test program.
- Activity 1B.2: Develop guidance on HIV home testing, including a quality assurance protocol, and assess readiness of providers to implement home testing.
- Activity 1B.3: Expand use of HIV home testing among at risk individuals unlikely to receive traditional in-person HIV testing.

Strategy 1C: Increase the rate of annual HIV re-screening among persons at elevated risk for HIV in both healthcare and non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening and increase ways of maintaining communication with clients.

- Activity 1C.1: Develop provider-to-patient communication tools to support providers identify at risk clients who are due for HIV re-screening and increase systematic ways of maintaining communication with clients.
- Activity 1C.2: Develop a plan for evaluating impact of the provider-to-patient communication tools on client re-screening.
- Activity 1C.3: Expand implementation and use of provider-to-patient communication tools among LAC DPH funded HIV prevention providers.

Key Partners and HIV Workforce: FQHCs and Community Health Centers, Emergency Departments, HIV and STD Testing Providers, HIV prevention providers, private providers, academic medical provider training programs including colleges and universities, Building Healthy Online Communities-NASTAD, LAC Department of Health Services, LAC Department of Mental Health, LAC Sherriff's Department, homeless service providers, and City of Long Beach and City of Pasadena Health Departments, LAC DPH Substance Abuse Prevention and Control Program and other DPH programs and divisions.

Outcomes:

- Increased routine opt-out HIV screenings in healthcare and other institutional settings
- Increased local availability of and accessibility to HIV testing services
- Increased HIV screening and re-screening among persons at elevated risk for HIV infection
- Increased knowledge of HIV status
- Increased HIV diagnoses

Monitoring Data Sources: DHSP HIV Surveillance (eHARS)

EHE Plan - Pillar 2: Treat

Leading Indicators:

1) Increase the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95%.
2) Increase the proportion of diagnosed PLWH who are virally suppressed to 95%.

Strategy 2A: Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons newly diagnosed with HIV.

- Activity 2A.1: Increase county-wide capacity to provide same-day rapid linkage to care during expanded hours and days for persons newly diagnosed with HIV.
  Activity 2A.2: Develop a network of HIV care providers who offer same day appointments with rapid ART disbursement.

Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not eligible for Ryan White Program-supported services, persons with mental illness, and persons with substance use disorders.

- Activity 2B.1: Comprehensively assess unmet mental health needs of PLWH and identify gaps and areas of improvement in the mental health provider network in LAC.
- Activity 2B.2 Develop partnerships to meet the SUD (particularly meth use disorder) needs of persons at risk for HIV or PLWH and improve the capacity of SUD providers to address the sexual health needs of clients and ensure access to HIV-related services, as needed.
- Activity 2B.2: Develop a report that summarizes critical gaps in the current system and makes recommendations for improvement and investment of County resources, including Ryan White Program funds.

Strategy 2C: Expand the promotion of Ryan White Program services to increase awareness, access to, and utilization of available medical care and support services for PLWH.

- Activity 2C.1: Assess how clients are currently learning about available RWP services. Identify existing and new resources to assist with promotion and educational outreach including, but not limited to, print materials and online resources.

Strategy 2D: Develop and implement an emergency financial assistance program that supports PLWH experiencing financial hardship to allow for better treatment adherence or engagement in medical care and/or supportive services.

- Activity 2D.1: Determine processes and program operations for financial assistance that are aligned with federal funding guidance and restrictions.
- Activity 2D.2: Identify potential partners positioned to serve PLWH and implement an emergency financial assistance program.

Strategy 2E: Improve the delivery of HIV services and client satisfaction rates by supporting strategies to address workforce burnout, improve staff capacity to better meet the needs of PLWH, and expand the availability of staff training tied to trauma informed care, stigma reduction, implicit bias, and medical mistrust.

- Activity 2E.1: Conduct assessment to identify factors contributing to staff burnout and attrition as well as gaps in skills or knowledge around trauma informed care, stigma reduction, implicit bias, and medical mistrust.
- Activity 2E.2: Support programs or provide technical assistance in response to identified needs.

Strategy 2F: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH.

- Activity 2F.1: Determine processes and program operations for housing assistance that are aligned with federal funding guidance and restrictions.
- Activity 2F.2: Identify potential housing partners positioned to serve PLWH and implement an expanded housing program.

Strategy 2G: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH.

- Activity 2G.1: Develop processes and program operations for a pilot program that is acceptable to clients and is aligned with federal funding guidance and restrictions.
- Activity 2G.2: Identify potential clinical sites, train staff on pilot processes, and implement program.
- Activity 2G.3: Develop a robust evaluation plan to determine continued use of financial incentives and potential for expansion to other populations.

Key Partners and HIV Workforce: Ryan White Program-supported HIV service providers, HIV medical providers outside of Ryan White Program network, FQHCs and Community Health Centers, HIV and STD Testing Providers, Housing Opportunities for Persons with AIDS (HOPWA), LAC DHS Housing for Health program, Los Angeles County Homeless Services Authority (LAHSA), additional housing and homeless service providers, immigrant rights groups, public and private health plans, LAC Department of Mental Health, LAC Department of Health Services, and City of Long Beach and City of Pasadena Health Departments.

Outcomes:

- Increased rapid linkage to HIV medical care
- Increased early initiation of ART
- Increased support to providers for linking, retaining, and re-engaging PLWH to care and treatment
- Increased utilization of RWP core services among PLWH
- Increase viral suppression among PLWH

Monitoring Data Sources: HIV Casewatch, DHSP HIV Surveillance (eHARS), Medical Monitoring Project (MMP)

EHE Plan - Pillar 3: Prevent

Leading Indicator:

- Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% from a 2017 baseline of 21.5%.
- Increase the number of syringe service programs by 50%.

Strategy 3A: Accelerate efforts to increase PrEP use (particularly for populations with the highest rates of new HIV diagnoses and low PrEP coverage rates) by adopting new strategies at LAC funded PrEP Centers of Excellence tied to client retention, PrEP navigation, community education, supporting alternatives to daily PrEP, and expanding PrEP support groups.

- Activity 3A.1: Conduct an in-depth landscape analysis of current PrEP resources and services among primary care providers in high morbidity areas, among providers who serve transgender persons, women's health providers, and SUD providers.
- Activity 3A.2: Implement systematic and innovative strategies at LAC DPH-funded PrEP Centers of Excellence for enhanced client communication to promote retention in PrEP and sexual health services.
- Activity 3A.3: Increase capacity of LAC DPH staff to provide more robust PrEP navigation services to clients served through County STD clinics, Partner Services, and those receiving PrEP/PEP at community pharmacies.
- Activity 3A.4: Disseminate simple fact-based social marketing PrEP messaging to increase knowledge and awareness of PrEP, alternatives to daily PrEP, and help combat misinformation regarding cost, access, and safety.
- Activity 3A.5: Work with local stakeholders to identify the potential role for PrEP support groups or PrEP ambassadors to support new and continued PrEP use in affected communities.

Strategy 3B: Increase availability, use, and access to comprehensive syringe services programs (SSPs).

- Activity 3B.1: Collaborate with the Los Angeles County Substance Abuse Prevention and Control Program to identify opportunities to increase the capacity of SSPs, improve the provision or linkage of SSP clients to HIV and STD prevention and treatment services, and expand the availability of contingency management services to persons with substance use disorder, including meth use.
- Activity 3B.2: Explore ideas for alternate models of prevention service delivery (e.g., vouchers which can be taken to pharmacies in exchange for clean syringes and home HIV test kits).

Key Partners: FQHCs and Community Health Centers, PrEP Centers of Excellence, HIV and STD Testing Providers, LAC STD clinics, LAC DPH Substance Abuse Prevention and Control Program, County of Los Angeles and City of Los Angeles-funded SSPs, pharmacies, general practitioners and private healthcare providers, family planning clinics (including Planned Parenthood), schools and colleges, community leaders and advocates, and Region IX PACE Program.

Outcomes:

- Increased referral and linkage of persons with indications for PrEP
- Increased PrEP prescriptions compared to number with indications overall and in areas with high HIV diagnosis rates
- Decreased racial and ethnic disparities in PrEP uptake
- Increased capacity of SSP service providers to directly provide or link clients to HIV prevention and care services
- Reduced new HIV infections

Monitoring Data Source: Multiple PrEP monitoring and evaluation data, DHSP HIV Surveillance (eHARS), National HIV Behavioral Surveillance (NHBS).

EHE Plan - Pillar 4: Respond

Leading Indicators:

1) Develop and maintain capacity for cluster and outbreak detection and response.
2) Increase the proportion of people newly diagnosed with HIV that are interviewed for Partner Services within 7 days of diagnosis to at least 85%.

Strategy 4A: Refine processes, data systems, and policies for robust, real-time cluster detection, time-space analysis, and response

- Activity 4A.1: Develop a protocol, training materials, and standard operation plan.
- Activity 4A.2: Continue community engagement regarding the use of HIV molecular surveillance for cluster detection to inform its best use and identify and mitigate any unintended consequences.
- Activity 4A.3: Expand routine epidemiological analysis of recent infection by person, place, and time to identify hot-spot locations and sub-populations associated with recent infection to inform rapid investigation and intervention.

Strategy 4B: Refine current processes to increase capacity of Partner Services to ensure people newly diagnosed are interviewed and close partners are identified and offered services in a timely and effective manner.

- Activity 4B.1: Increase capacity of LAC DPH to provide Partner Services to all newly diagnosed persons in LAC.
- Activity 4B.2: Implement new STD surveillance system to enhance the identification and assignment of new HIV cases to LAC DPH staff for timely follow-up and Partner Services.

Key Partners: California Office of AIDS, City of Long Beach and City of Pasadena Health Departments, HIV and STD Service Providers

Outcomes:

- Increased number of newly diagnosed people with HIV interviewed by Partner Services staff
- Improved data systems and surveillance data for real-time cluster detection and response
- Improved policies and funding mechanisms to respond to and contain HIV clusters and outbreaks
- Improved knowledge of networks to contain HIV transmission clusters and outbreaks
- Increased number of testing providers offering HIV recent infection testing
- Increased new HIV diagnoses

Monitoring Data Source: Partner Services data (STD Casewatch), Local HIV clusters

LAC DPH Funding Sources specific to EHE: HRSA 078 Ending the HIV Epidemic ($3,083,808), CDC Ending the HIV Epidemic ($3,360,658), HRSA CARES Act ($1,263,368)

Table 1: Funding Sources and Allocations

The table below includes funding at the LAC DPH level as well as external funding that will play an important role in EHE Plan implementation. Please Note: This is not an exhaustive list.

Funding Source	Diagnose	Treat	Prevent	Respond
HRSA Ending the HIV Epidemic		X		X
CDC Ending the Epidemic Program Implementation	X		X	
HRSA CARES		X		
HRSA Ryan White Program Part A	X	X	X	
HRSA Ryan White Program Part B		X	X	
HRSA Ryan White Program Minority AIDS Initiative		X	X	
CDC Integrated HIV Surveillance and Prevention	X		X	X
CDC HIV Treatment Improvement Demonstration Project		X	X	
CDC National HIV Behavioral Survey and TG Supplement			X	
CDC Medical Monitoring Project		X		
State OA HIV Surveillance	X		X	
SAPC Non-Drug Medi-Cal	X		X	
County/City of LA SSP Funding			X	
EHE funding to Federally Qualified Health Centers	X	X	X	
EHE funding to Academic Institutions/Research	X	X	X	X
EHE funding to AIDS Education and Training Centers	X	X	X	

Appendix A: Acronyms

ACDC	Acute Communicable Disease Control Program
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CCALAC	Community Clinic Association of Los Angeles County
CDC	Centers for Disease Control and Prevention
CHIPTS	Center for HIV Identification, Prevention and Treatment Services
DHSP	Division of HIV and STD Programs
eHARS	Enhanced HIV/AIDS Reporting System (DHSP HIV Surveillance)
EHE	Ending the HIV Epidemic
FQHC	Federally Qualified Health Center
FDA	Food and Drug Administration
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
IDU	injection drug use
LAC	Los Angeles County
LACHAS	Los Angeles County HIV/AIDS Strategy
LAC DPH	Los Angeles County Department of Public Health
LAHSA	Los Angeles County Homeless Services Authority
LRP	Linkage and Re-engagement Program
MCC	Medical Care Coordination
MMP	Medical Monitoring Project
MSM	Men who have Sex with men
NASTAD	National Association of AIDS Directors (formerly National Association of State and Territorial AIDS Directors
NHBS	National HIV Behavioral Surveillance
OA	Office of AIDS
OASH	Office of the Assistant Secretary for Health
PACE	Prevention through Active Community Engagement
PLWH	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PEP	Post Exposure Prophylaxis
PWID	Persons Who Inject Drugs
RWP	Ryan White Program
SAPC	Substance Abuse Prevention and Control
SSP	Syringe Service Programs
SUD	substance use disorders
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection

Appendix B: Commission on HIV - November 2019 Meeting Agenda

LOS ANGELES COUNTY COMMISSION ON HIV

REVISED

2019 Annual Meeting Agenda

Thursday, November 14, 2019 | 9:00AM – 4:00PM

St. Anne's Conference Center | 155 North Occidental Blvd., Los Angeles CA 90026

RENEWED OPPORTUNITIES AND COLLABORATIONS IN TIME OF URGENCY TO END THE HIV EPIDEMIC

I.	**Registration**	8:30 AM – 9:00 AM
II.	**Call to Order, Roll Call & Approval of Agenda**	9:00 AM – 9:05 AM
III.	**Welcome, Opening Remarks & Meeting Objectives**	9:05 AM – 9:30 AM
	Cheryl A. Barrit, MPIA, Executive Director, Commission on HIV (COH) **Grissel Granados, MSW**, COH Co Chair & **Al Ballesteros, MBA**, COH Co Chair **Emily Gantz-McKay**, President/Managing Director EGM Consulting, LLC	
IV.	**Ending the HIV Epidemic: What Do We Know?**	9:30 AM – 11:15 AM
	Mario J. Pérez, MPH, Director, Division of HIV and STD Programs (DHSP), Los Angeles County Department of Public Health **Raphael J. Landovitz, MD**, **MSc** Co-Director, UCLA Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) **Britt Skaathun**, **PhD, MPH**, Postdoctoral Fellow, Infectious Diseases & Global Public Health, School of Medicine, University of California San Diego (UCSD) **Marisa Ramos, PhD**, Interim Chief, Office of AIDS, California Department of Public Health **CDR Michelle Sandoval-Rosario**, Director, Prevention through Active Community Engagement (PACE) Program Region 9, Los Angeles **LCDR Jose Antonio Ortiz**, Deputy Director, Prevention through Active Community Engagement (PACE) Program Region 9, Los Angeles	
V.	**Facilitated Group Discussion**	11:15 AM – 11:45 AM
VI.	**Lunch**	11:45 AM – 12:15 PM
VII.	**Leadership to End the HIV Epidemic:** **Insights on Public Health and Community Partnerships and Sustained Action**	12:15 PM – 1:00 PM
	Barbara Ferrer, PhD, MPH, MEd, Director, Los Angeles County Department of Public Health **Jeffrey Gunzenhauser, MD, MPH**, Disease Control Bureau Director and Chief Medical Officer, Los Angeles County Department of Public Health **Louise McCarthy, MPP**, President and CEO, Community Clinics Association of Los Angeles County (CCLAC)	
VIII.	**Facilitated Group Discussion**	1:00 PM – 1:30 PM
IX.	**Break**	1:30 PM – 1:45 PM
X.	**Creating an Effective and Responsive Community Planning Structure**	1:45 PM – 2:45 PM
XI.	**Public Comments**	2:45 PM – 3:15 PM
XII.	**Summary, Closing Remarks & Roll Call**	3:15 PM – 3:30 PM
XIII.	**Networking Opportunity for Community Stakeholders**	3:30 PM – 4:00 PM

Appendix C: **Ending the HIV Epidemic Steering Committee**

Astrid Reina, PhD	Los Angeles County Department of Mental Health
Barbara Roberts	LAC DPH Substance Abuse and Prevention Control Division
Bridget Rogala, MPH	California State University Long Beach
Charles Robbins, MBA	Health Management Associates
Devan Rose	Translatin@ Coalition
Erin Jackson-Ward, MPH	Cedars-Sinai Medical Center
Javontae Wilson	In the Meantime Men's Group
Jerry P Abraham, MD, MPH, CMQ	Los Angeles County Medical Association
Lindsey P. Horvath	City of West Hollywood
Louise McCarthy, MPP	Community Clinic Association of Los Angeles County
Luis Garcia, Ed.D, MSW	Weingart Center
Mariana Marroquin	Trans Wellness Center
Matthew Gray Brush, MPH	Advocate
Raniyah Copeland, MPH	Black AIDS Institute
Robbie Rodriguez	Equality California
Tyreik Gaffney-Smith	APLA Health
Zelenne L. Cardenas	Social Model Recovery Systems

Appendix D: Letter of Concurrence from the Los Angeles County Commission HIV
Letter begins on the following page.

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

December 16, 2020

Mario J. Pérez, MPH, Director
Division of HIV and STD Programs (DHSP)
Department of Public Health, County of Los Angeles
600 South Commonwealth Avenue, 10th Floor
Los Angeles, CA 90005

Dear Mr. Pérez:

As Co-Chairs of the Los Angeles County Commission on HIV (Commission), we concur with the Los Angeles County Ending the HIV Epidemic Plan and we hope that that our collective efforts, at the local, state, and federal levels, will indeed lead to an end to HIV, once and for all. As described in the plan, the Commission worked in partnership with the County to help shape the plan and engage stakeholders in providing input in ensuring that the plan reflected the needs and voices of the local community.

The Division of HIV and STD Programs (DHSP) is to be commended for soliciting broad community input in developing the plan and for refining the document to integrate feedback from stakeholders. DHSP's addition of an overall strategy ("ensure strategies and activities of the EHE initiative in Los Angeles County address and improve health inequities, dismantle racism in all forms, and focus on the communities most impacted by HIV in a client-centered, people first approach") is an important statement that we hope will become a common and widely accepted strategy for the HIV movement in Los Angeles County.

Time and time again, local planning councils have collaborated with health departments to develop plans to address HIV, STD, and health disparities. This is not the first plan that local jurisdictions have developed with significant community input. We call upon the County to join community members in demanding that the federal government dedicate the same level of urgency, attention, and investment that have been marshalled for COVID to end HIV. While we seek to extinguish the COVID pandemic, let us not forget, that people living with HIV and communities that shoulder the disproportionate burden of the disease, have been fighting for an HIV/AIDS cure for thirty years and counting.

We recommend that DHSP and all stakeholders continue to intentionally and meaningfully engage people living with HIV in the decision-making process and in designing and implementing prevention and care programs. It is therefore necessary and fitting for us to amplify the impassioned plea of the Commission's Consumer Caucus and Black/African Community Task Force: Nothing About Us Without Us. We remain committed to collaborating with DHSP to monitor our progress towards meeting our EHE goals, implement modifications to our local workplans as needed based on our successes and challenges, and keep community stakeholders engaged in all aspects of our planning and implementation. We appreciate the opportunity to work with you and your staff.

Sincerely,

Alvaro Ballesteros Co-Chair

Bridget Gordon Co-Chair

cc: David Lee, Co-Chair Elect

Appendix E: Rapid ART Resources and References

Department of Health and Human Services Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral in adults and adolescents living with HIV. Available at: https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines.

Getting to Zero Rapid Committee. San Francisco Program for Rapid ART Initiation and Linkage to Care Standard Operating Procedures. Available at https://www.gettingtozerosf.org/getting-to-zero-resources/.

New York State Department of Health AIDS Institute Clinical Guidelines Program. When to Initiate Antiretroviral Therapy, With Protocol for Rapid Initiation. Available at: https://www.hivguidelines.org/antiretroviral-therapy/when-to-start-plus-rapid-start/.

World Health Organization. Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. Available at https://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/.

Coffey S, Bacchetti P, Sachdev D, et al. RAPID ART: High virologic suppression rates with immediate ART initiation in a vulnerable urban clinic population. AIDS. 2019 April 1;33(5):825-832.

Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med. Aug 11, 2011;365(6):493-505.

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