Los Angeles County
Integrated HIV Prevention and Care Plan, 2022-2026

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COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY
COMMISSION ON HIV

COUNTY OF LOS ANGELES
CALIFORNIA

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Section I: Executive Summary of Integrated Plan

The *Los Angeles County Integrated HIV Prevention and Care Plan, 2022-2026* is Los Angeles County's third integrated HIV services plan. Led by the Los Angeles County Commission on HIV's Priorities, Planning and Allocations (PP&A) Committee, this plan was developed in partnership with the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP) and a vast array of community and organizational partners. The plan is developed in response to the *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022-2026* disseminated by the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC), and as such presents a blueprint for HIV service coordination along the entire spectrum of HIV prevention and care.

The Integrated Plan is designed to reflect local vision, values, needs and strengths. It is also designed to align with *California's Integrated Statewide Strategic Plan for Addressing HIV, HCV, and STIs from 2022-2026,* and *The National HIV/AIDS Strategy (2022–2025).* In 2020, the *Ending the HIV Epidemic Plan for Los Angeles County, 2020-2025*[1] (EHE Plan) was developed and disseminated. As described in more detail below, this document served as the core of the Integrated Plan.

The Integrated Plan's seven priority populations are:

1. Latinx men who have sex with men (MSM)
2. Black/African American MSM
3. Transgender persons
4. Cisgender women of color
5. People who inject drugs (PWID)
6. People under the age of 30, and
7. People living with HIV who are 50 years of age or older

These populations were prioritized given the disproportionate impact of HIV and other STDs that they endure, as substantiated by the most current data, and as described in more detail throughout this document. With the exception of people living with HIV who are 50 years of age or older, these priority populations mirror the priority populations found in the EHE Plan. The latter category was included given the aging of the HIV-positive population and concerns related to the long-term impact of living with HIV and co-morbidities.

a. Approach

The EHE Plan formed the foundation for the Integrated Plan and provided Los Angeles County (LAC) an opportunity to add goals, objectives and strategies in response to newer data and more recent developments in the field since the EHE was originally crafted. The EHE Plan was also written and structured in accordance with the CDC's 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. The Integrated Plan herein contains sections of the EHE Plan, including the situational analysis and the goals and objectives, that have been updated and expanded since 2020.

[1]https://www.lacounty.hiv/wp-content/uploads/2021/04/EHE-Plan-Final-2021.pdf

b. Documents submitted to meet requirements

The Integrated Plan fully meets submission requirements for each section (see Appendix 1 Checklist) through the use of existing materials, updated materials and newly developed materials, including the following: [2]

- Section I: Executive Summary of Integrated Plan: New material is submitted for this section.
- Section II: Community Engagement and Planning Process: A combination of new material and narrative from the EHE Plan are used in this section. The description of the Jurisdictional Planning Process includes material from the EHE Plan and a description of planning process steps that were taken since the EHE Plan was released.
- Section III: Contributing Data Sets and Assessments: The Data Sharing and Use subsection contains new material. The Epidemiological Snapshot is material largely based on the most recent HIV surveillance report, the *HIV Surveillance Annual Report 2021*,[3] as well as STD data provided by DHSP. The Resource Inventory and Needs Assessment consists largely of new material, including new HIV testing data.
- Section IV: Situational Analysis: The Situational Analysis is updated material based on the EHE Plan with new narrative in some sections.
- Section V: 2022-2026 Goals and Objectives: Goals and Objectives are updated based on the EHE Plan.
- Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up: The Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up is new material.
- Section VII: Letters of Concurrence: The Letter of Concurrence is new material.

Section II: Community Engagement and Planning Process

Jurisdictional Planning Process*:* Because the EHE Plan forms the core of the Integrated Plan, the narrative below first describes the EHE community engagement process followed by the Integrated Plan community engagement process.

EHE Community Engagement Process: 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 DHSP 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. Stakeholders included the LAC Commission on HIV (local Ryan White Program (RWP) planning body), LAC Substance Abuse Prevention and Control (SAPC), LAC Acute Communicable Disease Control (ACDC), the California Department of Public Health Office of AIDS (California OA), the University

[2] See Appendix 1: *Integrated Prevention and Care Plan Guidance Checklist* for more information

[3] Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. Published June 29, 2022. http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf. Accessed 7/3/22.

of California at Los Angeles (UCLA) Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), the local EHE Steering Committee,[4] people living with HIV/AIDS (PLWH) and a broad network of community-based service providers. Planning meetings also took place in Oakland and San Diego. In addition, LAC DHSP engaged in meetings and site visits with multiple federal partners to inform local EHE efforts.

Local Prevention and Care Integrated Planning Body: The LAC 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 36 members (all appointed by the Board of Supervisors) who represent the diversity of LAC and communities impacted by HIV. Currently, 42% of the commissioners identify as PLWH, 25% identify as Latinx MSM; 14% identify as women of color; and 6% identify as transgender. Other EHE and Integrated Plan priority populations are well represented on the various caucuses, including the Black/African American Caucus, the Transgender Caucus, the Aging Caucus, the Women's Caucus, and the Consumer Caucus.

After the release of the LAC HIV/AIDS Strategy (LACHAS), DHSP 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. Through extensive outreach and promotion to the existing network of HIV planning, program and service partners as well as special invites to key stakeholders and elected officials not traditionally engaged in HIV efforts, over 750 community stakeholders were reached in the call-to-action meetings. Summary reports from these meetings included health district demographics, key takeaways, and top insights from the group discussions were developed and distributed to the community. The Commission was integral in promoting LACHAS, encouraging community involvement, and identifying 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 Plan, 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 while transitioning from LACHAS to the EHE Plan, and 3) Garner input on the leadership necessary to achieve EHE goals. Attendees included community stakeholders, PLWH, service providers, elected officials and/or their representatives, community clinics, County partners (Department of Mental Health, Department of Public Health, Department of Health Services and Substance Abuse and Prevention Control), universities, neighborhood associations, and faith-based organizations.

The meeting included a panel of representatives from the California OA; DHSP 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

[4] http://publichealth.lacounty.gov/dhsp/EHE/Biosketches_EHE_SteeringCommittee_040521.pdf

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.

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 in discussions focused on innovative community engagement and mobilization efforts that include bringing new voices to the table to end the 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 prioritize for new or increased mobilization around EHE, and 3) How can the development of a new 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 DHSP 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 to be considered for inclusion in the EHE Plan including recommendations from the Black/African American Community Taskforce.

Local Service Provider Partners: Local service providers, including those who represent federally qualified health centers (FQHCs), medical providers in private practices and community clinics, and a variety of community-based organizations (CBOs) are represented and engaged through various committees, coalitions, working groups, and networks across LAC. There is a strong network of LAC DHSP funded CBOs 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 outcomes. 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 Epidemic's Statewide Coalition that address policy and advocacy on the intersection between HIV, sexually transmitted diseases (STDs), and viral hepatitis. By actively working with these groups and coalitions, LAC DHSP gained 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 were active in the development and refinement of the EHE Plan. LAC DHSP 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 collectively work to ensure that existing HIV plans, programs and related goals in these jurisdictions are aligned with the LAC EHE Plan.

In addition to the existing service provider network, LAC DHSP 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 DHSP will continue to work with the LAC 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 DHSP 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) also provided valuable feedback and perspectives tied to the EHE Plan.

Integrated Plan Community Engagement Process: The development of the Integrated Plan was a collaborative process between the Commission on HIV (the local HIV planning council), LAC DHSP, and community stakeholders. As part of its existing structure, the Commission's Planning, Priorities and Allocations (PP&A) Committee leads needs assessment activities, planning, and resource allocations. As such, the PP&A Committee spearheaded the Integrated Plan planning process with the assistance of a contracted consultant. It was decided early on that, rather than have a dedicated task force to develop the plan, planning steps would be integrated into the overall work of the Commission.

The development of the Integrated Plan began in July of 2021 with a presentation at the Commission on HIV monthly meeting. During this meeting, the purpose and requirements of the Integrated Plan were presented to all attendees including Commission members and the public. The history of planning and the blueprint for plan development were also discussed, particularly given that many members had not previously been a part of any planning process. Following this initial meeting, the consultant leading the planning process met with numerous groups and individuals to develop each section of the plan, as described below.

To develop the needs assessment section, DHSP and Commissioners were hesitant to engage in any new assessment activities, given that much assessment had recently taken place to develop the EHE Plan and other local HIV/STD reports. However, as planning progressed, issues related to system and workforce capacity began to emerge as key barriers to achieving HIV-related goals. Thus, it was decided to take steps to assess this particular issue by developing and distributing an online survey in English and Spanish. The survey was developed with a team of stakeholders including PLWH, academic partners, and staff representing CBOs, FQHCs, and DHSP. To ensure that the voices and perspectives of priority population members and PLWH were reflected in the Integrated Plan, listening sessions were conducted with members of priority population groups (Black MSM, women of color, trans persons, people who inject drugs (PWID), people younger than 30 and PLWH 50 and older). The consultant worked with various community stakeholders to organize and facilitate these groups. For example, to convene a group of Black MSM, the consultant worked with staff at a community-based organization that primarily serves Black gay and bisexual men to recruit 16 participants. This listening session was co-facilitated by a staff member and the consultant. The other listening sessions were convened in a similar manner. These listening sessions attracted 86 community members, many of whom identified as PLWH. Survey and listening session findings, largely qualitative in nature, complimented the use of secondary data sources.

The EHE goals and objectives served as a foundational starting point to develop the Goals and Objectives section. A series of five workgroup meetings designed to capture ideas for additional goals, objectives, and strategies were convened. Workgroup participants included co-chairs of the Commission, the PP&A Committee, the Public Policy Committee, and community members, including PLWH.

a. **Entities involved in process**: Representatives from the following entities and population groups met to develop the Integrated Plan:
   - The Los Angeles County Department of Public Health, Division of HIV and STD Programs
   - The City of Long Beach Health Department
   - The City of West Hollywood Health Department
   - The California State Office of AIDS
   - The AIDS Coordinator for the City of Los Angeles
   - Service providers and Commission members that represented at least 20 different community-based organizations, hospitals or universities serving PLWH or at risk for HIV
   - People with HIV including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis C
   - Ryan White Program Part C and D HIV clinical providers
   - Ryan White Program Part F – AETC providers
   - Faith-based CBOs
   - Community health clinics and Federally Qualified Health Centers (FQHCs)
   - Substance use treatment providers
   - Hospital planning agencies and health care planning agencies
   - Mental health providers
   - Formerly incarcerated PLWH
   - Social services providers including housing and homeless services representatives

b. **Role of the RWHAP Part A Planning Council/Planning Body**: The Los Angeles County Commission on HIV serves as the local Ryan White HIV/AIDS Program (RWHAP) Part A Planning Council. The Commission's Priorities, Planning and Allocations (PP&A) Committee spear-headed the development of the Integrated Plan. Commission staff and PP&A leadership met regularly with the consultant to oversee the development of the Integrated Plan. The consultant provided updates at the monthly Commission meeting and PP&A meeting.

c. **Role of Planning Bodies and Other Entities**: Throughout the development of the Integrated Plan, the consultant and/or Commission leadership met with members of the EHE Steering Committee and DHSP staff that are tasked with implementation of the EHE Plan. EHE Steering Committee members expressed an interest in making sure that the Integrated Plan was aligned with the EHE Plan, that community stakeholders were engaged in the planning process and that the Integrated Plan reflected new developments in the field (e.g. the use of long acting injectables for PrEP and HIV treatment). The consultant and other planning team members also convened and/or participated in over 35 meetings to engage with a variety of groups, caucuses and task forces throughout the County including:

   - The Commission on HIV's:
   - Aging Caucus
   - Women's Caucus
   - Transgender Caucus
   - Black/African American Community Task Force (Later renamed the Black Caucus)
   - Consumer Caucus

- Prevention Planning Work Group
- Standards and Best Practices Committee
- Public Policy Committee

- Long Beach Community Planning Group
- Service Planning Area (SPA) 2 HIV/AIDS Consortium Meeting
- SPA 4 Provider Meeting
- Los Angeles County Department of Public Health, DHSP
- Los Angeles County Department of Public Health, Acute Communicable Disease Control (ACDC)
- Community groups consisting of priority population members (outlined in more detail in the Needs Assessment section)

d. **Collaboration with RWHAP Parts**: Providers from Ryan White HIV/AIDS Program Parts B, C, D and F were engaged in the planning process in a variety of ways. In early 2022, a meeting was convened with 12 representatives from seven different RWP Part C, D and F recipient organizations. Participants identified several key topics to be included in the Integrated Plan including a need to focus on social determinants of health and co-occurring disorders (especially syphilis, methamphetamine use and mental health issues); workforce development and capacity issues; culturally congruent services; and an aging population of PLWH.

   Planning team members also met with stakeholders that were involved in the development of other Integrated HIV Plans within or inclusive of LAC in order to ensure alignment and avoid duplication of efforts. These plans included *California's Integrated Statewide Strategic Plan for Addressing HIV, HCV, and STIs from 2022-2026; the Long Beach HIV/STD Strategy, 2019-2021 and the West Hollywood HIV Zero Strategic Plan, 2016-2021.* Although the time frame for the latter two plans had ended, it was important to meet with the planners to learn from their experiences and identify any priority areas to highlight in the LAC Integrated Plan. Key issues identified included a need to focus on stigma, social determinants of health and co-occurring disorders (including housing, mental health and meth use), and broadening harm reduction efforts.

e. **Engagement of People with HIV:** PLWH were engaged in all stages of the planning process, including needs assessment, priority setting, development of goals and objectives, and development of the implementation plan. As noted above, 42% (or 15) of the 36 Commissioners are PLWH. Each of the six community listening sessions included PLWH and 57% of the community survey participants identified as PLWH. Priority setting took place at PP&A Committee meetings which are chaired by two PLWH. Goals and objectives and an accompanying implementation plan were developed over the course of several meetings, all of which included PLWH as active participants. In addition, the Integrated Plan was a key agenda item at the Commission's Annual Planning meeting with many people with HIV in attendance. There was also a public comment period of 30 days whereby PLWH and other key stakeholders were invited to review the Plan and provide feedback. All feedback obtained was used to help shape the final version of the Plan. The monitoring, evaluation and improvement of the Plan will be spearheaded by the PP&A Committee, with PLWH serving as active participants.

f. **Priorities:** Key priorities that arose out of the planning and community engagement process included the need to:
   - Embrace a status neutral approach to planning and implementation – equally respecting PLWH

and people at risk for HIV, their strengths, and their needs
- Address social determinants of health, especially housing
- Address co-occurring disorders including other STDs, mental health issues and meth use disorder
- Expand harm reduction services
- Address HIV-related disparities, particularly the disparities experienced by Black/African Americans
- Increase health literacy among PLWH and people at risk for HIV
- Increase workforce capacity
- Meet the needs of PLWH age 50 years old and older and/or long-term survivors
- Create more holistic services, especially for cisgender and transgender women
- Align funding streams and resources to ensure that PLWH and people at risk for HIV are able to seamlessly access high quality services

g. **Updates to Other Strategic Plans Used to Meet Requirements**: As noted, portions of the LA County EHE Plan were utilized to develop the Integrated Plan. LA County uses surveillance data, assessment data, and the ongoing feedback of key stakeholders, including PLWH to update plans on a regular basis, typically annually.

Section III: Contributing Data Sets and Assessments

The *Contributing Data Sets and Assessments* section is comprised of four major sub-sections: (1) Data Sharing and Use; (2) Epidemiologic Snapshot; (3) HIV Prevention, Care and Treatment Resource Inventory; and (4) Needs Assessment.

DATA SHARING AND USE

Multiple data sources are utilized in LAC to monitor the HIV and STD epidemics, track service utilization, better understand service needs and assess progress in achieving county-wide and national HIV-related goals. The County uses the Electronic HIV Reporting System (eHARS), a CDC-developed information system for collecting, storing, and retrieving HIV surveillance data. In addition to eHARS, the main data sources include HIV incidence surveillance and molecular surveillance. Collectively, these data sources give LAC the ability to track the extent of the County's HIV epidemic including persons who are diagnosed and receiving care as well as those who are diagnosed and not in care. They also provide the data needed to develop the HIV Care Continuum measures, including the number of PLWH who are linked to care, in receipt of care, retained in care, and virally suppressed.

Data from population-based surveys conducted among key populations at increased risk for HIV and people living with HIV (PLWH) were also used to inform the Integrated Plan. This includes LAC data collected for the CDC-funded National HIV Behavioral Surveillance System from 2004 to 2019 and Medical Monitoring Project from 2015 to 2019.

National HIV Behavioral Surveillance (NHBS): LAC is one of 20 sites participating in this national CDC-funded HIV biobehavioral surveillance effort that allows state and local health departments to monitor HIV prevalence and risk behaviors among select populations at risk for HIV infection. These populations include men who have sex with men (MSM), persons who inject drugs (PWID), heterosexuals at increased risk for HIV infection (HET), and transgender (TG) women. NHBS participants were residents of

LAC and at least 18 years of age. Participants who provided informed consent completed an interviewer-administered anonymous standardized questionnaire about HIV-related behaviors and underwent confidential rapid HIV and standard Hepatitis B and C testing. In this document, key findings from NHBS available to date in LAC are reported. Results may not be generalizable to the broader population groups represented.

Medical Monitoring Project (MMP): The MMP is a national HIV surveillance system funded by the CDC and implemented by local health departments. The aim of MMP is to provide locally and nationally representative data on behavioral and clinical outcomes in a sample of persons receiving HIV medical care. MMP uses a two-stage probability-based sampling strategy that draws from the National HIV Surveillance System (NHSS) to select survey participants: the first stage is selecting the geographic areas to participate, and the second stage is selecting adults diagnosed with HIV and reported to NHSS within those participating areas. Sampled persons were recruited to participate in person, by telephone, or by mail. To be eligible for MMP, the person had to be living with diagnosed HIV infection, aged ≥18 years, and residing in an MMP project area. Participants were recruited via telephone, by mail, or in person. Interview questions include demographic information, health care use, met and unmet needs for ancillary services, sexual behavior, depression and anxiety, gynecologic and reproductive history (females only), drug and alcohol use, and use of prevention services.

Other datasets that LAC uses that contribute to the assessment of need and HIV-related health outcomes among people at risk for or living with HIV within the County include:

(1) Ryan White Program (RWP) client and service utilization data through Casewatch (LAC's RWP client data system);
(2) HIV testing data for testing conducted through DHSP's contracted providers;
(3) STD Casewatch data; and
(4) U.S. Census Bureau data, including data from the annual American Community Survey

LAC utilizes an evidence-based approach to planning that relies on an understanding of HIV surveillance and other sources of data. To ensure that planning participants, including Commission members and members of the community were well-versed in the most recent data, an HIV epidemiology training was conducted during the Planning, Priorities and Allocation Committee meeting in July 2022. This training presented key epidemiology terms as well as their application in examining the current LAC HIV epidemiology profile of PLWH, people at risk for HIV, and trends in the epidemic.

EPIDEMIOLOGIC SNAPSHOT

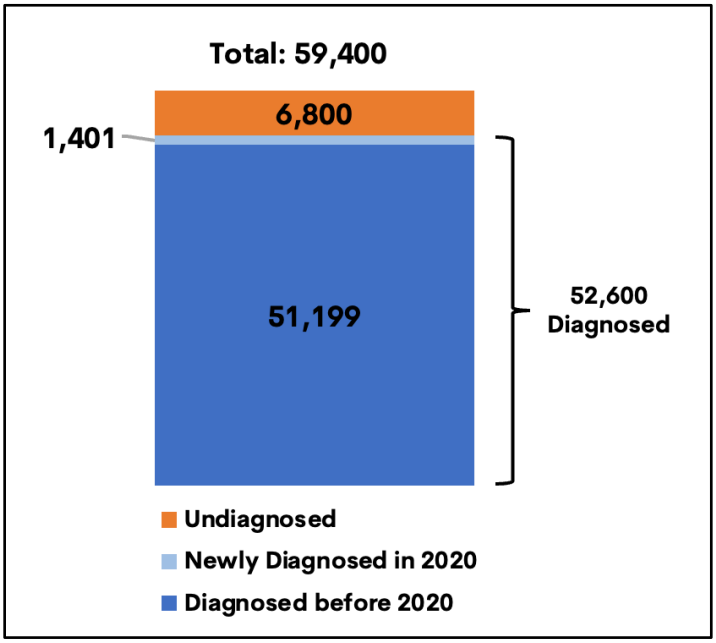
The Gabrielino Tongva, Fernandeño Tataviam, and Ventureño Chumash are the First People and original stewards of the land that today we call Los Angeles County, California. As the most populous county in the United States, LAC is home to an estimated 9,861,224 residents as of 2022. The County's urban, suburban and rural communities span over 4,000 square miles and comprise 88 incorporated cities and approximately 140 unincorporated areas. LAC is among the most ethnically and economically diverse regions in the nation with immigrants making up over a third of the County's population.[5] An estimated 69,144 Angelenos are homeless on any given night[6] and over 14,000 inmates are housed in county jails - the largest jail system in the U.S.[7]

[5] https://www.census.gov/quickfacts/fact/table/losangelescountycalifornia/POP645220
[6] https://www.lahsa.org/documents?id=6515-lacounty-hc22-data-summary
[7] https://www.prisonpolicy.org/origin/ca/2020/report.html

I. People Living with HIV in LA County

At the end of 2020, there was an estimated 59,400[8] PLWH,[9] aged 13 years and older in LAC, including 1,401 who had been newly diagnosed (in 2020) and an estimated 6,800[10] persons who were unaware of their infection (Figure 1). As described in more detail below, HIV continues to be driven by social determinants of health and co-occurring disorders and disproportionately impacts some population groups more than others.

Figure 1: People Living with HIV in LA County, 2020



a) Geographic Distribution of People Living with Diagnosed HIV (PLWDH): The County is made up of 26 different health districts which overlay eight distinct Service Planning Areas (SPAs).[11] As depicted in Figure 2, HIV diagnoses and prevalence are unevenly distributed geographically across the County with the highest density of both those newly diagnosed with HIV (between 2016-2020) and all PLWDH found in the central and southern regions. Among all 26 Health Districts, Hollywood-Wilshire, Central, and Long Beach are considered the three epicenters for HIV, reporting the largest numbers of new HIV diagnoses (170, 126 and 92, respectively) and PLWDH at year-end 2021 (9,352, 6,708 and 4,237 respectively).

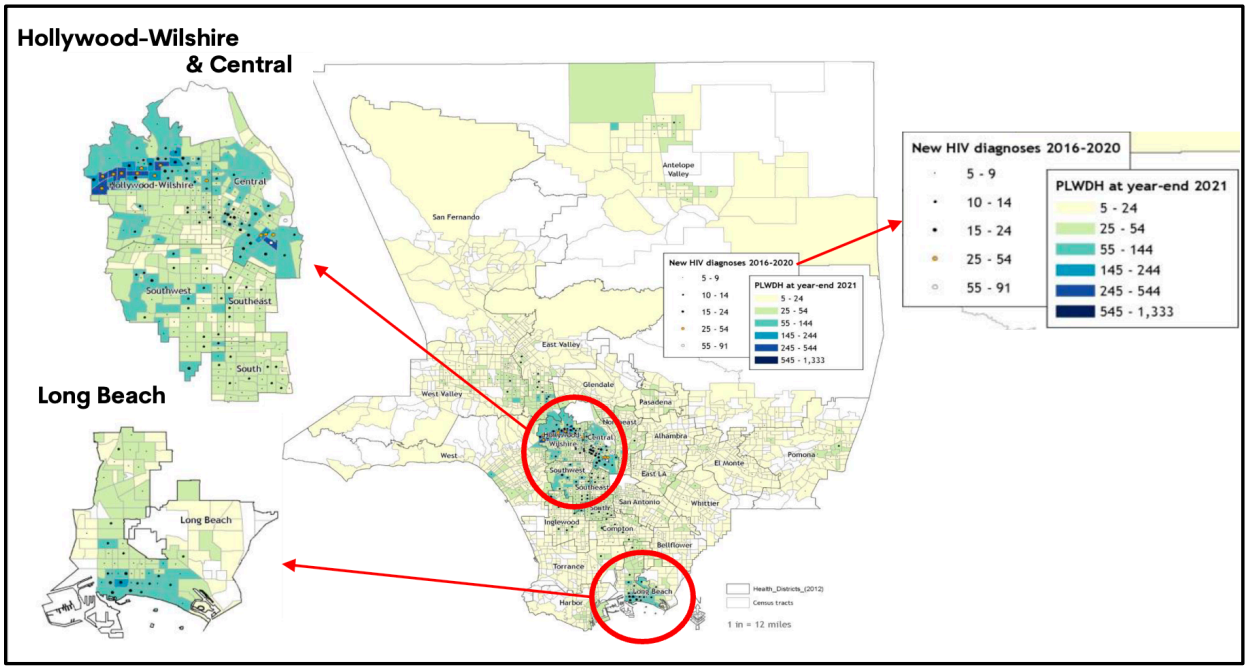
[8] 95% Confidence Interval: 57,500 – 61,300

[9] Throughout this document, "People Living with HIV," or "PLWH," is meant to denote *all* people living with HIV, whether or not they are diagnosed. This figure is always an estimation given that we are unsure of the exact number of people with HIV who are undiagnosed. By contrast, "People Living with Diagnosed HIV," or "PLWDH," is meant to denote all people who have been diagnosed with HIV and are living in LAC. This number does not include those who are undiagnosed.

[10] 95% Confidence Interval: 4,800 – 8,700

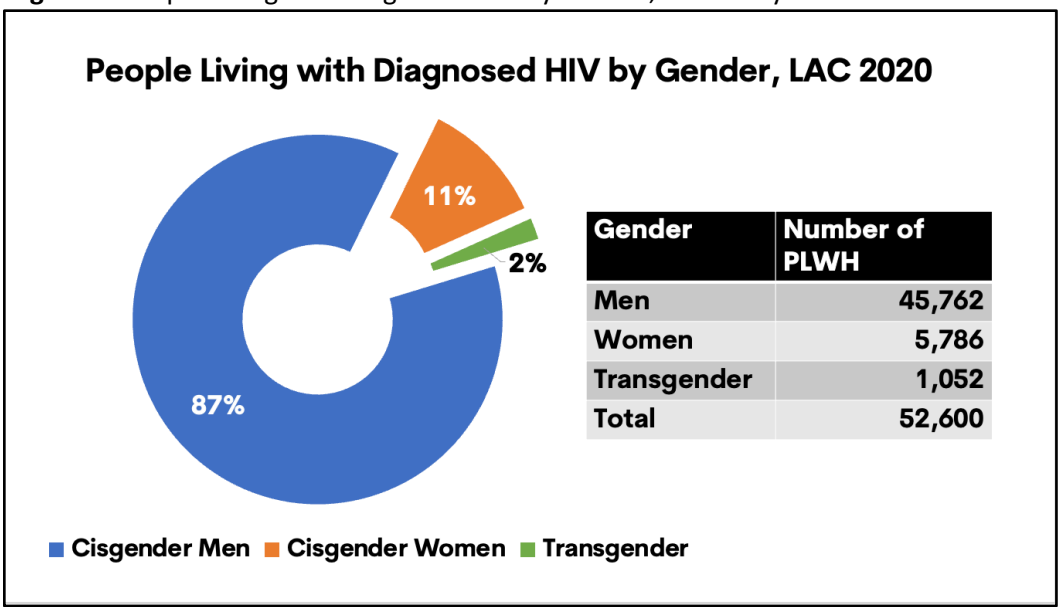
[11] (1) SPA 1: Antelope Valley, (2) SPA 2: San Fernando Valley, (3) SPA 3: San Gabriel Valley, (4) SPA 4: Metro, (5) SPA 5: West, (6) SPA 6: South, (7) SPA 7: East, and (8) SPA 8: South Bay

Figure 2: Geographic Distribution of PLWDH at year-end 2021 & Persons Newly Diagnosed with HIV, 2016-2020, LA County



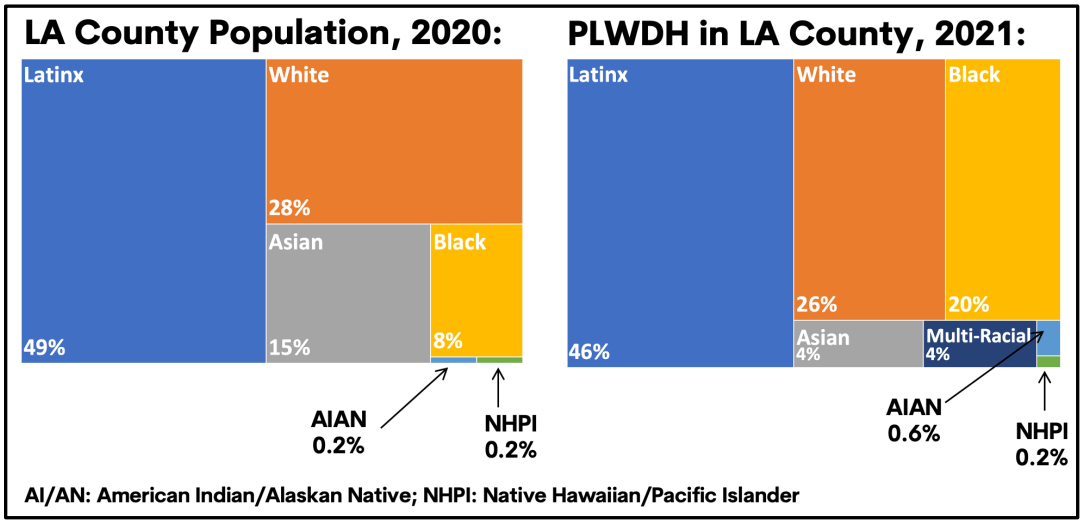
b) People Living with Diagnosed HIV in LA County, 2020: Of the 52,600 PLWDH in 2020, 87% were cisgender men, 11% were cisgender women and 2% were transgender persons (Figure 3). With respect to race/ethnicity, Latinx people make up the greatest proportion of PLWDH (46%), followed by the White population (26%), the Black/African American population (20%), the Asian population (4%), and those who identify as multi-racial (4%). The American Indian/Alaskan Native (AI/AN) and Native Hawaiian/ Pacific Islander (NH/PI) populations collectively make-up less than 1% of PLWDH. The Black/African American population is significantly over-represented among PLWHD, given that Black/African Americans make up 8% of the County's overall population, but 20% of the population of PLWDH. AI/AN people are also over-represented among PLWDH, given that they make up 0.2% of the overall population, but 0.6% of PLWDH (Figure 4).

Figure 3: People Living with Diagnosed HIV by Gender, LA County 2020



Gender	Number of PLWH
Men	45,762
Women	5,786
Transgender	1,052
Total	52,600

Figure 4: Racial/Ethnic Composition of LA County,[12] 2020 Compared to Racial/Ethnic Composition of PLWDH in 2021

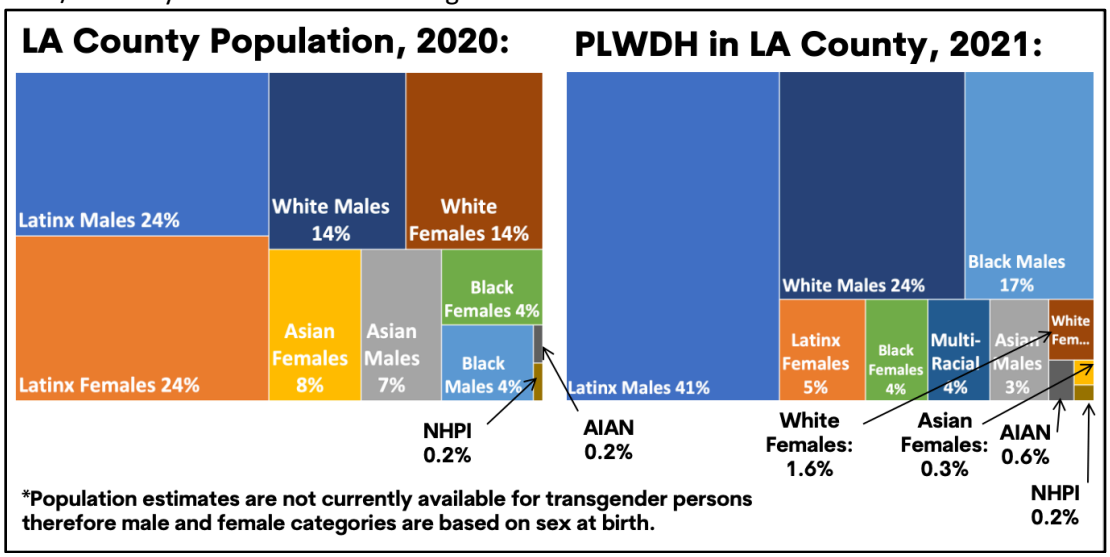


With respect to sex at birth and race/ethnicity (Fig. 5), the populations most impacted by HIV are Latinx males who represented 41% of all PLWDH followed by White males (24%) and Black males (17%). Combined, these groups represent 82% of all PLWDH in LAC. HIV disparities are even more pronounced when the population of PLWDH is compared to the overall population. For example, Latinx males represent 24% of the LAC population and 41% of PLWDH; Black males represent 4% of the population, and 17% of PLWDH; and White males represent 14% of the population and 24% of PLWDH. Altogether, AI/AN, NH/PI and multi-racial men and women represented less than 5% of PLWHD. [13]

[12] Based on the 2020 population estimates provided by LAC ISD & contracted through Hedderson Demographic Services.

[13] PLWDH with unknown race/ethnicity were not presented in the graph (n=69). NH/PI and AI/AN represented less than 1% and were presented for males and females combined due to limited visibility on the graph. Population estimates for multi-racial persons are not available.

Figure 5: Race/Ethnicity and Sex at Birth among LA County Residents, 2020, Compared to Race/Ethnicity and Sex at Birth among PLWDH in 2021

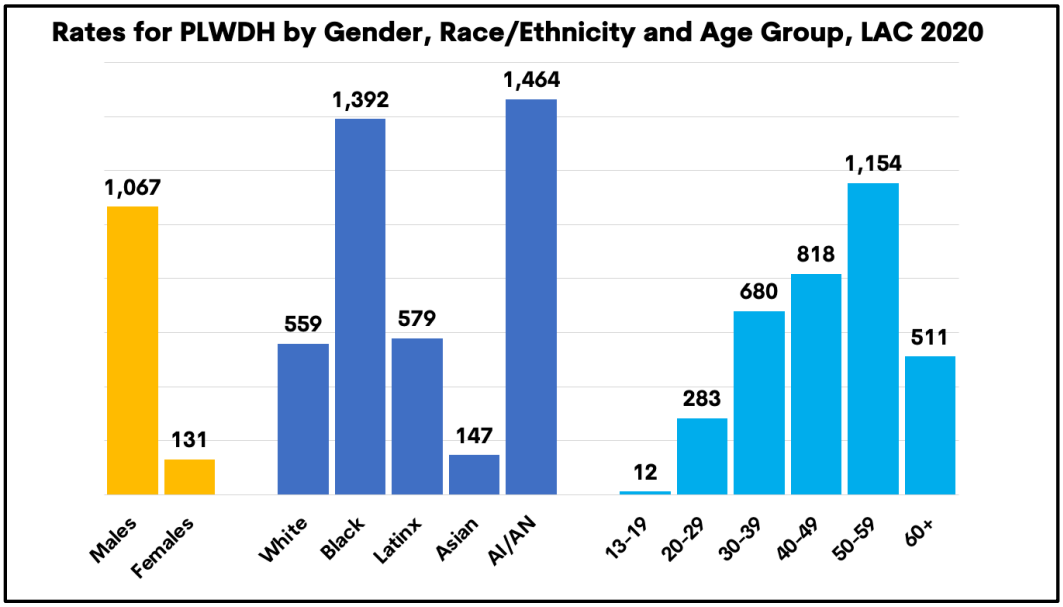


While Latinx people make up the largest *proportion* of PLWDH, AI/AN people have the highest *rates* of HIV.[14] The Black/African American population also has extremely high rates of HIV per 100,000 population (1,392) compared to Latinx (579), White (559) and Asian (147) populations. Rates are also significantly higher among males (1,067) versus females (131); and among those aged 50-59 (1,154) and 40-49 (818) compared to other age groups (Fig. 6).

Rates for transgender people are not typically calculated, given the lack of reliable population estimates and the relatively small population size compared to cisgender men and women. However, the UCLA School of Law Williams Institute has recently published transgender population estimates based on data from the CDC's Behavior Risk Factor Surveillance System and Youth Risk Behavior Survey.[15] They estimate that in California, among adults, 0.49% (150,100) identify as transgender and among youth ages 13 to 17 in the U.S., 1.93% (49,100) identify as transgender. They also report that of those that identify as transgender in the U.S., 38.5% are transgender women, 35.9% are transgender men, and 25.6% reported they are gender nonconforming. If we were to apply these percentages to LAC, we would find that there are approximately 38,050 people 18 or older in LAC that identify as transgender (7,765,339 people 18 or older in LAC x 0.49%); and that approximately 14,649 (38,050 x 38.5%) of them identify as transwomen, that 13,660 (38,050 x 35.9%) of them identify as transmen, and that 9,741 (38,050 x 25.6%) of them identify as gender nonconforming. Given that there are approximately 1,052 transgender PLWDH in LAC, the rate of HIV infection among trans persons would be 2,764 per 100,000 population. Assuming that approximately 90% of all transgender PLWDH are transwomen (1,052 x 90% = 947), the HIV rate among transwomen would be 6,464.

[14] Given the relatively small population size of AI/AN people, rates may not be fully accurate.
[15] Herman, J., Flores, A. & O'Neill, K. (2022). *How Many Adults and Youth Identify as Transgender in the United States?* The Williams Institute, UCLA, Los Angeles, CA.

Figure 6: Rates for PLWDH by Gender, Race/Ethnicity and Age Group, LA County, 2020



c) People Newly Diagnosed with HIV: In 2020, 1,401 persons aged 13 years and older were newly diagnosed with HIV, down from 1,560 persons in 2019. Since 2016, the overall diagnosis rate has decreased from 22 (per 100,000 population) to 16. The gap between male and female new diagnoses rates has also decreased slightly although the rate among males is still ten times that of females (Figure 7). Rates have also decreased across all race/ethnicities although Black/African Americans continue to have the highest rates compared to other groups (Figure 8). Those aged 20-29 and 30-39 also continue to have the highest rates compared to other age groups (Figure 9).

Figure 7: HIV Diagnoses Rate by Sex at Birth[16], LA County, 2016-2020

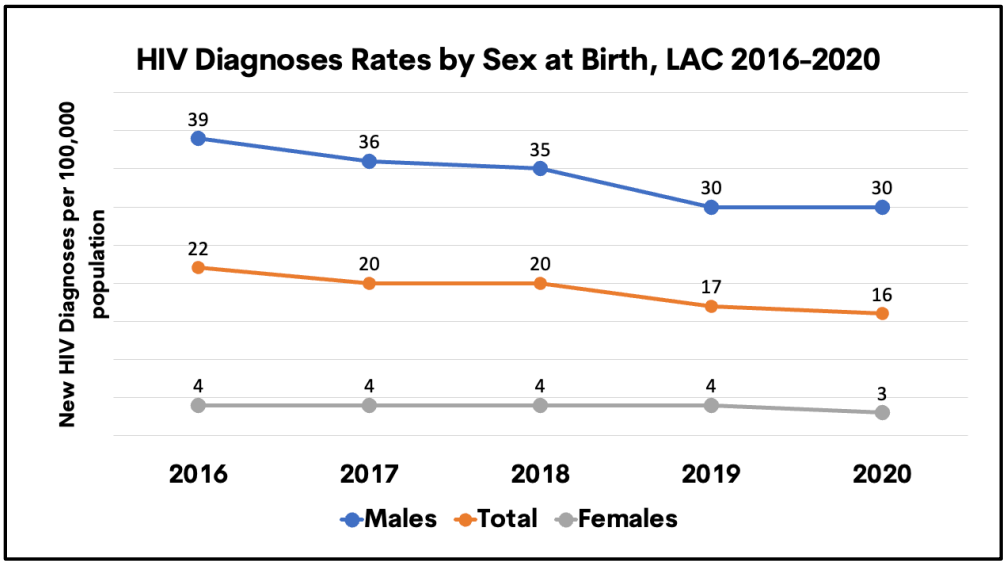


Figure 8: HIV Diagnoses Rate by Race/Ethnicity[17], LA County, 2016-2020

[16] Rates are not available for trans persons given their small population size

[17] Rate is unknown for AI/AN in 2019

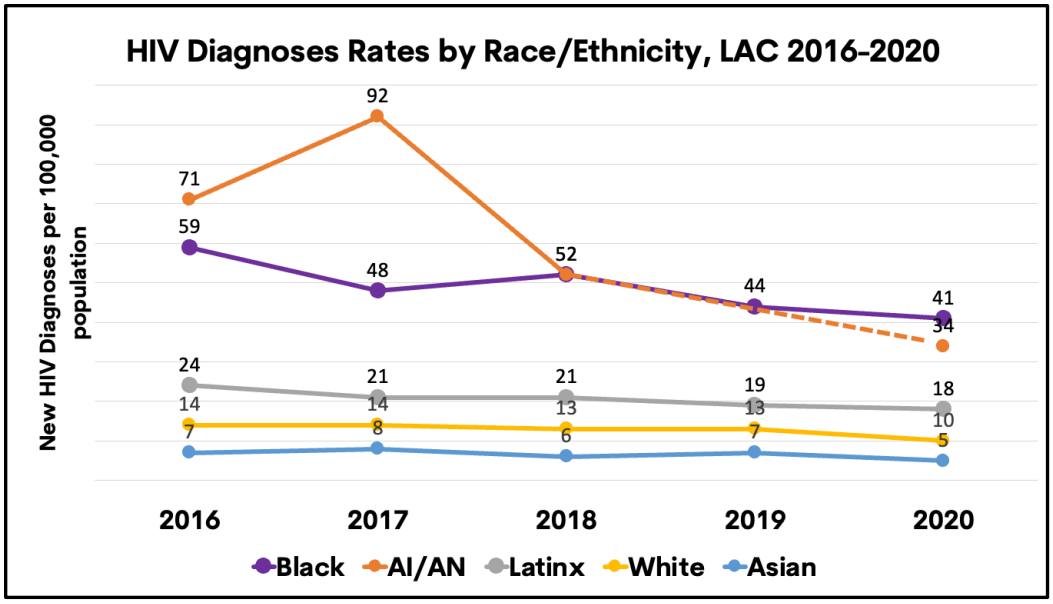


Figure 9: HIV Diagnoses Rate by Age Group, LA County, 2016-2020

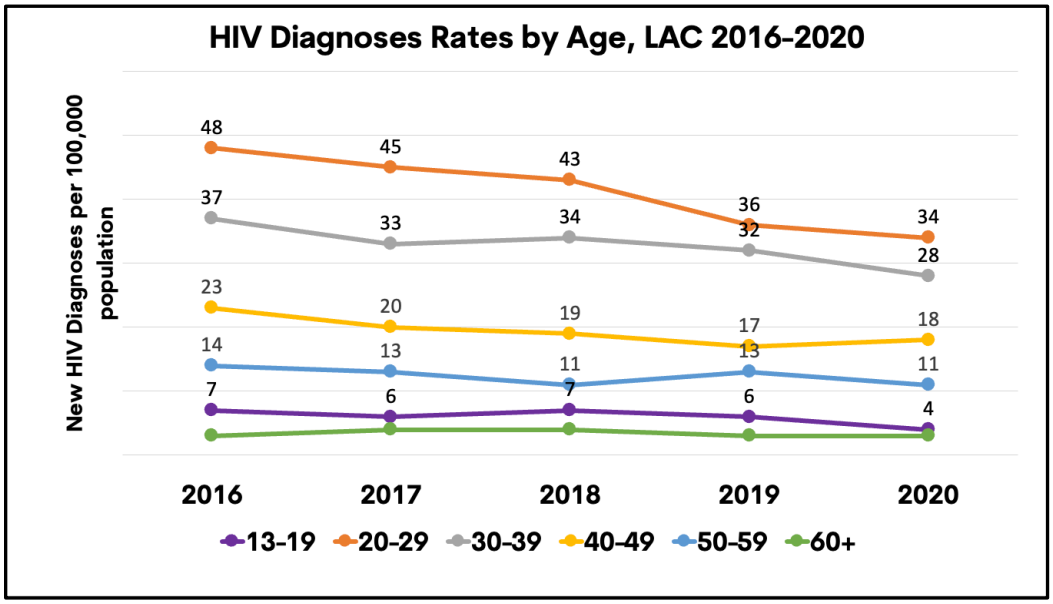
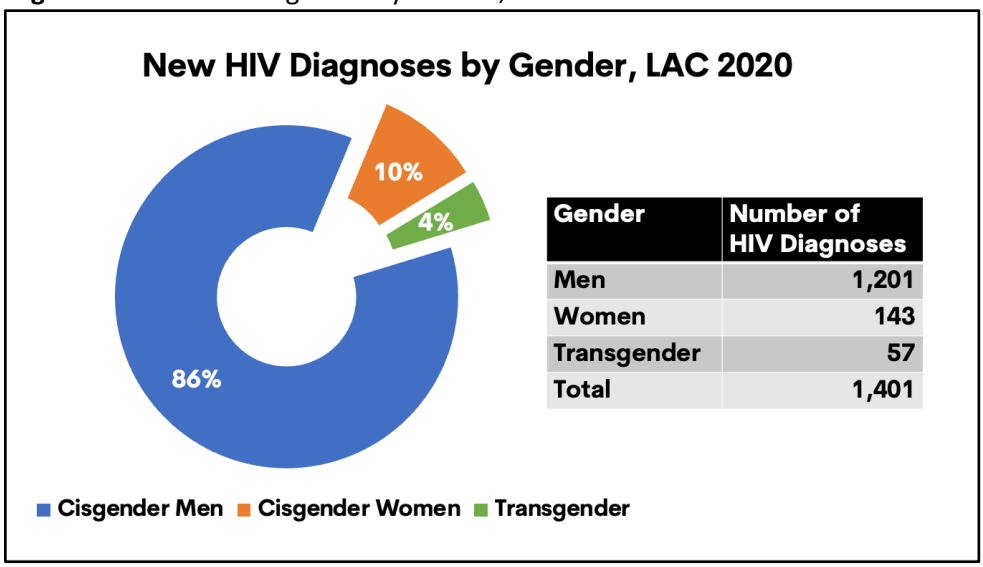


Figure 10: New HIV Diagnoses by Gender, LAC 2020



Gender	Number of HIV Diagnoses
Men	1,201
Women	143
Transgender	57
Total	1,401

Cisgender men made up most of the new HIV diagnoses in 2020 (N=1,201, 86%). Cisgender women (N=143) and transgender persons (N=57) represented 10% and 4% respectively of new HIV diagnoses in 2020 (Figure 10). Among the 57 transgender persons newly diagnosed with HIV in 2020, notably, all identified as transgender women.

In 2020, among males, those aged 20-29 (65) and 30-39 (48); and Black/African Americans (76) had the highest rates of new HIV diagnoses. Among females, those aged 30-39 (7) and Black/African Americans (10) had the highest rates of new HIV diagnoses (Figures 11 and 12).

Figure 11: HIV Diagnoses Rates among Males & Females by Age Group, LAC 2020

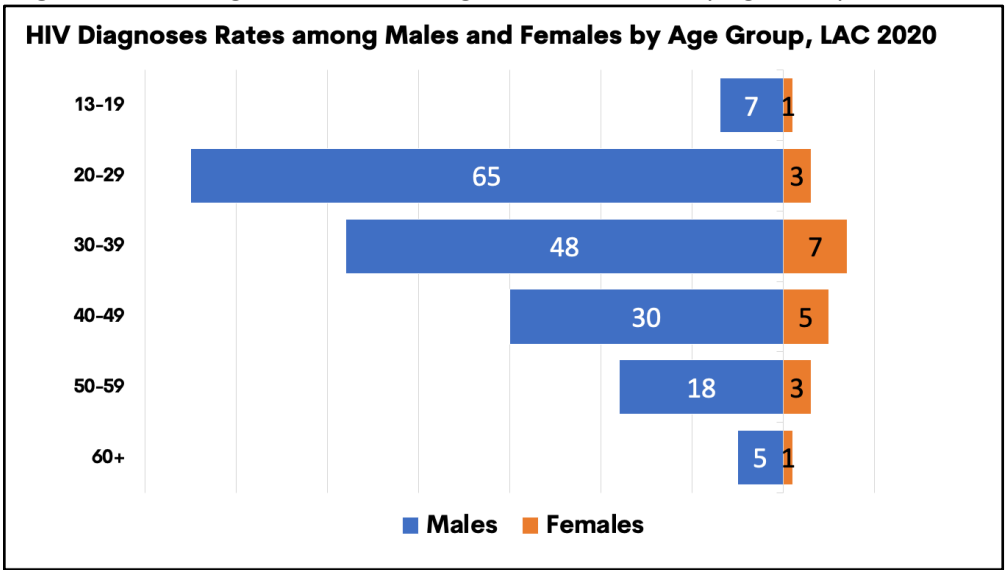
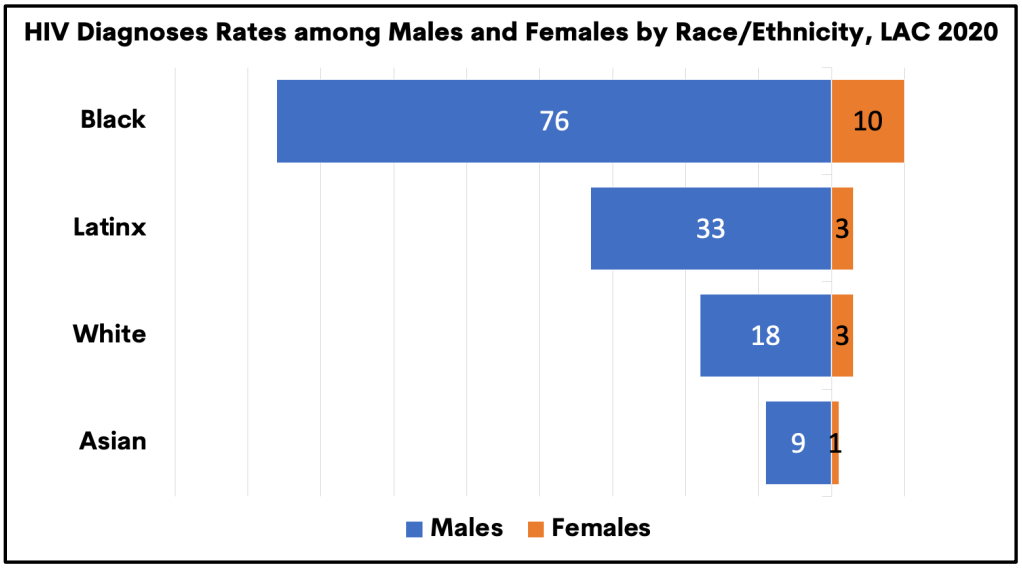
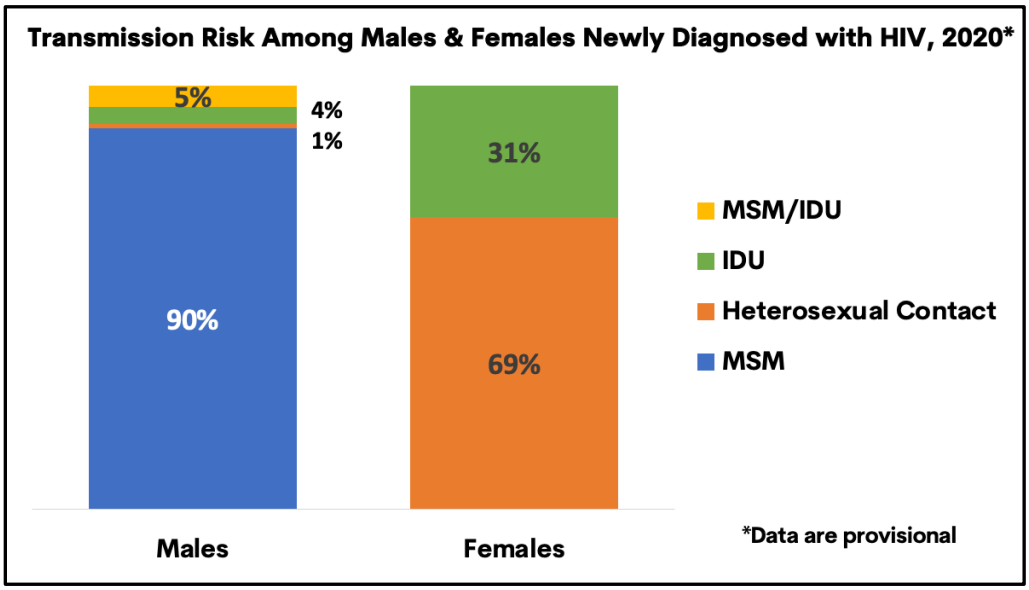


Figure 12: HIV Diagnoses Rates among Males & Females by Race/Ethnicity, LAC 2020



In 2020, the primary HIV transmission risk for newly diagnosed males was having sex with other men (90%), followed by IDU (5%), MSM/IDU (4%) and heterosexual contact (1%). The primary HIV transmission route among females newly diagnosed with HIV was heterosexual contact (69%). In 2020, the percentage of cases with IDU as the primary transmission route among females increased to 31% compared to 25% in the previous year (Figure 13).

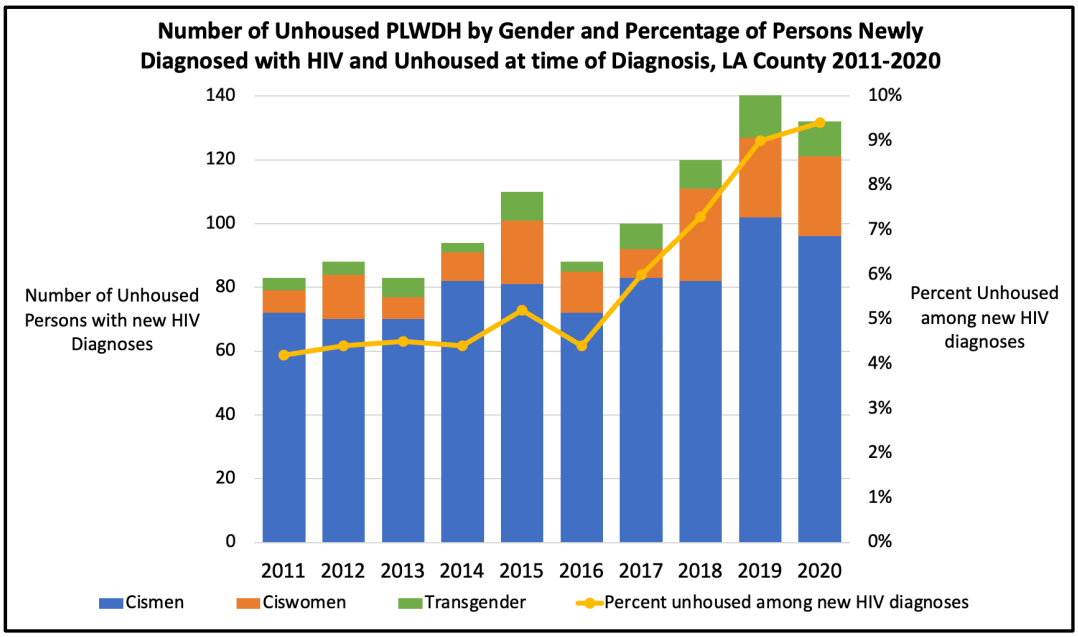
Figure 13: Transmission Risk Among Males & Females Newly Diagnosed with HIV, LAC 2020



Perinatal Transmission: In LAC, although the number of HIV-positive pregnant women has decreased over time, the number of perinatal HIV transmissions is increasing. In 2020 there were four infants who acquired HIV perinatally resulting in a rate of 8 per 100 HIV-exposed infants. Notably, common maternal risk factors included meth use (n=3), being unhoused (n=3), mental illness (n=3), syphilis (n=3) and a history of incarceration (n=2).

Unhoused: Since 2011, the percentage of persons newly diagnosed with HIV who were unhoused has more than doubled from 4.2% to 9.4%. In 2020, among 132 unhoused persons with a new HIV diagnosis, 73% were cisgender men, 19% were cisgender women and 8% were transgender. However, the HIV diagnoses rates of the unhoused have been relatively stable over this time, indicating that the increase in the unhoused population likely explains the increases in HIV diagnoses (Figure 14).

Figure 14: Number of Unhoused PLWDH by Gender and Percentage of Persons Newly Diagnosed and Unhoused at time of Diagnosis, LA County, 2020



Stage of HIV disease among Newly Diagnosed: Information on stage of HIV disease at the time of diagnosis provides direct insight into the timeliness of an HIV diagnosis. The HIV surveillance case definition of HIV has four stages: Stage 0, 1, 2, and 3. Stage 0 includes those with acute infection at diagnoses (Acute HIV) and those with no evidence of acute infection at diagnosis. Acute HIV is based on the difference in days between the first HIV-positive test result and last HIV-negative test result. If the difference falls within 60 days, HIV is classified as acute HIV.[18] The criterion for Stage 1 disease is CD4 ≥ 500 cells/µL within 90 days of diagnosis. Stage 2 is CD4 between 200-499 cells/µL within 90 days of diagnosis. Stage 3 criteria include either CD4 < 200 cells/µL within 90 days of HIV diagnosis or a diagnosis of an opportunistic illness within 90 days of HIV diagnosis.

In 2020, 15% of new HIV diagnoses were diagnosed at Stage 0, with over half of those diagnosed at Stage 0 having acute HIV at diagnosis (Figure 15). The proportion of PLWDH with acute HIV was highest among men, persons aged 20-29 years, and MSM. One in five new HIV diagnoses presented with CD4+ T-cells < 200 cells/µL at the time of diagnosis in 2020, indicative of late-stage HIV disease. The proportion of PLWDH with late-stage disease (Stage 3) was highest among females, those who identified as Latinx or multi-racial, those over 40 years of age, and those with IDU or heterosexual transmission risk (Figure 16).

[18] The number of newly diagnosed persons with stage 0 are likely underestimated due to under-reporting of HIV-negative test results.

Figure 15: Stage of HIV Disease among Newly Diagnosed PLWH, LA County 2020

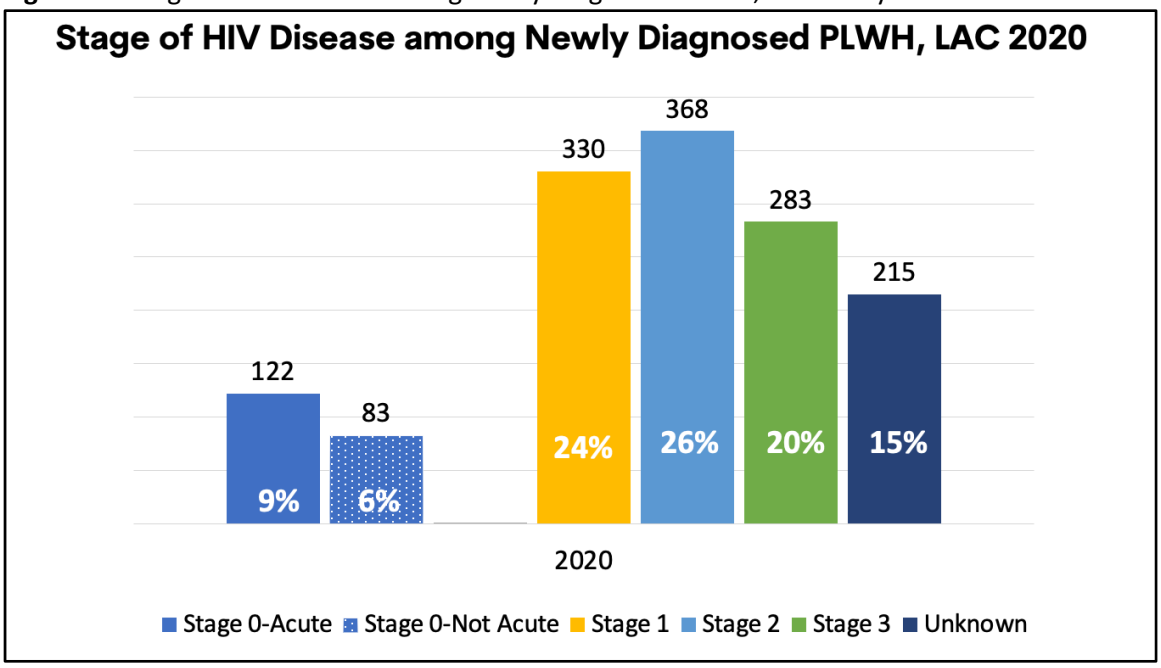
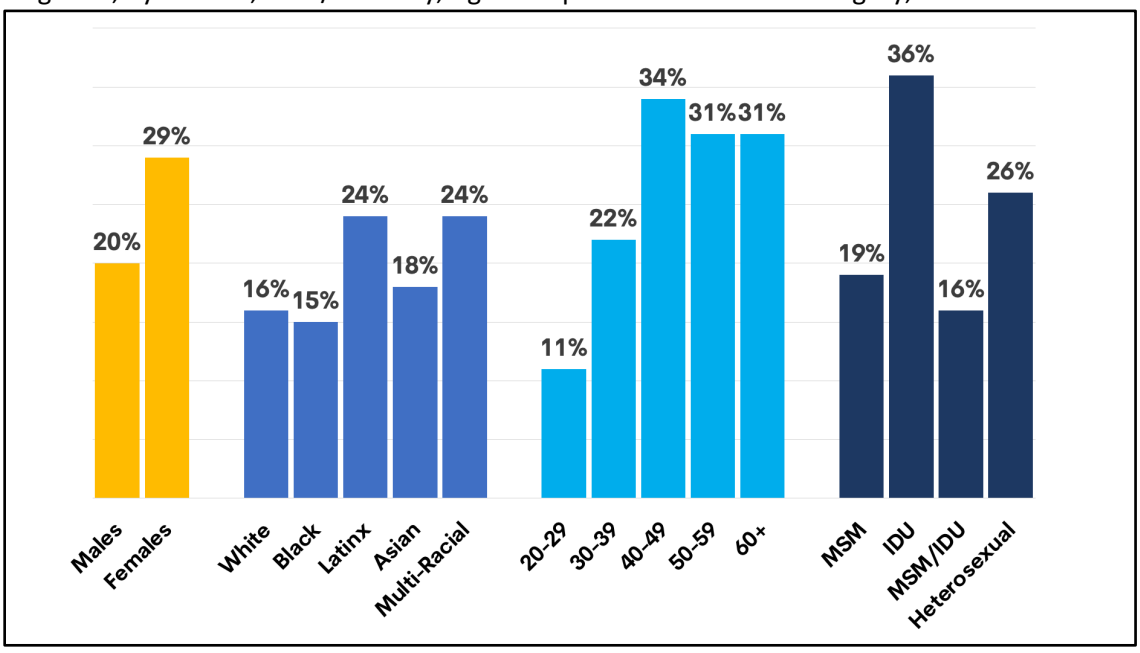


Figure 16: Percentage of Newly Diagnosed Presenting with Late-Stage Disease (Stage 3) at Time of Diagnosis, by Gender, Race/Ethnicity, Age Group and Transmission Category, LAC 2020



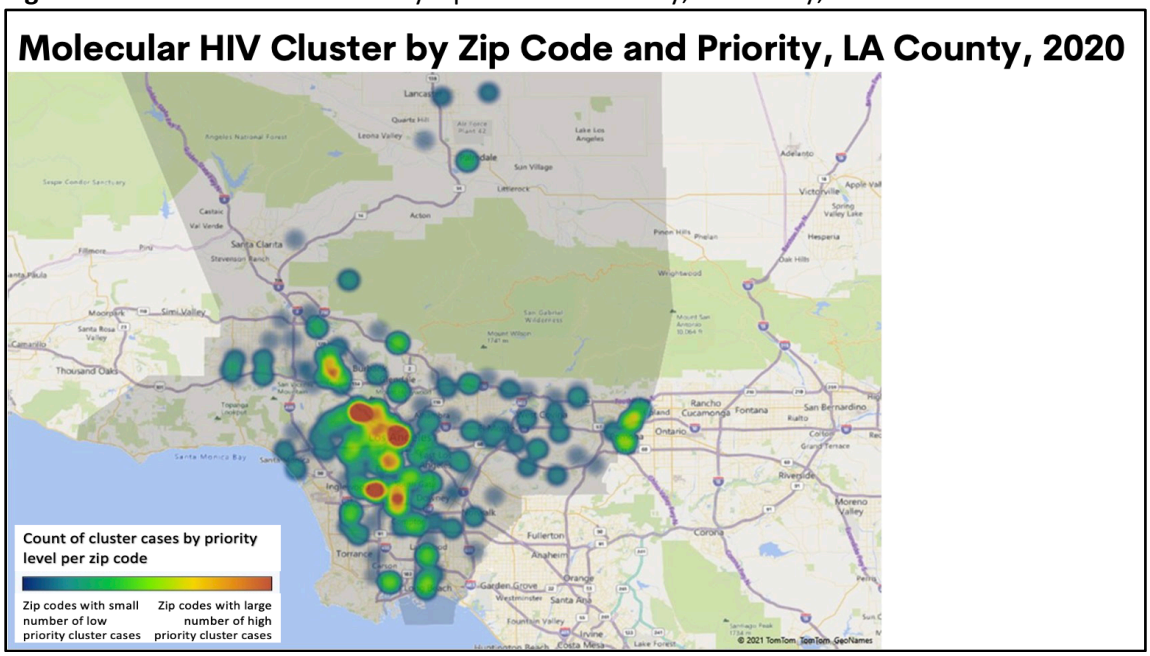
*Stage 3: Either CD-4 <200 w/in 90 days of diagnosis or diagnosis of opportunistic illness w/in 90 days

High Priority Cluster Areas: Federal guidelines for the care and treatment of PLWDH recommend HIV viral genotype testing at initiation of HIV care to determine whether an individual's HIV strain is resistant to certain drugs. The genotype testing, which results in a genetic sequence report reflecting an individual's HIV viral strain, is reported to DPH along with other HIV laboratory and clinical test results.

Molecular HIV Surveillance is the collection and analysis of HIV genotype data generated through HIV drug resistance testing. Through a comparison of the viral genotype reports of PLWDH in the local area, it can be determined if there are multiple people with a highly similar HIV strain. Because HIV's genetic sequence constantly evolves, people whose viral strains are highly similar are likely to be in the same social HIV transmission network (i.e., transmission cluster).[19] Transmission clusters with numerous newly HIV diagnosed individuals may indicate that recent and rapid HIV transmission is occurring among a group of individuals. When a cluster is identified, it can inform the delivery of services and interventions to minimize transmission in a geographic area and prioritize efforts to those who need them the most.

In 2020, 7% of persons newly diagnosed with HIV were associated with a priority transmission cluster. These persons were more likely to be aged 13-29 years, Latinx, and have MSM transmission risk compared with persons newly diagnosed with HIV who were not associated with a priority cluster. Persons associated with a priority transmission cluster were also more likely to reside in the Southeast, San Antonio, Northeast, and Antelope Valley Health Districts; report methamphetamine use and anonymous partners; and have syphilis co-infection. The geographic distribution of the transmission clusters and priority level for follow-up are presented below in Figure 17. The blue clusters are low priority (< 5 persons with new HIV diagnoses between 2018-2020), the green as medium priority (≥ 5 persons with new HIV diagnoses between 2018- 2020), and the red as high priority (≥ 5 cases diagnosed in 2020).

Figure 17: Molecular HIV Cluster by Zip Code and Priority, LA County, 2020



d) New HIV Infections[20]: The annual number of new HIV infections reflect infections acquired in a

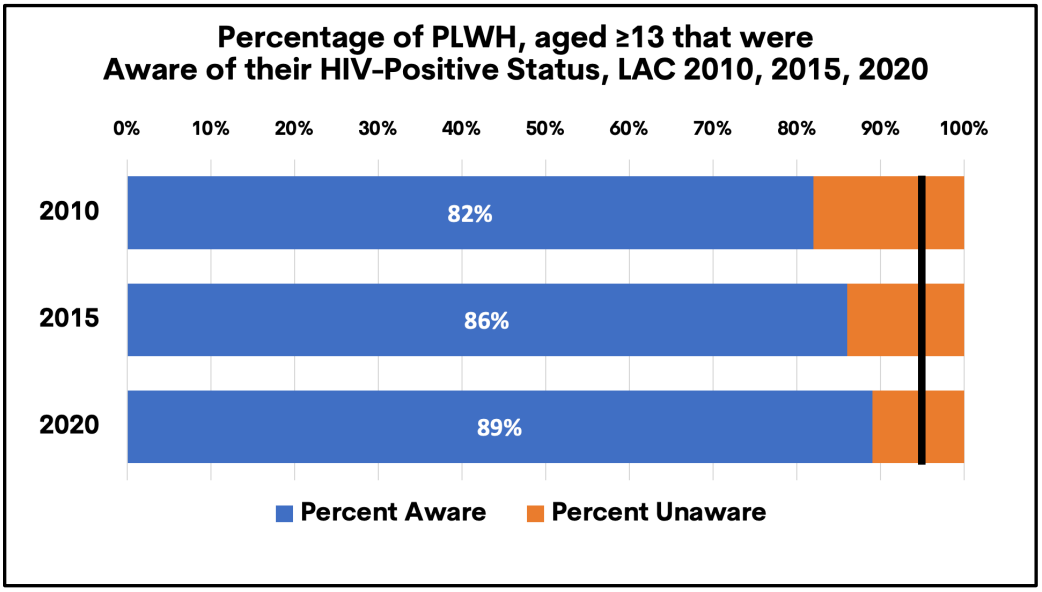
[19] It is important to note that this information cannot be used to determine either direct transmission or the direction of transmission between any two individuals.

[20] HIV incidence is approximated using CDC's CD4 depletion model, which uses HIV surveillance data and the first CD4 value after HIV diagnosis to estimate HIV incidence, HIV prevalence, and percentage of undiagnosed HIV. The date of HIV acquisition is estimated for each person with a CD4 test using the model. To account for persons without a CD4 test result, persons with CD4 test results are assigned a weight based on the year of HIV diagnosis,

calendar year. Some new infections are diagnosed soon after acquiring HIV, but the majority are not. When the number of new HIV infections is high, HIV continues to spread, because most people with a new infection are not aware they are living with HIV. New infections provide information on recent transmission and serve as a barometer to assess whether HIV prevention strategies are reducing transmission. Trends in new infections generally track with trends in new diagnoses unless transmission is very low or high in the population. An estimated 1,400 persons aged 13 years and older acquired HIV in 2020. These new infections may or may not have been diagnosed that year.[21] Estimates are not considered true values and should be interpreted along with a range of values that is likely to contain the true value with a certain degree of confidence (such as a 95% confidence interval). In 2020, the 95% confidence interval for the estimated number of new infections ranged from a low of 900 infections to a high of 1,990 infections. The number of persons newly diagnosed and the estimated number of persons who acquired HIV (new infection) have declined between 2010 and 2020. In 2010, there were an estimated 2,300 new infections and 2,186 new HIV diagnoses. In 2020, 1,404 persons were newly diagnosed with HIV, reflecting both new and old infections. An estimated 1,400 persons acquired HIV in 2020, reflecting new infections, some of whom were not diagnosed.

e) People Living with Undiagnosed HIV: In 2020, an estimated 11% of PLWH, or 6,800, were unaware of their HIV status.[22] Since 2010, awareness of HIV has increased among PLWH from 82% to 89% (Fig. 18), however, since 2019, awareness of HIV-positive status decreased across all age, sex and race/ethnicity categories, with the largest decrease observed among cisgender women (-6 percentage points).

Figure 18: Percentage of PLWH that were Aware of their HIV Status, 2010, 2015, 2020



Bolded line indicates the EHE Plan and Integrated Plan goal of 95% awareness by 2025

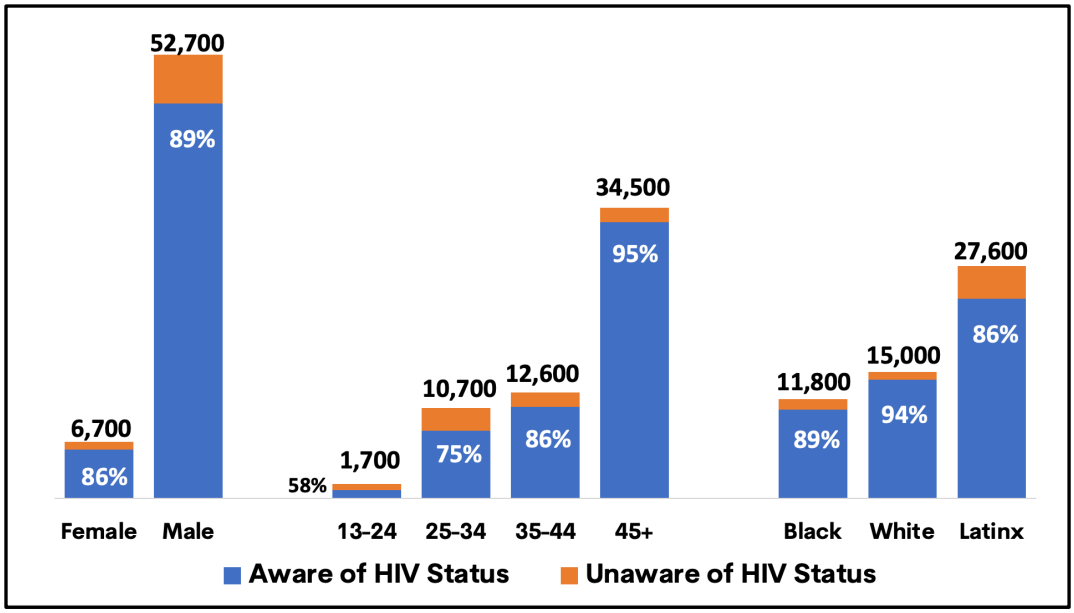
sex, race/ethnicity, transmission category, age at diagnosis, disease classification, and vital status at the end of the specified year.

[21] The annual number of new HIV diagnoses is the number of PLWH who received an HIV diagnosis in a calendar year. A new HIV diagnosis is *not* equivalent to a new infection that was acquired in a calendar year. Many people live years before they are diagnosed while some are diagnosed soon after acquiring HIV. Based on local data, the majority of new HIV diagnoses each year were infections acquired over a year ago.

[22] Estimated using the CD4-based model developed by the Centers for Disease Control and Prevention. https://journals.lww.com/jaids/Fulltext/2017/01010/Using_CD4_Data_to_Estimate_HIV_Incidence,.2.aspx.

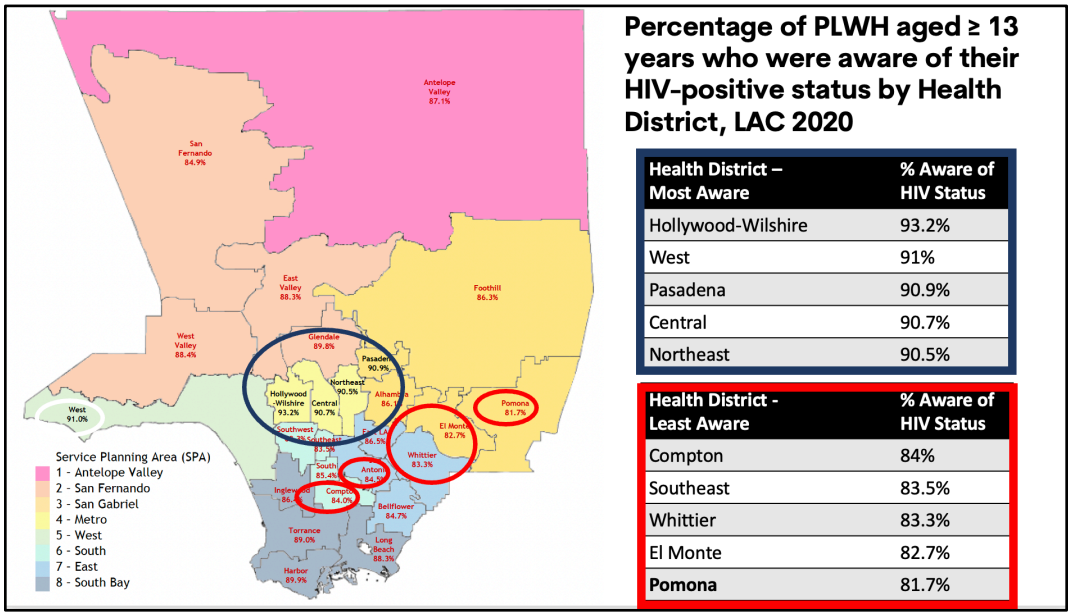
Among PLWH in 2020, the largest gaps in knowledge of HIV-positive status existed for younger persons, where approximately 42% of persons aged 13-24 years and 25% of persons aged 25-34 years with HIV were not aware of their HIV-positive status. Females and people who were Latinx or Black were also more likely to be unaware of their status compared to other groups (Figure 19).

Figure: 19: Awareness of HIV-Positive Status among PLWH by Sex at Birth, Age Group and Race/Ethnicity, LAC 2020



The percentage of PLWH who were aware of their HIV-positive status also varied by location. There were five Health Districts with at least 90% of PLWH aware of their HIV status - Hollywood-Wilshire, West, Central, Northeast and Pasadena. Conversely, the five Health Districts with the least percentage of PLWH aware of their status were Compton, Southeast, Whittier, El Monte and Pomona (Figure 20).

Figure 20: Percentage of PLWH who were aware of their HIV Status by Health District, LA County 2020



Percentage of PLWH aged ≥ 13 years who were aware of their HIV-positive status by Health District, LAC 2020

Health District – Most Aware	% Aware of HIV Status
Hollywood-Wilshire	93.2%
West	91%
Pasadena	90.9%
Central	90.7%
Northeast	90.5%

Health District - Least Aware	% Aware of HIV Status
Compton	84%
Southeast	83.5%
Whittier	83.3%
El Monte	82.7%
Pomona	81.7%

II. Clinical & Behavioral Characteristics of PLWH and People at Risk for HIV

Clinical and behavioral characteristics of PLWH and people at-risk for HIV are largely compiled through the use two biobehavioral surveillance efforts, the National HIV Behavioral Surveillance (NHBS) and the Medical Monitoring Program (MMP).

Since 2016, the NHBS has surveyed four different population groups: MSM, persons who inject drugs (PWID), heterosexuals at increased risk for HIV and transgender women. Across all NHBS participants living with HIV, 83% of MSM and 80% of transwomen were aware of their HIV-positive status. In contrast, only 63% of PWID were aware of their status[23].

MSM: Among MSM, over the course of five rounds of NHBS spanning over a decade, HIV prevalence has consistently been highest among Black MSM. In the most recent surveillance round (2017), 36% of Black MSM were living with HIV compared with 18% of Latinx MSM and 15% of White MSM. In 2017, HIV testing within the previous 12 months was high among MSM of all race/ethnicity groups, with 90% of White MSM reporting testing, and 83% of both Latinx and Black MSM reporting testing. Reports of condomless anal sex ranged from 71% among Black MSM to 79% among Latinx MSM. Twenty-eight percent of Black MSM, 25% of Latinx MSM and 24% of White MSM reported having an STD diagnosis. Exchanging sex for money or drugs was also highest among Black MSM (11%), compared to Latinx (7%) and White MSM (7%). Knowledge of PrEP was high (>92%) among MSM irrespective of race/ethnicity. Among participants who reported HIV-negative or unknown HIV status, 36% of White MSM had used PrEP within the past 12 months compared with 29% of Latinx MSM and 22% of Black MSM. Among MSM, the overlapping epidemic of meth use contributes to increased risk of HIV acquisition. Methamphetamine use is frequently associated with increased unsafe sexual activity and meth-using MSM are much more likely to have multiple sexual partners and report inconsistent condom use than MSM who do not use meth.

Transgender Women: NHBS data found that in 2019, transwomen had the highest HIV positivity rate (1 in 3 were HIV-positive) compared with other populations at elevated risk of HIV, with Black transwomen having the highest positivity rate (52%), compared with Latinx (30%) and White (9%) transwomen. Black transwomen were more likely to practice condomless anal sex and exchange sex for drugs or money but less likely to test recently for HIV than their Latinx and White counterparts. Meth use was also high among transwomen, with 33% of White transwomen, 28% of Black transwomen, and 17% of Latinx transwomen reporting use. PrEP knowledge was also high, however use of PrEP among HIV-negative transwomen in the past 12 months was low. The majority (91%) of HIV-negative transgender women had heard of PrEP and a little over half (55%) had discussed PrEP with a healthcare provider. Twenty-seven percent had taken PrEP in the last 12 months and 21% were PrEP persistent. Most respondents (70%) in the 2019 cycle reported a household income at or below the FPL and 42% were currently unemployed. Nearly 1 out of 2 participants (47%) reported being homeless at the time of the interview and 23% had been incarcerated in the previous 12 months. Over half of participants reported anal sex without a condom in the past 12 months (57%) and 35% reported having sex in exchange for food, shelter, money, or drugs. Nearly 2 out of 3 transwomen participating in NHBS reported having experienced verbal harassment over the last 12 months because of their gender identity or presentation. One out of 5 participants reported having seriously considered suicide. Recent sexual abuse was also reported by nearly 1 out of 5 respondents.

[23] Results for PWID may be unstable due to small numbers and should be interpreted with caution.

People Who Inject Drugs (PWID): Substantial disparities exist among PWID along the diagnosis and care cascade. About one in three PWID living with HIV did not know they were infected (compared to one in five transwomen and one in six MSM). Once diagnosed, PWID had lower levels of receipt of care, retention in care and viral suppression than those with MSM and heterosexual contact transmission risk. A higher percentage of PWID aged 18-29 years reported sharing syringes or injection equipment (50% and 74%) compared with PWID aged >30 years (32% and 56%). Conversely, 15% of those 30 or older and 10% of those 18-29 reported exchanging sex for money or drugs. Injection of methamphetamines during the past 12 months increased from 59% in the 2015 IDU NHBS cycle to 68% in the 2018 IDU cycle. Non-injection use of methamphetamine also increased significantly (32% to 75%).

At-Risk Heterosexuals: In the 2016 heterosexual cycle, a total of 526 persons ≥ age 18 who reported having vaginal or anal sex with a partner of the opposite sex in the past 12 months were surveyed. Of these, 54% were male and 46% female. Of the women surveyed, 57% were Black, 36% Latina and 2% were White. Eighty-three percent reported no more than a high school diploma/GED and 82% reported a household income at or below the FPL. Eighty-four percent had health insurance, 11% reported being homeless at the time of the interview, and 14% had been incarcerated in the previous 12 months. Heterosexual cisgender women were more likely to have tested for HIV and STDs than heterosexual men. Among women, more Black women reported condomless sex with a casual partner, receiving money or drugs in exchange for sex, and having concurrent sexual partnerships that Latinx women. More recently, data suggest that meth is also contributing to increased HIV risk among heterosexual people with syphilis.

III. Other STDs[24]

In recent years, STD rates have dramatically increased in LAC. According to provisional 2021 data, 28,115 gonorrhea cases and 5,746 early syphilis cases were reported to LAC - continuing the overall trend of increases in annual cases. In the last decade, there has been an 847% increase in syphilis rates among females and a 128% increase among males. Alarmingly, the number of reported congenital syphilis cases increased over 20 times between 2012 and 2021.

Chlamydia: In 2021, of the 52,121 cases, more than half were seen in cisgender females (56%) and 20-29 years old (54%). Hollywood-Wilshire (959 cases per 100,000), Central (1,035 cases per 100,000), South (987 cases per 100,000) and Southwest (956 cases per 100,000) Health Districts had rates about two times the rate of infection in LAC (545 cases per 100,000).

Gonorrhea: In 2021, the rate among African Americans (769 per 100,000) was more than four times that of Whites and Latinx people (168 and 185 per 100,000, respectively). The Hollywood-Wilshire and Central Health Districts had rates (906 and 796 per 100,000, respectively) that were approximately three times the rate of infection in LAC (294 per 100,000). Most of the gonorrhea case were among cisgender males (71%) and those aged 20-34 (63%).

Syphilis: In LAC, 5,746 early syphilis cases were reported in 2021 with a rate of 60 per 100,000, reflecting a 2% rate increase compared with the 2019[25] rate and a 161% increase compared with 2012. Rates were

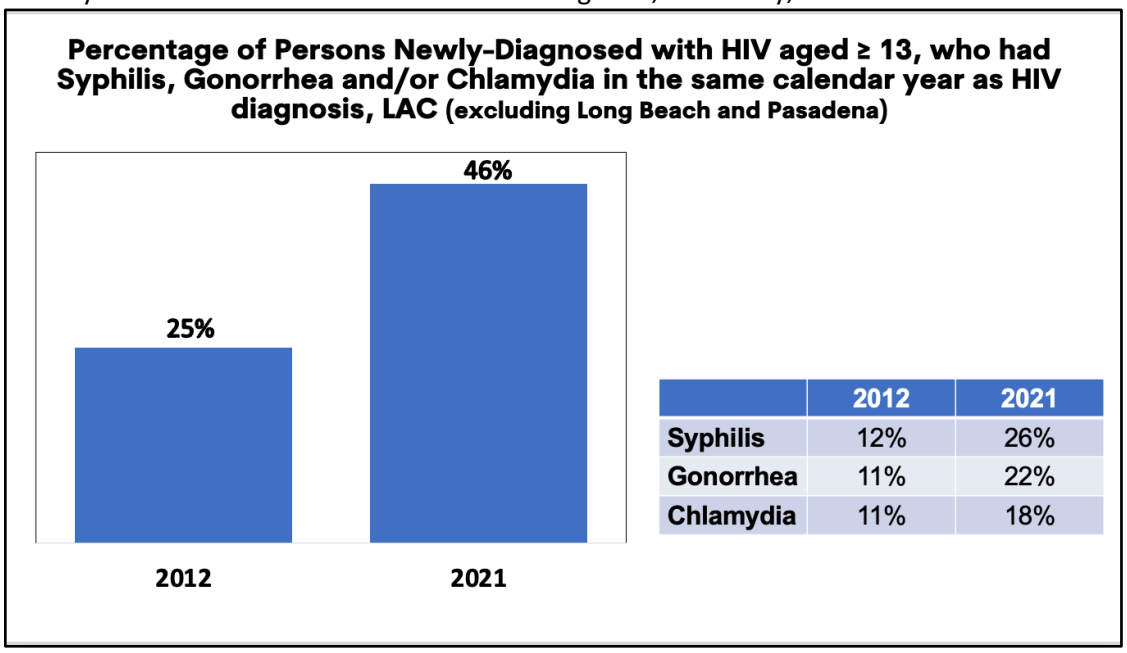
[24] All 2021 data are provisional, and 2020 population estimates were used as a proxy for 2021

[25] Due to underreporting of STDS in 2020 due to the COVID-19 pandemic, a comparison with 2020 STD data may be unreliable.

higher among males (99 per 100,000) compared to females (18 per 100,000); however, from 2019 to 2021, there was a 64% increase in early syphilis rates among females compared to a 5% decrease among males. Transgender individuals represented 3.4% of the early syphilis cases. Rates were highest in persons aged 25-29 among females (56 per 100,000) and among males aged 30-34 (265 per 100,000). The rate among African Americans (142 per 100,000) was more than three times that of Whites (46 per 100,000) and more than four times that of Latinos (60 per 100,000). Hollywood-Wilshire and Central Health Districts had a rate (205 per 100,000) that was more than three times the rate of infection in LAC (60 per 100,000). Increasing rates of syphilis among MSM/W, women and newborns (congenital syphilis) represent a concurrent epidemic with meth use disorder in LAC. As syphilis rates increase rapidly among women, LAC has reported 113 and 123 congenital syphilis (CS) cases in 2020 and 2021, respectively. After a rapid decline since 2006, LA County also had a perinatal HIV transmission rate of 7% in 2020, the highest ever seen, with three of the four babies also co-infected with CS. Maternal risk factors for congenital syphilis include meth use, unstable housing, mental illness, and lack of prenatal care.

STD and HIV Co-infection: Persons with syphilis, gonorrhea, and/or chlamydia are at an increased risk of acquiring HIV due to biological and behavioral factors. STDs among PLWH can also increase HIV viral load and the risk of forward HIV transmission. The percentage of persons newly diagnosed with HIV who had one or more STDs in the same year nearly doubled from 25% in 2012 to 46% in 2021. In 2012, 11% of those newly diagnosed with HIV had chlamydia in the same year; 11% had gonorrhea and 12% had syphilis. By 2021, those percentages grew to 18%, 22% and 26%, respectively. This reflects a rapid rise in the total number of syphilis cases in LAC over the same period (Figure 21).

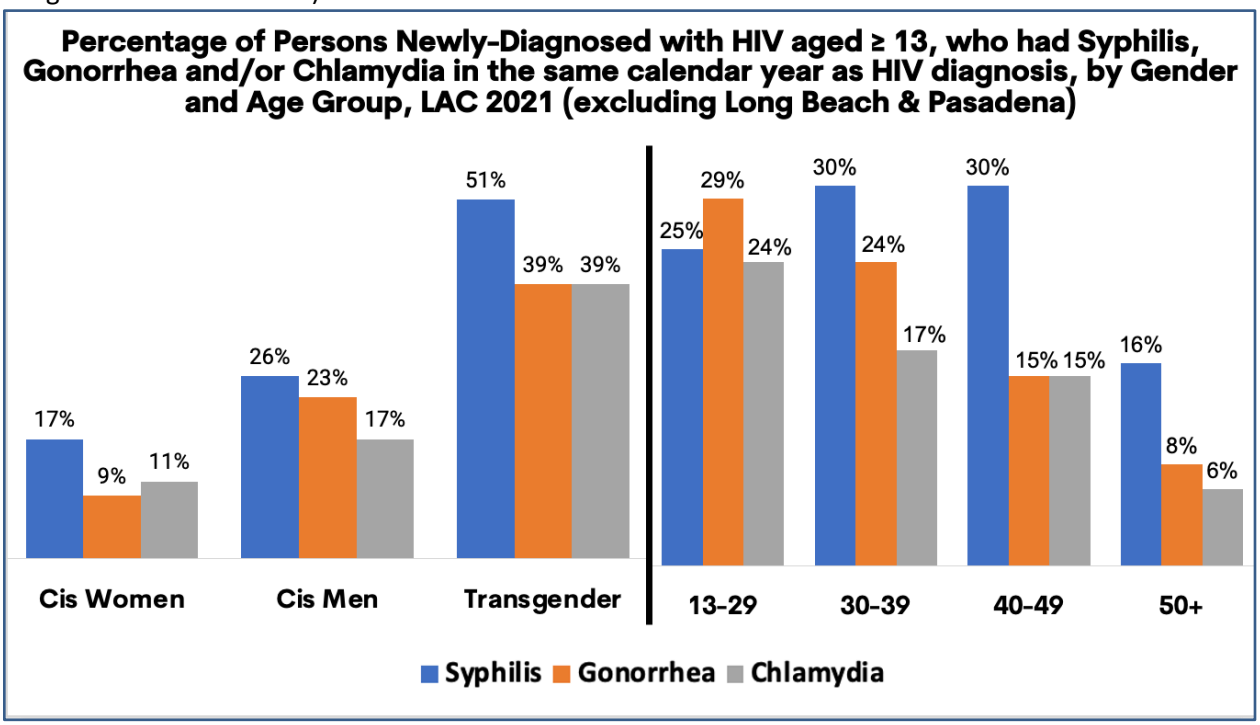
Figure 21: Percentage of Persons Newly Diagnosed with HIV who had Syphilis, Gonorrhea and/or Chlamydia in the Same Calendar Year as HIV Diagnosis, LA County, 2012 and 2021



	2012	2021
Syphilis	12%	26%
Gonorrhea	11%	22%
Chlamydia	11%	18%

In 2021, percentages of syphilis, gonorrhea and/or chlamydia co-infections among people newly diagnosed with HIV were highest in the transgender population. Among both cisgender women and cisgender men with newly diagnosed HIV, syphilis co-infection was higher than co-infection with other STDs. By age group, syphilis co-infection was highest among people aged 30-49 years old, while co-infection with gonorrhea and chlamydia was highest among people aged 13-29 years (Figure 22).

Figure 22: Percentage of persons newly diagnosed with HIV who had syphilis, gonorrhea, and/or chlamydia in the same calendar year as HIV diagnosis by STD, gender and age group, LAC (excluding Long Beach and Pasadena) 2021



Hepatitis C Virus: In the U.S., the majority of persons become infected with hepatitis C virus (HCV) by sharing needles or other equipment used in injecting drugs.[26] In 2019, among the 1,952 (47%) reported acute cases in the U.S. that included risk information for injection drug use, 1,302 (67%) reported injection drug use. Since the early 2000s there have been notable increases in HCV incidence among young people (15–29 years old), mostly associated with increases in opioid and injection drug use (IDU).[27] Subpopulations with higher injection drug use typically include unhoused persons and criminal justice-involved individuals. In the most recent (2018) NHBS survey cycle targeting PWID, of the 510 people screened for HCV, HCV antibody prevalence was 58% and the prevalence of HCV and HIV co-infection was 1%. PLWDH who are co-infected with HCV are more likely than those with HCV alone to develop end-stage liver disease, and higher viral loads for both HIV and HCV results in increased transmission risks.

COVID-19: Between January 2021 to March 2022, there were 6,048 cases of COVID-19 among PLWDH, representing a rate of 1,249 cases of COVID-19 and HIV co-infection per 10,000 PLWD.[3] Rates of COVID-19 and HIV co-infection among PLWDH were highest among females, persons aged 18-29 years, Latinx persons, residents of SPA 8 (South Bay), persons with MSM/IDU transmission risk and unhoused persons. Persons with HIV and COVID-19 co-infection had higher levels of hospitalization, intensive care

[26] https://www.cdc.gov/hepatitis/statistics/2019surveillance/Introduction.htm

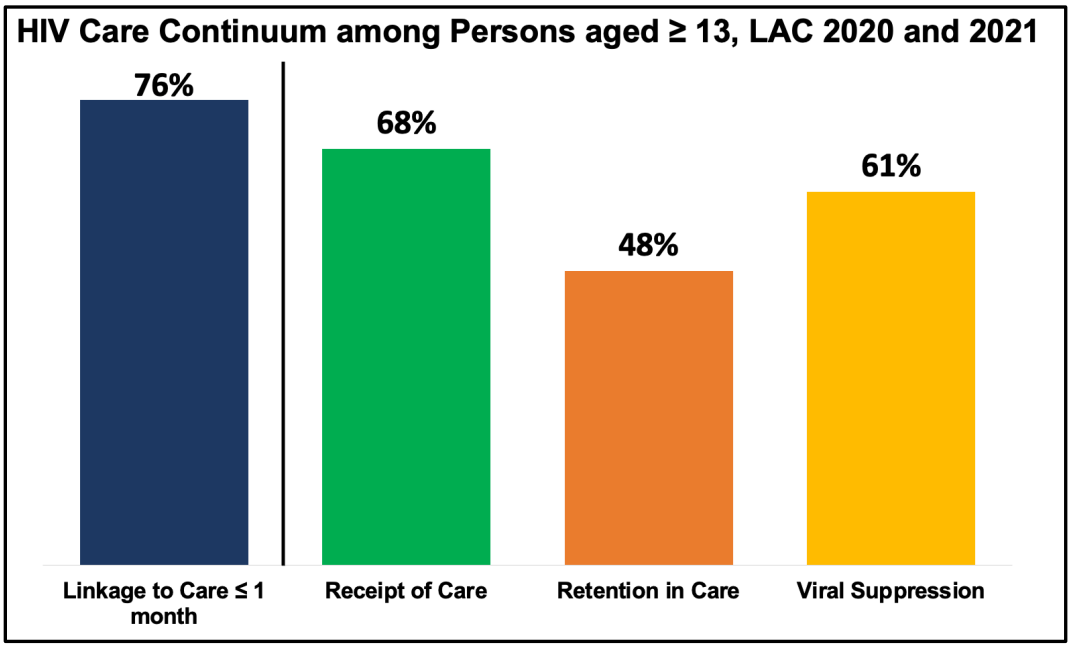
[27] Gicquelais RE, Foxman B, Coyle J, Eisenberg MC. Hepatitis C transmission in young people who inject drugs: Insights using a dynamic model informed by state public health surveillance. Epidemics. 2019; 27:86–95. doi: 10.1016/J.EPIDEM.2019.02.003.

unit admission, intubation, and death compared with all COVID-19 patients, regardless of COVID-19 vaccination status. However, COVID-19 vaccination reduced the risk of these severe outcomes for both HIV and COVID-19 co-infected patients and COVID-19 patients.

IV. HIV Care Continuum

The HIV Care Continuum is a series of steps starting from when a PLWH receives a HIV-positive diagnosis through the achievement of viral suppression. The HIV care continuum includes the following: (1) among persons receiving a diagnosis of HIV in a given calendar year, the percentage of persons who were linked to HIV care within 1 month of diagnosis (defined as ≥ 1 CD4/VL/Genotype test reported within 1 month of HIV diagnosis); and (2) among all persons living with diagnosed HIV, the percentage of persons who (a) received HIV care (defined as ≥ 1 CD4/VL/Genotype test per year)[28], (b) were retained in HIV care (defined as ≥ 2 CD4/VL/ Genotype tests at least three months apart per year), and (c) were virally suppressed (defined using most recent viral load) per year. The base population for measuring linkage to HIV care is persons who received a HIV-positive diagnosis in a given calendar year, whereas the base population for the downstream steps in the continuum of care is all persons who were diagnosed with HIV through the prior calendar year and living in LAC with diagnosed HIV in the current year. The latter ensures that there is at least one year of follow-up to measure receipt in care, retention in care, and viral suppression.

Figure 23: HIV Care Continuum, LA County 2020 and 2021



As depicted in Figure 23, 76% of people newly diagnosed with HIV **in 2020** were linked to care within one month; and among all PLWDH **in 2021**, 68% received HIV care at least once in the calendar year, 48% were retained in care, and 61% were virally suppressed. Table 1 provides an overview of HIV Care Continuum outcomes across different characteristics of PLWDH, with the poorest outcomes in each group highlighted in red font.

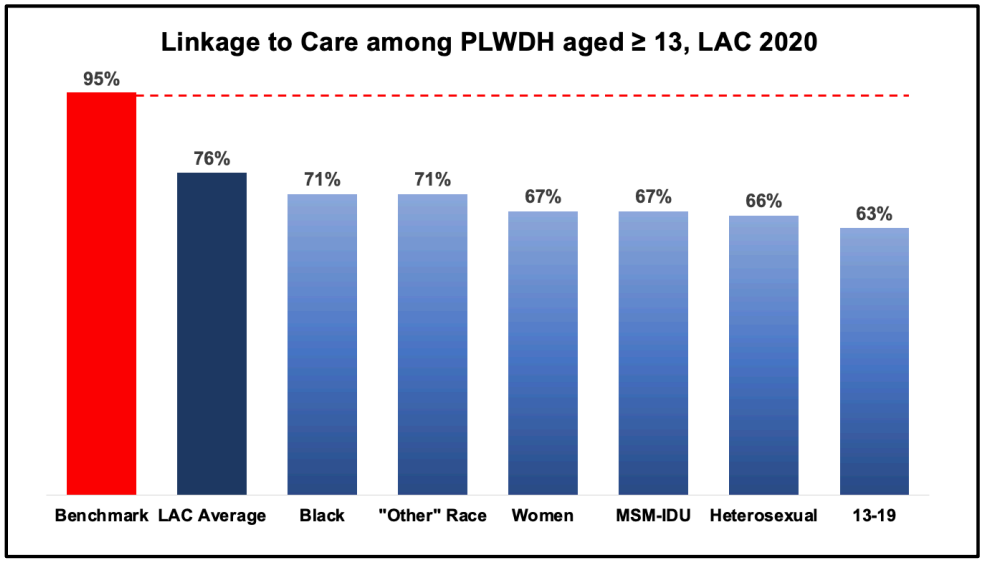
[28] "Receipt of Care" and "Engagement in Care" are synonymous terms

Table 1: HIV Care Continuum Outcomes among Select Characteristics of PLWDH, 2020-21

Characteristic	Linked to Care within 1 month	Engaged in Care	Retained in Care	Virally Suppressed
Men	77%	68%	48%	61%
Women	**67%**	**67%**	**47%**	59%
Transgender	81%	69%	49%	**56%**
13-19	63%	85%	59%	78%
20-29	76%	74%	45%	64%
30-39	78%	68%	**43%**	**59%**
40-49	73%	**66%**	47%	59%
50-59	78%	68%	50%	62%
60+	76%	67%	51%	62%
Black	**71%**	**63%**	**42%**	**54%**
Latinx	79%	68%	49%	61%
White	73%	69%	48%	63%
Asian	90%	72%	51%	68%
NH/PI	--	73%	47%	63%
AI/AN	86%	66%	**42%**	57%
Multi-race	**69%**	81%	55%	71%
MSM	78%	69%	48%	62%
IDU	75%	**57%**	**40%**	**48%**
MSM/IDU	67%	67%	47%	56%
Heterosexual	**66%**	66%	48%	60%
Total	**76%**	**68%**	**48%**	**61%**

Linkage to Care: Linkage to HIV care is typically tracked as being linked to HIV care within one month of HIV diagnosis. However, initiating HIV care services should occur faster, ideally within one week, to ensure that HIV treatment can start immediately. Though timeliness of linkage to care has improved, only 76% of persons who were newly diagnosed in 2020 were linked to HIV care within one month and only 54% were linked to HIV care within one week. Among persons aged 13 years and older newly diagnosed with HIV in 2020, groups that were least likely to be linked to care within one month of diagnosis were cisgender women (67%), Black/African Americans (71%), those whose race/ethnicity was classified as “Other” (71%), persons aged 13-19 years (63%), and persons with heterosexual (66%) and MSM/IDU (67%) transmission risk (Figure 24).

Figure 24: Linkage to Care within 1 Month of Diagnosis, among PLWDH, LAC 2020



Receive Care/Retained in Care/Viral Suppression: Once linked to HIV care, performance along the HIV care continuum remains low. In 2021, only seven in ten PLWDH received care services, five in ten were retained in care, and six in ten were virally suppressed. The percentage of PLWDH who were receiving HIV care and retained in care were similar across gender groups, while the percentage who were virally suppressed was slightly lower among transgender persons. Adolescents had better HIV care outcomes than their counterparts, while persons aged 30-49 had the poorest outcomes across all age groups. With respect to race/ethnicity, Blacks/African Americans had the worst HIV care outcomes compared with other groups. Persons whose transmission risk was IDU had the lowest levels of receipt of care, retention in care and viral suppression. The greatest disparities in viral suppression were among Black sub-populations, cisgender women and transgender persons, persons aged 30-49 years, and persons whose transmission risk included injection drug use (Figure 26). By geographic area, unsuppressed viral load was highest in the Central Health District, followed by the South, Southeast, Harbor, Hollywood-Wilshire, West, and Northeast.

Figure 25: HIV Care Continuum, LA County, 2021

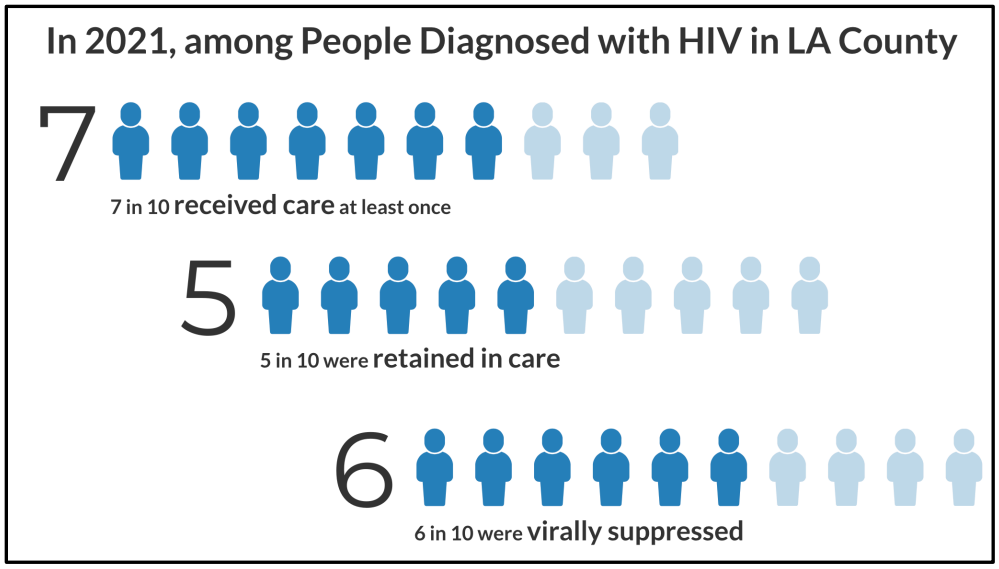


Figure 26: Viral Suppression among PLWDH, LA County 2021

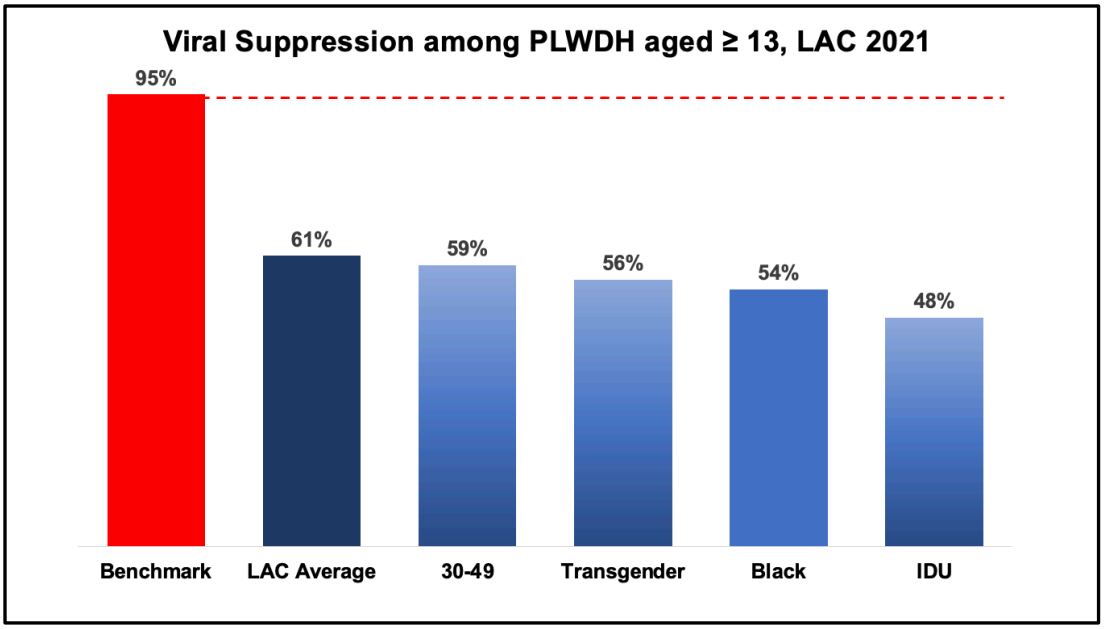
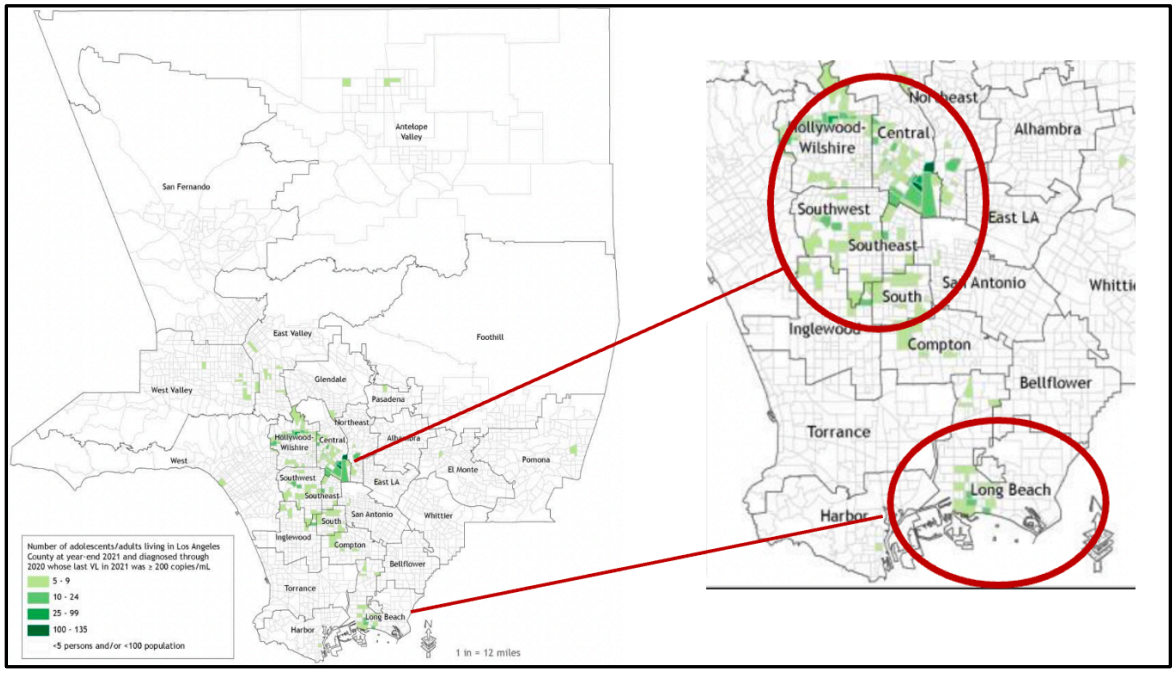


Figure 27: Unsuppressed Viral Load[29] by Census Tract among persons diagnosed through 2020 and living in LAC at year-end 2021 (N=1,687)*

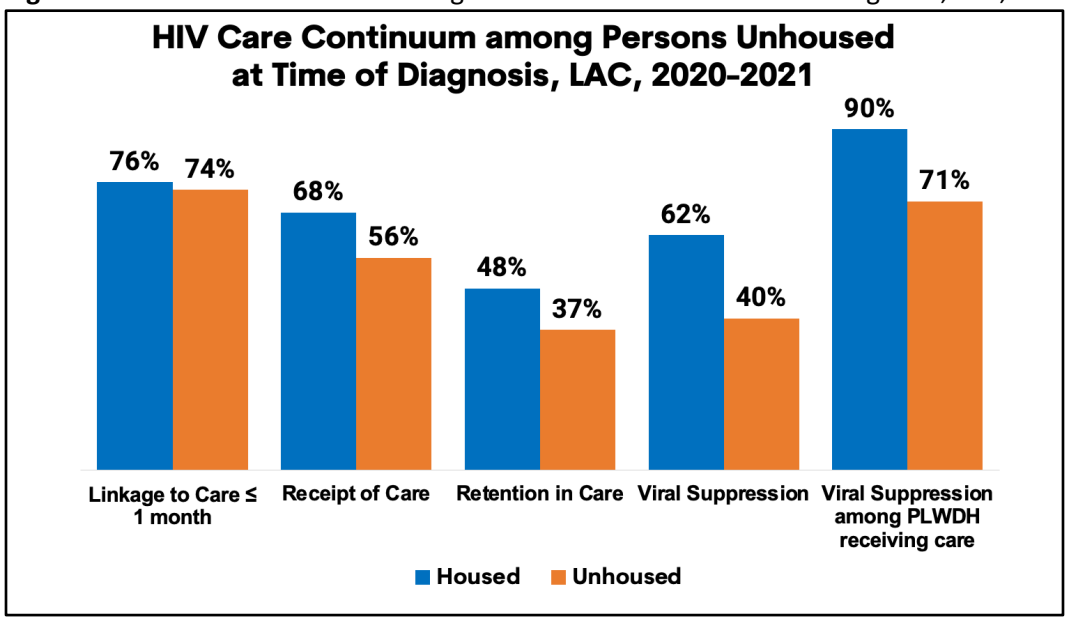


[29] Unsuppressed viral load: numerator includes PLWDH whose last VL test in 2021 was unsuppressed (HIV-1 RNA ≥ 200 copies/mL; denominator includes PLWDH diagnosed through 2020 and living in LAC at year-end 2021 based on most recent residence. PLWDH without a VL test in 2021 were considered virally unsuppressed. Analysis excludes PLWDH diagnosed through 2020 and living at year-end 2021 who (1) had missing census tract information, (2) were receiving care but never had a viral load test, (3) were not receiving care for >12 months at year-end 2021, or (4) were in census tracts with small sample sizes. Exclusions represented 68% of PLWDH diagnosed through 2020 and living in 2021 whose last viral load was unsuppressed.

Timeliness of Care and Viral Suppression: Among persons newly diagnosed with HIV in 2020 with treatment information included in their case reports, 74% had initiated treatment within one month of diagnosis and 89% within three months of diagnosis. Timeliness from HIV diagnosis to viral suppression has improved over time, but early viral suppression is lagging. In 2021, only 51% of PLWDH were virally suppressed within three months of diagnosis while 76% of PLWDH were virally suppressed within 12 months of diagnosis.

Unhoused: Persons living with HIV who are unhoused continue to experience suboptimal outcomes along the HIV care continuum. Compared with housed persons, unhoused persons had lower rates of receiving HIV care, retention in care, and achieving viral suppression in 2021.

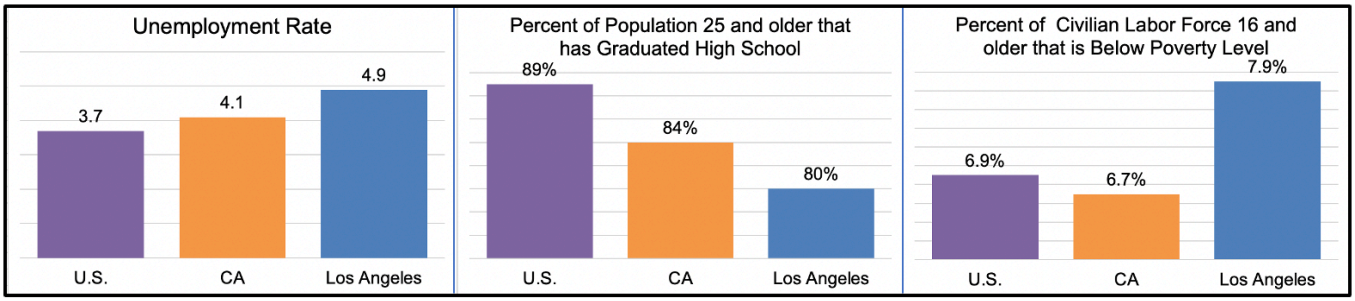
Figure 28: HIV Care Continuum among Persons Unhoused at Time of Diagnosis, LAC, 2020-21



V. Social Determinants of Health

Key social determinants of health including housing status, poverty, and recent incarceration, increase the risk of HIV acquisition and transmission. While data for social determinants of health are not as widely or consistently collected as demographic information, it is critically important to understand how these factors contribute to the experience of people at increased risk for HIV and those living with HIV. As depicted in the figure below, compared to both the state of California and the U.S., LAC fares worse with respect to key social determinants of health. LAC has a higher unemployment rate, a higher percent of its population living in poverty, and a lower percentage of its adult population that has graduated high school.

Figure 29: Select Social Determinants of Health, LA County Compared to California and U.S., 2021



Limited socio-economic data is collected on the HIV case report forms that are used to populate the population-level case surveillance, therefore, additional data from the MMP, NHSB, and RWP Part A programmatic data are utilized to better understand the impact of social determinants of health on people at risk for and living with HIV in LAC. The MMP data is intended to be representative of all PLWDH in LAC. The RWP Part A data is representative of PLWDH in LAC who received at least one RWP-funded service in Year 31 (March 1, 2021-February 28, 2022). A total of 21,877 clients, or approximately two out of every five PLWDH in LAC, received at least one core or support RWP service in Year 31.

Poverty: Based on data collected in MMP, it was estimated that nearly half of PLWDH in LAC from 2015-19 were living at or below the Federal Poverty Level (FPL) in the past 12 months. Among RWP clients in Year 31, 64% were living at or below FPL. RWP subpopulations who were the most impacted by poverty were those recently incarcerated (85.4%), transgender persons (78.4%), and cisgender women (75.7%). Of the 501 transgender women who participated in the LAC NHBS in 2019, 70% reported living in poverty in the past year. Likewise, of the 511 PWID who participated in the LAC NHBS in 2018, 75% reported a household income below the federal poverty level.

Housing Status: Based on estimates from MMP, approximately 11% of PLWDH in 2015-19 experienced homelessness in the past 12 months. Among RWP clients experiencing homelessness, most (80%) were living at or below FPL in the past 12 months and nearly half were MSM of color (47%). The largest percentages of RWP clients experiencing homelessness were among recently incarcerated (33%), trans persons (25%), and PWID (23%). Among the transgender NHBS participants, 47% had experienced homelessness in the past year; and 64% of the PWID participants were currently homeless.

Experience with the Justice System: MMP estimates that approximately 2% of PLWDH in 2015-19 were incarcerated in the past 12 months. Information on experience with the justice system for RWP clients is collected as "recent incarceration" (in the past 24 months) and "ever-incarcerated," and in Year 30 was reported for 16,656 clients. Of these, 8% were recently incarcerated and 18% were ever-incarcerated. Among clients who were recently incarcerated, 85% were living at or below FPL in the past 12 months and one-third were experiencing homelessness. The largest percentages of RWP clients recently incarcerated were among those experiencing homelessness, using injection drugs, and identify as transgender. Twenty-three percent of the transgender NHBS participants and 46% of the PWID participants reported recent incarceration (within past 12 months).

VI. Priority Populations

Based on HIV and STD disparities detailed above, the priority populations for the Integrated HIV Prevention and Care Plan, 2022-2026 are: Black MSM; Latinx MSM; Women of Color; Persons of Trans Experience; PLWH Aged 50 and Older; Persons Under 30; and PWID. This mirrors the EHE priority

populations, with the added category of PLWH Aged 50 and Older. These priority populations are also aligned with the National HIV/AIDS Strategy: 2022–2025 priority populations: gay, bisexual, and other men who have sex with men, in particular Black, Latino, and American Indian/Alaska Native men; Black women; transgender women; youth aged 13–24 years; and people who inject drugs.

HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

The LAC HIV Prevention, Care and Treatment Resource Inventory is depicted in Table 2. Los Angeles County has identified an estimated $425,945,143 in HIV-related funding, 57% of which is attributed to Medi-Cal ($242,424,556) expenditures. Although comprehensive in nature, the inventory is a point- in-time estimate and is still incomplete, given that some financial data are not available (e.g. Medicare and private insurance companies' financial data are not available). As local private fundraising can vary dramatically from year to year, this information was not collected and is also excluded from this report.

Organizations and Agencies Providing HIV Care and Prevention Services in Los Angeles County: There are at least 52 organizations/agencies that are not a part of the County system and at least 14 different County departments that provide HIV care and/or prevention services in LAC.

HRSA and CDC Funding Sources: HRSA and CDC funding is detailed in Table 2 and summarized below:

HRSA Funding:

- Part A: $42,142,230 for RWP Year 32 -Year 1 of a 3-year award. The direct recipient of Part A funding, DHSP, contracts with 27 subrecipients to deliver Part A core and support services. All Ryan White funds are used as 'payor of last resort' and are designed to fill the gaps where other resources are insufficient or do not exist at all. Ryan White Part A funds are an integral part of LAC's safety net of services targeting PLWH at all stages of the HIV Care Continuum. Part A grant funds core and support services for PLWH including AOM, Oral Health, Early Intervention Services (EIS), Emergency Financial Assistance Services, Home and Community Based Health Services, Mental Health Services, Medical Case Management (Medical Care Coordination or MCC), Non-medical Case Management (Benefits Specialty), Food Bank and Home Delivered Meals, Housing Services - Residential Care Facility for the Chronically Ill (RCFCI) and Transitional Residential Care Facility (TRCF), Legal Services, Linguistic Services, Medical Transportation, and Outreach Services (Linkage and Reengagement Program). The Commission on HIV conducts a priority setting and resource allocation process in which they review existing and anticipated funding from all other public and private sources, including other Ryan White funds (Parts B, C, D, and F). DHSP manages funds from local, state, and federal sources to avoid duplication. Client eligibility screening for Ryan White services is entered into LAC's current Ryan White client database, Casewatch. This client-level data system enables service providers to ensure that Part A funds are used as a last resort. Using non-medical case management funding, LAC funds "Benefits Specialty" services, which help PLWH identify the non-Ryan White resources for which they are eligible.

- Minority AIDS Initiative (MAI) - $3,780,205, March 1, 2022-February 28, 2023 - Year 1 of a 3-year award. DHSP, the direct recipient of MAI funds, contracts with subrecipients to provide Housing (permanent supportive housing), and Non-medical Case Management (Transitional Case Management) in LAC.

- Part B: $5,446,809, April 1, 2022- March 31, 2023 - Year 4 of a 5-year award. DHSP receives Part B base grant funds, and contracts with subrecipients to fund Housing Services (RCFCI and TRCF), and Substance Use Residential services. The Commission on HIV allocates Part A and Part B funds

together through its priority and allocation process.

- Part C-Early Intervention Services (EIS): $5,859,855. HRSA provides Part C-EIS funds directly to 13 organizations throughout LAC. As many of these organizations also receive Part A funds, DHSP requires that they allocate Part C and Part A resources individually for services supported by both funding streams, and they are required to provide detailed budgets for each to prevent overlap. Part C EIS funds provide comprehensive outpatient primary health care to PLWH. Appropriate use of Part C funds includes HIV counseling and testing; monitoring of disease progression; treatment of HIV; diagnosis and treatment of related infections; and case management and assistance accessing other federal, state, and local programs that could provide needed health and support services to PLWH.

- Part D: Women, Infants, Children, and Youth: $1,777,658. HRSA directly funds three organizations in Los Angeles County to provide Part D services targeting women, infants, children, and youth (Table 2). Part D funds can be used similarly to Part A and C funds with the difference being the intended target population of women, infants, children, and youth. Similar to Part C, the three organizations funded for Part D also receive Ryan White Part A funding. DHSP requires that funding allocations and services delivered are tracked separately to ensure there is no duplication.

- Part F – Dental Reimbursement Program: $1,975,156. HRSA directly funds three dental schools in Los Angeles County. For the schools that also receive Part A funding for oral health services, DHSP requires that Part A and Part F funds do not duplicate services.

- Part F – AIDS Education and Training Center (AETC): $788,056.00. The Los Angeles office of the Pacific AETC provides a wide variety of training and education to healthcare providers. DHSP and the Commission on HIV collaborate with the AETC in training sessions, conferences, and consultations on various topics, and plan on working closely with the AETC to build workforce capacity and educate providers about emerging issues as part of its work over the next five years.

- Part F – Special Projects of National Significance: $410,000 – September 30, 2022 – September 29, 2023 – Year 3 of a 3-year grant. Two CBOs in LAC were funded with this grant: Building Capacity to Implement Rapid Start to Improve Care Engagement Initiative, the purpose of which is to accelerate the initiation of ART and entry into HIV medical care for people with HIV who are newly diagnosed, new to care, or out of care.

- Ending the HIV Epidemic - $6,168,850, March 1, 2022-February 28, 2023 - Year 3 of a 5-year grant. HRSA's EHE grant awarded to DHSP supports 1) data system infrastructure development and systems linkages; 2) surveillance improvements and building organizational capacity, 3) emerging practices, evidence-informed and evidence-based interventions for diagnosis and rapid linkage to care; 4) reengagement in care and viral suppression; and 5) community engagement, information dissemination specifically calling attention to the activities for PLWH who are not virally suppressed.

- Ending the HIV Epidemic- Primary Care HIV Prevention - $8,159,376 –April 1, 2022-March 31, 2023. Year 1 or Year 2 of a 2-year grant. In LAC, 17 FQHCs were awarded EHE funding in 2021 and 7 were awarded EHE funding in 2022 (15 other FQHCs were awarded funds in 2020, but those grant terms have ended). This grant is used to expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure care services are well coordinated. Funds are

also used to strengthen partnerships with community organizations such as HRSA's Ryan White HIV/AIDS Program-funded organizations and health departments.

CDC Funding:

- Ending the HIV Epidemic - $3,360,658 – August 1, 2022-July 31, 2023 – Year 3 of a 5-year grant. This grant supports HIV prevention strategies, including 1) HIV self-testing; 2) community engagement; 3) increased access to syringe services; 4) increased screening for PrEP; 5) HIV prevention media campaigns; and 6) improved surveillance data for real-time HIV cluster detection and response.

- Integrated HIV Surveillance and Prevention - $17,950,095 – January 1, 2022-December 31, 2022 – Year 5 of a 5-year grant. This grant awarded to DHSP supports 11 HIV surveillance and prevention strategies including active and passive surveillance; outbreak investigation; data management, analysis and reporting; comprehensive individual-level and community-level HIV-related prevention services; and data-driven planning.

- HIV Treatment Improvement Demonstration Project - $597,083 - January 1, 2022-December 31, 2022 - Year 5 (1-year extension in 2022) of a 4-year grant. The two goals of this project are 1) increase infrastructure to improve classification of provider-level HIV surveillance data and 2) provide technical assistance on quality improvement to increase viral suppression, retention in care, and durable viral suppression among low performing providers in Los Angeles County.

- National HIV Behavioral Survey & TG supplement - $716,168 - January 1, 2022-December 31, 2022 - Year 1 of a 5-year grant. This grant supports Los Angeles County's participation in this four-cycle national survey (MSM, IDU, Heterosexuals, and TG). Survey findings are used for the planning purposes, program development, and resource allocation.

- Medical Monitoring Project - $728,648 - June 1, 2022-May 31, 2023 - Year 3 of a 5-year grant. This grant supports Los Angeles County's participation in the national surveillance project designed to learn more about the experiences and needs of PLWH (in and out of care).

- Strengthening STD Prevention and Control for Health Departments - $3,356,049 - January 1, 2022-December 31, 2022 - Year 4 of a 5-year grant. This grant is used to support five strategy areas: STD surveillance, disease investigation and intervention, screening and treatment, promotion and policy, and data management and utilization. No more than 10% of grant funds support contracts.

- STD Prevention and Control for Health Departments –Disease Investigation Specialist (DIS) Workforce Development Infrastructure - $6,598,516 - January 1, 2022-December 31, 2022 – Year 2 of a 5-year grant. This grant supports expanding, training, and sustaining local DIS workforce to support increased capacity to conduct disease investigation, linkage to prevention and treatment, case management and oversight, and outbreak response for COVID-19 and other infectious diseases.

- Gonococcal Isolates Surveillance Project - $15,000 - August 1, 2019-July 31, 2020. This Epidemiology and Laboratory Capacity (ELC) grant supports participation in the national sentinel surveillance system to monitor trends in antimicrobial susceptibilities of Neisseria gonorrhoeae strains in the US among selected STD clinics and covers salary, fringe benefits and supplies.

- Transgender Status-Neutral Community-to-Clinic Models to End the HIV Epidemic (CDC-RFA-PS22-2209) - $500,000 – September 30, 2022 – September 29, 2023, Year 1 of a 4-year grant. This grant was awarded to St. John's Well Child and Family Center to develop a community-to-clinic model for integrated status-neutral HIV prevention and care services, gender-affirming services including hormone therapy, and primary health care. Navigation will also be used to link TG persons to services as needed for mental health and substance use disorder and other essential support services. This model will increase use of HIV prevention and treatment by TG persons to decrease HIV transmission and improve overall health and wellbeing.

- Comprehensive High-Impact HIV Prevention Programs for YMSM and YTG Persons of Color (CDC-RFA-PS22-2203) - $2,500,000 – April 1, 2022 – March 31, 2023 – Year 1 of a 5-year grant. Four CBOs in LAC were awarded with funding to implement comprehensive high-impact HIV prevention programs to address health disparities among YMSM of color, YTG persons of color, and their partners with the goal of reducing HIV transmission and HIV-associated morbidity and mortality.

- Comprehensive High-Impact HIV Prevention Programs for CBOs (CDC-RFA-PS21-2102) - $3,000,000 – July 1, 2022 – June 30, 2023 – Year 1 of a 5-year grant. Six CBOs in LAC were awarded with funding to implement comprehensive high-impact HIV prevention programs to enhance their capacity to increase HIV testing and referrals to Partner Services, link PLWH to HIV medical care and ART, provide or refer prevention and essential support services, including SSPs, for persons with HIV and persons at risk for acquiring HIV, and increase program monitoring and accountability.

Additional Funding Sources: Additional sources of HIV funding include HUD's HOPWA program, Substance Abuse and Mental Health Services Administration (SAMHSA) programs, and funding from the State of California:

HUD:

- HOPWA Program – $27,323,580 - Fiscal Year 2021 -The City of Los Angeles receives HOPWA funding for Short-term Rent, Mortgage and Utility assistance payments, Tenant-based Rental Assistance, Transitional Housing Units and Permanent Housing Units.

SAMHSA:

- MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS - $2,999,994 – September 30, 2022 – September 29, 2023 – Year 1 of a 5-year grant. Six CBOs in LAC are funded with this grant to increase engagement in care for racial and ethnic underrepresented individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for or living with HIV/AIDS and receive HIV/AIDS services/treatment.

- MAI: High Risk Populations- $1,500,000 – September 30, 2022 – September 29, 2023 – Year 1 of a 5-year grant. Three CBOs in LAC are funded with this grant to increase engagement in care for racial and ethnic underrepresented individuals with substance use disorders (SUD) and/or co-occurring substance use and mental disorders (COD) who are at risk for or are living with HIV/AIDS and receive HIV/AIDS services/treatment.

- The Substance Abuse and HIV Prevention Navigator Program- $3,177,012– September 30, 2022 – September 29, 2023 – Year 1 of a 5-year grant. Fifteen CBOs in LAC are funded with this grant to provide services to those at highest risk for HIV and substance use disorders. The program proposes to use a navigation approach (Community Health Workers, Neighborhood Navigators, and Peer

Support Specialists) to expedite services for these populations.

- Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults- $1,582,000– August 30, 2022 – August 29, 2023 – Year 1 of a 5-year grant. Eight CBOs in LAC are funded with this grant to build solid foundations for delivering and sustaining quality and accessible state of the science substance abuse and HIV prevention services.

- MAI: Service Integration- $485,000– September 30, 2022 – September 29, 2023 – Year 1 of a 5-year grant. One CBO in LAC is funded with this grant to reduce the co-occurring epidemics of HIV, Hepatitis, and mental health challenges through accessible, evidence-based, culturally appropriate treatment that is integrated with HIV primary care and prevention services.

- TCE-HIV: High Risk Populations- $500,000– September 30, 2022 – September 29, 2023 – Year 1 of a 5-year grant. One CBO in LAC is funded with this grant to focus on high risk populations including racial/ethnic minority populations, such as black young men who have sex with men (YMSM) (ages 18-29), and other high-risk populations such as Latino YMSM and men who have sex with men (MSM) (ages 30 years and older), and gay, bisexual, and transgender individuals who have a SUD or COD who are HIV positive or at risk for HIV/AIDS.

- Harm Reduction Program- $1,196,880 – September 30, 2022 – September 29, 2023 – Year 1 of a 3-year grant. Two CBOs and DPH-SAPC in LAC are funded with this grant to support community-based overdose prevention programs, syringe services programs, and other harm reduction services.

State of CA:

- DPH State Block Grant - HIV Surveillance CA Surveillance - $1,972,378.00 - July 1, 2022-June 30, 2023. This grant supports active and passive HIV surveillance, data management, analysis and reporting.

- STD General Funds Allocation - $547,050- July 1-June 30 - Year 4 of a 5-year grant. These funds support CT/GC Patient Delivered Partner Therapy (PDPT) Demonstration Project, condom distribution, training for PHNs and PHIs and DHSP staff.

- STD Management and Collaboration Project - $1,952,013 - July 1, 2022-June 30, 2023 - Year 4 of 5-year grant. These funds support condom distribution, rapid syphilis test kits, and screening and treatment of new STD infections among persons at high risk for HIV. These include, but are not limited to; MSM, MSM that report substance use, Cis-gender women of color, Transgender Individuals and Young Men of color.

Strategy for coordinating the provision of substance use prevention and treatment services: DHSP works very closely with the Department of Public Health's Substance Abuse and Prevention Control (SAPC) division to coordinate the provision of substance use disorder prevention and treatment services. Examples of ongoing collaborations with SAPC include cross-training staff in integrating HIV and STD testing in harm reduction and substance use prevention and treatment programs; addressing methamphetamine and HIV in outreach, services, and policy interventions; and working with the City of Los Angeles to expand safe consumption sites.

Services and activities provided by organizations in the jurisdiction; and how services will maximize the quality of health and support services available to people at-risk for or with HIV: Collectively, the CBOs, FQHCs, clinics, faith-based organizations, universities, hospitals, and County departments provide comprehensive HIV prevention and care services including: HIV testing and treatment, STD screening and treatment, HCV screening and treatment, linkage to and reengagement in care, medication adherence, retention in care, PrEP/PEP, social marketing, health education and risk reduction, case management, partner services, medical care coordination, syringe services, sexual and reproductive health, substance use disorder treatment, harm reduction, mental health, housing, transportation, legal services, and more.

The Commission on HIV and DHSP are responsible for planning the continuum of HIV prevention and care services in Los Angeles County. As part of this responsibility, they conduct various needs assessment activities to understand the extent of need for services, as well as barriers to accessing those services. They also gather as much financial data that is available regarding HIV-related resources to identify gaps in current resources and are responsible for prioritizing and allocating Ryan White Part A and CDC funding to address service gaps, of which DHSP is the grantee. Through these oversight and coordination processes, DHSP and the Commission on HIV work in tandem to maximize the quality of health and support services available to people at-risk for or with HIV.

a. **Strengths and Gaps:** The strength and resilience of the Los Angeles County HIV service system has been demonstrated over the past few years as we continue to weather complex public health and social challenges. These challenges include competing public health crises that tax our systems (e.g. COVID-19, Mpox, overdose, etc.); HIV and STD disparities across multiple domains; waning workforce capacity to meet the needs of the HIV, STD, behavioral health syndemic; and persistent social struggles, including the housing crisis and racial and reproductive injustice. In spite of these challenges, we have maintained high-quality HIV and STD continuity of care, we have tested and adopted new models of service delivery (e.g. HIV self-test kits, telehealth, etc.), and we have expanded the number and diversity of HIV service partners. We have also witnessed technological and administrative advances in the field, including the arrival of long-acting injectables, and the expansion of revenue streams (e.g. Medi-Cal and EHD funding).

b. Approaches and Partnerships: Most of the data gathered to complete the HIV prevention, care and treatment inventory is publicly available online through various websites (e.g., CDC, HRSA, SAMHSA, etc.). The State of California Medi-Cal data for HIV positive individuals was also obtained online. Additional follow-up with individual grantees was conducted to obtain information regarding funding amount, contract period, services delivered, and/or impact along the HIV continuum to complete missing data. Additional information was obtained by talking to a number of key partners to understand the nature of some of their projects as well as to learn how they contribute currently to the continuum of services in Los Angeles County. These partners included the Cities of Los Angeles, West Hollywood and Long Beach, and the Pacific AIDS Education and Training Center, Los Angeles Region. The Division of HIV and STD Programs (DHSP) provided more detailed data on their funding for contracted services.

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

Table 2: HIV Resources Inventory

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	**Funding Source**	**Organization Receiving the Funding**	**Annual Award Amount**	**Services Delivered**	**HIV Diagnosis**	**Linkage to Care**	**Engagement or Retention in Care**	**Prescription of ART**	**Viral Suppression**	**Diagnose**	**Treat**	**Prevent**	**Respond**
HRSA	Ryan White Part A	DPH - DHSP	$42,142,230.00	Home Health Care, Medical Case Management, including Treatment Adherence Services, Mental Health Services, Oral Health Care, Outpatient/Ambulatory Health Services, Food Bank/Home Delivered Meals, Housing, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Early Intervention Services, Substance Abuse Residential, Emergency Financial Assistance, Other Professional Services Outreach	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part B	DPH - DHSP	$5,446,809.00	Housing, Substance Abuse Services (residential)			✓	✓	✓		✓		
HRSA	Ryan White Part C	AIDS Healthcare Foundation	$299,983.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ryan White Part C	AltaMed Health Services Corporation	$918,952.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Bartz-Altadonna Community Health Center	$280,589.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Charles R. Drew University of Medicine and Science	$403,977.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Dignity Health - St. Mary Medical Center	$881,556.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	JWCH Institute, Inc.	$262,990.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Northeast Valley Health Corporation	$447,805.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	T.H.E. Clinic, Inc.	$307,859.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Tarzana Treatment Centers, Inc.	$356,514.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	University of Southern California, School of Medicine	$325,259.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Venice Family Clinic	$319,569.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Watts Healthcare Corporation	$275,727.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part C	Los Angeles LGBT Center	$779,075.00	Outpatient/Ambulatory Health Services, Testing	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part D	AltaMed Heath Services Corporation	$139,246.00	Outpatient/Ambulatory Health Services	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part D	University of California, Los Angeles	$732,979.00	Outpatient/Ambulatory Health Services	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part D	University of Southern Caliifoma	$905,433.00	Outpatient/Ambulatory Health Services	✓	✓	✓	✓	✓	✓	✓		
HRSA	Ryan White Part F	University of California, Los Angeles	$1,245,924.00	Oral Health Care			✓		✓		✓		
HRSA	Ryan White Part F	University of Southern California	$728,752.00	Oral Health Care			✓		✓		✓		
HRSA	Ryan White Part F	Western University of Health Sciences	$480.00	Oral Health Care			✓		✓		✓		
HRSA	Ryan White Part F AETC	Univerity of California, Los Angeles	$788,056.00	Capacity building/technical assistance		✓	✓	✓	✓		✓	✓	

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
HRSA	Ryan White Program Part F, SPNS	AltaMed Health Services Corporation	$205,000.00	Capacity building/technical assistance			✓	✓	✓		✓		
HRSA	Ryan White Program Part F, SPNS	St. John's Well Child and Family Center	$205,000.00	Capacity building/technical assistance			✓	✓	✓		✓		
HRSA	Ryan White Minority AIDS Initiative	DPH-DHSP	$3,780,205.00	Outreach, Housing, Non-Medical Case Management Services		✓	✓	✓	✓		✓		✓
HRSA	Ending the HIV Epidemic	DPH-DHSP	$6,168,850.00	Medical Case Management, including Treatment Adherence Services, Surveillance, Data system infrastructure, EBIs for diagnosis and LTC, community engagement	✓	✓	✓	✓	✓	✓	✓		✓
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	All-Inclusive Community Health Center	$342,098.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Center for Family Health & Education, Inc.	$345,137.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Central Neighborhood Health Foundation	$348,808.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Eisner Pediatric & Family Medical Center	$365,537.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Harbor Community Clinic	$341,063.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Health Access For All, Inc.	$344,157.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Los Angeles Christian Health Centers	$347,216.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Mission City Community Network, Inc.	$342,198.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Pomona Community Health Center DBA Parktree CHC	$345,963.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	San Fernando Community Hospital	$340,405.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	South Central Family Health Center	$353,475.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Southern California Medical Center, Inc.	$346,672.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	The Los Angeles Free Clinic	$348,195.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Universal Community Health Center	$342,870.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Via Care Community Health Center	$346,411.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Westside Family Health Center	$345,390.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Yehowa Medical Services	$338,781.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Community Medical Wellness Centers USA	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	The Children's Clinic Serving Children and Their Families	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Asian Pacific Healthcare Venture, Inc.	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	University Muslim Medical Association, Inc.	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Benevolence Industries, Inc.	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Chinatown Service Center	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
HRSA	Ending the HIV Epidemic-FQHC Primary Care HIV Prevention	Community Health Alliance of Pasadena	$325,000.00	PrEP delivery, Testing	✓	✓	✓	✓	✓	✓	✓	✓	
CDC	Integrated HIV Surveillance and Prevention Programs	DPH - DHSP	$17,950,095.00	PrEP delivery, Surveillance	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDC	Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States	DPH - DHSP	$3,360,658.00		✓	✓	✓	✓	✓	✓	✓	✓	✓
CDC	HIV Treatment Demonstration Project	DPH-DHSP	$597,083.00	Capacity building/technical assistance, Surveillance			✓	✓	✓		✓		
CDC	National HIV Behavioral Survey and TG Supplement	DPH-DHSP	$716,168.00	Surveillance	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDC	Medical Monitoring Project	DPH-DHSP	$728,648.00	Surveillance			✓	✓	✓		✓	✓	✓
CDC	Strengthening STD Prevention and Control for Health Departments	DPH-DHSP	$3,356,049.00	STD screening, diagnosis and treatment, STD surveillance, Disease Investigation and Intervention									

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	**Funding Source**	**Organization Receiving the Funding**	**Annual Award Amount**	**Services Delivered**	**HIV Diagnosis**	**Linkage to Care**	**Engagement or Retention in Care**	**Prescription of ART**	**Viral Suppression**	**Diagnose**	**Treat**	**Prevent**	**Respond**
CDC	STD Prevention and Control for Health Departments- DIS Workforce Development Infrastructure	DPH-DHSP	$6,598,516.00	Disease Investigation and Intervention, STD Outbreak Response									
CDC	Gonococcal Isolates Surveillance Project	DHP-DHSP	$15,000.00	STD surveillance									
CDC	Comprehensive High-Impact HIV Prevention Programs for YMSM and YTG Persons of Color	AltaMed Health Services Corporation	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for YMSM and YTG Persons of Color	APLA Health & Wellness	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for YMSM and YTG Persons of Color	Los Angeles LGBT Center	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for YMSM and YTG Persons of Color	Special Services for Groups	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for CBOs	Via Care Community Health Center	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for CBOs	Los Angeles LGBT Center	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for CBOs	AltaMed Health Services Corporation	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for CBOs	Bienestar Human Services	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for CBOs	JWCH Institute, Inc.	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Comprehensive High-Impact HIV Prevention Programs for CBOs	APLA Health & Wellness	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
CDC	Transgender Status-Neutral Community-to-Clinic Models to End the HIV Epidemic	St. John's Well Child and Family Center	$500,000.00	PrEP delivery, Prevention for persons living with diagnosed HIV infection, Testing, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Bienestar Human Services	$499,999.00	SUD Treatment	✓					✓		✓	

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
SAMHSA	MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Special Services for Groups	$499,995.00	SUD Treatment	✓					✓		✓	
SAMHSA	MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Via Care Community Health Center	$500,000.00	SUD Treatment	✓					✓		✓	
SAMHSA	MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	Children's Hospital Los Angeles	$500,000.00	SUD Treatment	✓					✓		✓	
SAMHSA	MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	JWCH	$500,000.00	SUD Treatment	✓					✓		✓	
SAMHSA	MAI: SUD Treatment for Racial/Ethnic Minority Populations at High Risk for HIV/AIDS	St. John's Well Child and Family Center	$500,000.00	SUD Treatment	✓					✓		✓	
SAMHSA	MAI: High Risk Populations	St. John's Well Child and Family Center	$500,000.00	SUD Treatment	✓				✓			✓	
SAMHSA	MAI: High Risk Populations	Tarzana Treatment Centers	$500,000.00	SUD Treatment	✓					✓		✓	
SAMHSA	MAI: High Risk Populations	Volunteers of America, LA	$500,000.00	SUD Treatment	✓					✓		✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	AIDS Healthcare Corporation	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Center for Health Justice	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Los Angeles Gay & Lesbian Center	$182,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Los Angeles Centers for Alcohol and Drug Abuse	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Public Health Foundation Enterprises	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Reach, LA	$195,304.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Via Care Community Health Center	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Volunteers of America, Los Angeles	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Central City	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Children's Hospital Los Angeles	$250,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Sunrise Community Counseling Center	$250,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Special Services for Groups	$250,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	St. John's Well Child and Family Center	$250,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Azusa Pacific University	$199,708.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	The Substance Abuse and HIV Prevention Navigator Program	Tarzana Treatment Centers	$200,000.00	Prevention for persons living with diagnosed HIV infection, Navigation	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	AIDS Healthcare Corporation	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Center for Health Justice, Inc.	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Central City Neighborhood Partners	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Los Angeles Gay & Lesbian Center	$182,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Los Angeles Centers for Alcohol and Drug Abuse	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Public Health Foundation Enterprises	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	

3. CONTRIBUTING DATA SETS & ASSESSMENTS: RESOURCES INVENTORY

					HIV Care Continuum Steps Impacted					EHE Strategies			
Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Services Delivered	HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Via Care Community Health Center	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Capacity Building Initiative for Substance Abuse and HIV Prevention Services for At-Risk Racial/Ethnic Minority Youth and Young Adults	Volunteers of America, Los Angeles	$200,000.00	Capacity building/technical assistance	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	MAI: Service Integration	Tarzana Treatment Centers	$485,000.00	Mental Health Services, SUD Treatment	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	TCE-HIV: High Risk Populations	Behavioral Health Services, Inc.	$500,000.00	Mental Health Services, SUD Treatment	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Harm Reduction Program	LA County Public Health Department - SAPC	$398,960.00	Syringe services programs	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Harm Reduction Program	St. John's Well Child and Family Center	$398,960.00	Syringe services programs	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	Harm Reduction Program	Tarzana Treatment Centers, Inc.	$398,960.00	Syringe services programs	✓	✓	✓		✓	✓	✓	✓	
SAMHSA	SAMHSA Continuations	Special Services for Groups	$257,354.00	Mental Health Services, SUD Treatment	✓	✓	✓		✓	✓	✓	✓	
HUD	HOPWA	City of Los Angeles	$27,323,580.00	Mental Health Services, Housing			✓		✓		✓		
State of CA	State Block Grant - HIV Surveillance	DHP-DHSP	$1,972,378.00	Surveillance		✓					✓		
State of CA	STD General Funds Allocation	DHP-DHSP	$547,050.00	Condom distribution, CT/GC Patient Delivered Partner Therapy, Capacity building									
State of CA	STD Management and Collaboration Project	DPH-DHSP	$1,952,013.00	Condom distribution, Rapid Syphilis test kits									
Los Angeles County DPH Substance Abuse and Prevention Control (SAPC)	SAPC Non-Drug Medi-Cal	DPH-SAPC	$3,249,000.00	Substance Abuse Outpatient Care, Health Education/Risk Reduction, Substance Abuse Services - Residential	✓	✓	✓	✓	✓	✓	✓	✓	
Los Angeles County Net County Costs (NCC)	Net County Cost	DPH-DHSP	$18,467,000.00	Medical Case Management, including Treatment Adherence Services, Health Education/Risk Reduction, Referral for Health Care and Support Services , PrEP delivery	✓	✓	✓	✓	✓	✓	✓	✓	✓

NEEDS ASSESSMENT

Needs Assessment Activities and Data/Information Used to Inform Goals and Objectives: To assess the needs of PLWH and persons at risk for HIV in LAC, multiple assessment activities and methods were utilized. In addition to the review and analysis of secondary data listed below, primary qualitative data were collected for planning purposes via facilitated listening sessions for six priority population groups; an online survey to assess the capacity of the HIV workforce and service system from both provider and community member perspectives (HIV Workforce Capacity and Service System Survey); and facilitated stakeholder meetings (see c. Approach, below). The numerous secondary data sources and reports that were reviewed include, but are not limited to:

(1) Local and national HIV surveillance data, including various reports presenting data from LAC's National HIV Behavioral Survey (NHBS) and Medical Monitoring Project (MMP);
(2) HIV Care Continuum measures for LAC by subpopulation;
(3) Sexually Transmitted Disease (STD) surveillance data;
(4) LAC PrEP data;
(5) 2021 HIV testing data for DHSP publicly funded testing;
(6) 2020 Unmet Need report;
(7) Ryan White Program Year 31 Care Utilization Data;
(8) Black/African American Taskforce PrEP Focus Groups Report[30];
(9) DHSP-Funded Biomedical Prevention Services, Year 6 Report;
(10) Project Fierce Community Survey on STD Prevention Needs of Young Women of Color;
(11) Assessment of Unmet Mental Health Needs of PLWH; and
(12) CHIPTS' Study on Optimizing PrEP Delivery to Immigrant Latino MSM

Informing a Status-Neutral Approach to Develop Goals and Objectives: LAC is committed to a status neutral approach to addressing the needs of PLWH and of those at high-risk for HIV. This means that although the *types* of services that both groups need may vary, the *commitment* to making sure that people are able to access and remain engaged in those services is equal and unwavering, regardless of their HIV status. *Status neutral* also means that LAC is committed to providing high-quality services, regardless of a person's HIV status. Summarized below are the needs and barriers related to the services necessary to access HIV testing, to engage in prevention activities (for those who test negative), and to link to and remain engaged in HIV care and prevention (for those who test positive). Data analysis also rendered needs and barriers that were applicable *across pillars.* These include the need to address mental health challenges, substance use disorders and social determinants of health; and build the capacity of the HIV workforce.

Services People Need to Access HIV Testing: The need for HIV testing is clear as it is the first step to accessing necessary and appropriate prevention and/or treatment services, ultimately resulting in reduced transmission and improved health outcomes. Analysis of LAC NHBS data tells us that 15% of transgender respondents had *not* tested for HIV in the past 12 months; nor had 16% of MSM; 45% of PWID and 70% of high-risk heterosexuals. Testing rates varied across race/ethnicities with lower testing rates found among Black transgender respondents (80%); Latino and Black MSM (83%); White PWID (47%); and Latino heterosexuals (27%). HIV status awareness also differed across population groups with 83% of MSM, 80% of trans persons, 63% of PWID and 0% of heterosexuals[31] aware of their HIV-positive status (Table 3).

[30] Prepared by Equity & Impact Solutions
[31] However, only 1 person in the HET category was HIV-positive

Table 3: HIV Prevalence, Status Awareness, Testing & PrEP Use by NHBS Participants, LAC, 2017-19

	MSM	PWID	HET	TG
Survey Year	2017	2018	2019	2019
Sample Size	525	511	509	497
HIV Prevalence	21%	1.6%	0.2%	33%
Aware of Status Among HIV+	83%	63%	0%	80%
Tested Ever	99%	90%	73%	98%
Tested Past 12 Months	84%	55%	30%	85%
Current PrEP Use	29%	1%	0%	26%

In LAC, people living with undiagnosed HIV need low-barrier access to a variety of testing modalities in both clinical and non-clinical settings.

Clinical HIV Testing: HIV screening within clinical settings is crucial to increasing the number of PLWH who are aware of their status. In 2006, the Centers for Disease Control and Prevention (CDC) issued recommendations that screening for HIV should be performed routinely for all patients aged 13 to 64 years at least once in their lifetime, and at least once a year for those at higher risk. While typically the HIV positivity rates of routine screening programs in clinical settings is much lower than targeted HIV testing modalities that focus services on individuals with elevated HIV rates, they remain an important way to destigmatize HIV testing and infection. In LAC, clinical HIV testing takes place in primary care clinics, emergency departments, and sexual and reproductive health clinics.

Non-Clinical HIV Testing: Since the beginning of the epidemic, community members have advocated for non-clinical testing venues as settings in which individuals can seek HIV testing, sexual health education, and other services in a culturally affirming and confidential space. Settings include storefronts; mobile testing units; commercial sex venues, syringe service programs; and jails. Non-clinical HIV testing also increasingly relies on the distribution of HIV self-test kits. Targeted HIV testing identifies priority populations based on risk of acquiring HIV and often taps into social and sexual networks to do so. Through this model, community-based organizations (CBOs) leverage their relationships with community members and can utilize a wide range of outreach modalities to reach priority populations. County of Los Angeles-contracted HIV testing providers are selected for their expertise and strong track record of successfully reaching priority populations. All contracted providers are expected to provide 1) targeted HIV testing services, 2) hands-on assistance with linkage to HIV care for people testing HIV positive, and 3) education and referrals to PrEP and other prevention services for those who test negative but are at elevated risk of acquiring HIV. In 2021, DHSP-funded HIV testing had a 1.3% overall new HIV positive rate among the total 51,713 tests conducted in that year. However, this rate ranged by type of testing. Testing in healthcare settings rendered a 1.0% overall seropositive rate, while non-clinical testing rendered a 1.9% seropositive rate. Within the healthcare test setting, hospitals and primary care clinics had the highest positivity rates with 2.5% and 1.8%, respectively. Within non-clinical testing settings, HIV testing sites and community settings had the highest new positive rates, 2.4% and 1.3%, respectively (Table 4).

Table 4: DHSP Contracted Agencies HIV Testing[32] Volume, Positivity, Linkage to Care by Test Setting, 2021

	HIV Test Events		Positive HIV Tests – All Diagnoses			
Test Setting	**No. Tests**	**%**	**No. Positive Tests**	**%**	**Test Positivity %**	**LTC w/in 30 days %**
Healthcare Test Setting	**31,884**	**62%**	**334**	**48%**	**1.0%**	**65%**
Community STD Clinic	18,028	35%	153	22%	0.8%	69%
Community Health Center	6,843	13%	77	11%	1.1%	56%
Substance Abuse Treatment Facility	3,316	6%	35	5%	1.1%	43%
Primary Care Clinic	3,236	6%	58	8%	1.8%	78%
Hospital	444	1%	11	2%	2.5%	64%
Other	17	<1%	0	0%	0.0%	---
Non-healthcare Test Setting	**17,188**	**33%**	**331**	**48%**	**1.9%**	**29%**
HIV Testing Site	9,327	18%	228	33%	2.4%	27%
Community Setting	7,755	15%	102	15%	1.3%	33%
Correctional Facility	106	<1%	<5	0%	0.9%	0%-
Mobile Test Setting	**2,641**	**5%**	**29**	**4%**	**1.1%**	**17%**
Overall	**51,713**	**100%**	**694**	**100%**	**1.3%**	**46%**

HIV Self-Test Kits: Self-test kits provide an important low barrier option for individuals to confirm their HIV status. At the beginning of the COVID-19 pandemic, DHSP increased its investment in self-testing options by participating in a national self-test kit program, Take Me Home, and purchasing self-test kits for distribution through local providers. TakeMeHome provides an online platform by which health departments can provide free HIV self-tests. Between August 2020 to August 2022, 2,938 HIV self-test kits were requested via the TakeMeHome website. Among those that requested a test, over one-third reported to have never been tested for HIV; of those individuals, over 80% identified as men, and approximately 49% were under 30 years old. To date, over 15,000 self-test kits have been distributed.

Late Diagnoses: The number and percentage of late diagnoses among people newly diagnosed with HIV is indicative of a gap with respect to HIV testing. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition ≤ 3 months after a diagnosis of HIV infection. Among the 1,404 new diagnoses in LAC between January 1, 2020, and December 31, 2020, 286 (20.4%) were late diagnoses (Table).

- Among each of the three geographic epicenters of HIV: 15% of PLWDH in Hollywood-Wilshire Health District, in Central Health District, and in Long Beach Health District had a late diagnosis.
- The majority of late diagnoses were male (84%). Within each gender category 20% of males, 30% of females, and 7% of trans persons had a late diagnosis.
- Latinx were the largest racial/ethnic group among persons who were diagnosed late (62%); the highest percentages within each racial/ethnic group were among Latinx (24.1%) and those who identified as multiracial (23.8%).
- The highest number of late diagnoses were in people ages 25-34 years old, but the proportion of persons diagnosed late within each age group increased with age with 30% of persons 45-54, 31% of persons 55-64 years, and 44% of persons aged 65 or older being diagnosed late.

[32] Data from DHSP Contracted Agencies HIV Testing Programs as of November 10, 2022

Table 5: Numbers and Percentages of Late Diagnoses, Unmet Need and Unsuppressed Viral Load by Key Characteristics, LA County, 2020

	# PLWDH*	# New Diagnoses	# Late Diagnoses	# Unmet Need	# In Care, Not VS	Within Categories			Across Categories		
						% Late Diagnose	% Unmet Need	% In Care, Not VS	% Late Diagnose	% Unmet Need	% In Care, Not VS
LA County	44,090	1401	286	7279	4563	20.4%	16.5%	12.4%	100%	100%	100%
Priority Health Districts											
Central	5,097	128	19	973	695	14.8%	**19.1%**	**16.9%**	6.6%	13.4%	152%
Hollywood-Wilshire	7,925	171	26	1,312	891	15.2%	16.6%	13.5%	**9.1%**	**18%**	**19.4**
Long Beach	3,565	91	14	521	288	**15.4%**	14.6%	9.5%	4.9%	7.2%	6.3%
Gender Identity											
Male	38,464	1,201	239	6,319	3,937	19.9%	16.4%	12.2%	**83.6%**	**86.8%**	**86.3%**
Female	4,752	143	43	812	494	**29.7%**	**17.1%**	12.5%	15.0%	11.2%	10.8%
TG	871	57	4	146	132	6.8%	16.8%	**18.2%**	1.4%	2.0%	2.9%
Race/Ethnicity											
AI/AN	40	5	0	7	3	0.0%	17.5%	9.1%	0.0%	0.1%	0.1%
Asian	1,637	54	7	281	105	13.0%	17.2%	7.7%	2.4%	3.9%	2.3%
Black/AA	8,647	297	47	1,853	1,099	15.8%	21.4%	**16.2%**	16.4%	25.5%	24.1%
Latinx	19,315	735	177	2,673	1,867	**24.1%**	13.8%	11.2%	**61.9%**	**36.7%**	**40.9%**
NH/PI	43	1	0	13	4	0.0%	**30.2%**	13.3%	0.0%	0.2%	0.1%
White	11,772	261	44	1,851	1,179	16.9%	15.7%	11.9%	15.4%	25.4%	25.8%
Multi-Racial	2,182	42	10	340	266	23.8%	15.6%	14.4%	3.5%	4.7%	5.8%
Age											
13-24	1,063	226	16	220	155	7.1%	20.7%	**18.4%**	5.6%	3.0%	3.4%
25-34	7,643	571	97	1,735	954	16.9%	**22.7%**	16.1%	**33.9%**	23.8%	20.9%
35-44	9,279	298	77	1,834	1,072	25.8%	19.8%	14.4%	26.9%	**25.2%**	**23.5%**
45-54	10,875	199	60	1,622	1,062	30.2%	14.9%	11.5%	21.0%	22.3%	23.3%
55-64	10,889	84	26	1,363	996	**31.0%**	12.5%	10.5%	9.1%	18.7%	21.8%
65+	4,341	23	10	505	324	43.5%	11.6%	8.4%	3.5%	6.9%	7.1%

* Number of PLWDH reflects those who have had an HIV diagnosis, or any lab data reported over the last 5 years

To reach the estimated 6,800 people living with undiagnosed HIV, it will require at least 850,000 HIV tests at a 0.8% seropositive rate. This estimate, however, assumes that testing will reach undiagnosed individuals and that all have equitable access to HIV testing. Unfortunately, there are many barriers that prevent this equitable access, as described below in the *Barriers* section.

Services People At-Risk for HIV Need to Stay HIV Negative: For individuals who test negative for HIV, the testing encounter provides an opportunity to reenforce prevention behaviors and facilitate access to prevention tools and interventions including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs).

PrEP/PEP: DHSP estimates that 76,000 people in LAC could benefit from PrEP, 72% of whom (54,500) are Black and/or Latinx. Using several data sources, DHSP estimates that, overall, 39% of people in priority populations with an indication for PrEP are currently prescribed PrEP.

An assessment of PrEP knowledge, attitudes and behaviors among Black MSM, Latino MSM, and transgender persons was conducted between 2016-2020 via an app-based survey for the CDC PrIDE initiative.[33] Participants were asked about their awareness of PrEP, willingness to use PrEP, and PrEP use in the past 12 months. Between 2016-2020, awareness of PrEP increased from 86% to 92%, willingness to take PrEP increased from 73% to 93% and PrEP use increased from 20% to 31% collectively. PrEP awareness significantly increased among Latino MSM and trans persons through 2020 but remained relatively unchanged among Black MSM.

PrEP/PEP Centers of Excellence: In 2016, DHSP funded nine PrEP/PEP Centers of Excellence (COE) across LAC with the primary goal of increasing access to and use of PrEP among Black/ African American and Latino MSM, transgender persons and cisgender women. Today, there are 12 COEs funded by DHSP that offer multiple services, including insurance application assistance, medication adherence support, primary medical care, and referrals to other services (Figure 30). Through March 2022, 9,810 unique clients had received biomedical services through one or more COEs with 73% receiving PrEP services, 21% receiving PEP services, and 6% receiving both PrEP and PEP (Figure 31).

Analysis of utilization data gives us insights into the PrEP/PEP needs of at-risk individuals in LAC. According to the DHSP-Funded Biomedical Prevention Services Year 6 Report, between July 1, 2020-June 30, 2021, 3,235 clients were prescribed PrEP at a COE, including 2,250 new enrollees. The majority of PrEP clients were Latino (53%), MSM (88%) (Table 6). Fifty-three percent of enrolled clients were retained in PrEP services at a COE clinic for at least six months. Retention rates were impacted by both the type and duration of services accessed. For example, those who were retained, on average, received 25 minutes of education activities, 34 minutes of adherence activities and 57 minutes of retention activities. Comparatively, those who were lost to follow-up only received about half as many service minutes with an average of 12, 13 and 28 minutes, respectively.

Figure 30: PrEP/PEP Centers of Excellence

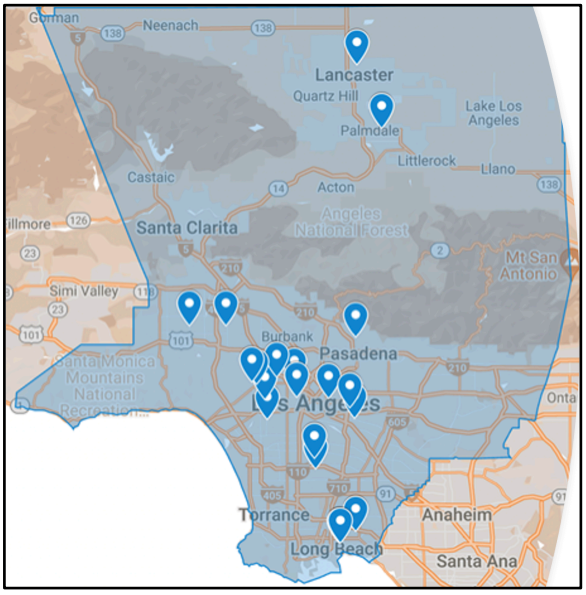
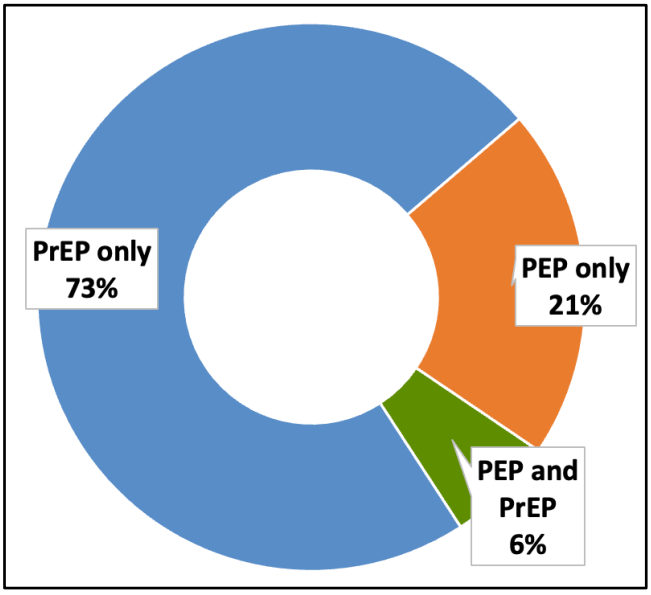


Figure 31: Biomedical Services Provided at COEs



[33] https://www.cdc.gov/hiv/research/demonstration/projectpride.html

Table 6: Centers of Excellence: Clients Prescribed PrEP between 7/1/20-6/30/22 (N=3,235)

HIV RISK GROUP				AGE GROUP						RACE/ETHNICITY				
MSM	Trans	PWID	HET	13-19	20-24	25-29	30-34	35-39	40+	Latino	B/AA	White	Asian	Other*
88%	12%	1%	1%	<1%	7%	21%	27%	19%	25%	53%	18%	15%	12%	<2%

*"Other" includes American Indian/Alaskan Native (<1%) & Native Hawaiian/Pacific Islander (1%)

Among the PrEP priority populations, retention rates and adherence rates were worse for Latino MSM, trans persons and cisgender women than they were for Black MSM.

- Among Black MSM, 538 were screened for biomedical HIV prevention, including 465 screened for PrEP only, 32 screened for PEP only, and 41 screened for PEP and PrEP. The top three indicators for PrEP were multiple partners, condomless receptive sex and anogenital STD. Forty-three percent of Black MSM were retained in PrEP services at a COE for at least 6 months.
- Among Latino MSM, 1,560 were screened for biomedical HIV prevention, including 1,377 screened for PrEP only, 69 screened for PEP only, and 69 screened for PEP and PrEP. The top three indicators for PrEP were multiple partners, condomless receptive sex and anogenital STD. Forty percent of Latino MSM were retained in PrEP services at a COE for at least six months.
- Among trans persons, 462 were screened for biomedical HIV prevention, including 374 screened for PrEP only, 63 screened for PEP only, and 25 screened for PEP and PrEP. The top three indicators for PrEP were multiple partners, condomless receptive sex and previous PEP and ongoing behavioral risk. Thirty-six percent of trans persons were retained in PrEP services at a COE for at least 6 months.
- Of the 377 people between the ages of 14-24 that were screened for PrEP, the top three indicators were multiple partners; condomless receptive sex; and anogenital STD/syphilis.

Harm Reduction and Syringe Services Programs

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. It is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.[34] Syringe Services Programs (SSPs) are excellent vehicles for harm reduction. Despite consistent evidence that SSPs, and needle-exchange in particular, work to reduce infections and save lives, [35] there remains a great deal of misinformation and stigma surrounding their existence. Contrary to some beliefs, SSPs do *not* increase the number of used syringes in communities, the use of drugs, or drug-related crimes. In addition to providing access to and disposal of syringes and injection equipment, SSPs are comprehensive community-based prevention programs that often provide vaccination, testing, education, case management and linkage to care, substance use treatment and PrEP. SSPs also serve as an important overdose prevention mechanism by providing low-barrier access to Medically Assisted Treatment (MAT) for opioid use disorder, and overdose prevention and response trainings; and distributing Naloxone kits and fentanyl information and test strips. Although there was a ban on using federal funds for syringe exchange until 2016, the City of Los Angeles has provided funding for syringe services since 1994 and the County of Los Angeles since 2006. Because SSPs provide a comprehensive set of services, as described above, the County now refers to the SSPs they fund as *Engagement and Overdose Prevention (EOP) Hubs* to more fully reflect the scope of the work they do. DPH-SAPC currently funds seven EOPs across the County that distribute close to a million sterile syringes and thousands of Naloxone kits every year. EOP services are provided through storefronts, street-based mobile sites and outreach efforts. In LAC, EOPs funded by the County are required to provide:

[34] https://harmreduction.org/about-us/principles-of-harm-reduction/

[35] Fernandes RM, Cary M, Duarte G, et al. Effectiveness of needle and syringe programmes in people who inject drugs – An overview of systematic reviews. BMC Public Health. 2017;17(1):309. doi:10.1186/s12889-017-4210-2.

- Needs-based/low threshold access to syringes
- Sharps containers and education on disposal
- Naloxone
- Safe injection supplies (tourniquets, alcohol swabs, water, band aids, cotton balls, cookers)
- Safe smoking supplies (pipes, lip balm, straight shooters)
- Wound care supplies
- Direct or referred testing for: HIV and HCV
- Referrals for treatment for HIV/HCV, substance use treatment, specialized mental health, or medical care.

In 2021, among the six[36] EOPs that were operating in LAC:

- 924,164 clean syringes were distributed (a 32% increase from 2017)
- All provided injection supplies and safer sex supplies;
- 5 out of 6 five provided overdose treatment (e.g. Naloxone), and HIV risk reduction counseling; a
- 4 out of 6 provided HIV testing

The majority of clients served were 30 years of age or older (90%) and cisgender males (76%). Thirty-nine percent were Latinx, 36% were White, 20% were Black/African American, and 5% were classified as "Other" race. In addition to the EOPs there are three SSPs in LAC that are certified by DPH-SAPC but not currently funded by them bringing the total amount of EOPs/SSPs operating in LAC to ten. Although the majority of EOPs and SSPs provide HIV testing, only two currently provide HIV, STD and HCV testing.

Services People Need to Rapidly Link to HIV Care: Linkage to care is an essential step to ensuring viral suppression. In 2020, 54% of people newly diagnosed with HIV were linked to care within seven days and 76% were linked within one month of diagnosis. Populations with lowest linkage to care rates were cisgender women (67%), Black/African Americans (71%) and those classified as "multi-racial" (69%), persons 13-19 years old (63%) and persons whose transmission risk included heterosexual contact (66%) or MSM/IDU (67%). Populations with the highest linkage to care rates were transgender persons (81%), those aged 30-39 and 50-59 (78%), Asians (90%), AI/ANs (86%) and those whose transmission risk was MSM (78%).

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. As depicted in Table 4, the percentages of those newly diagnosed with HIV who were linked to care within 30 days varied by test setting. The highest percentages were found among primary care clinics (78%), followed by community STD clinics (69%) and hospitals (64%). Conversely, the test settings that had the lowest linkage to care percentages were mobile test settings (17%), HIV testing sites (27%) and community settings (33%).

In addition to HIV testing services, linkage to care is achieved through other targeted programs. One such program is DHSP's Linkage and Re-engagement Program (LRP) designed to identify HIV-positive persons out of care, and their partners for linkage/re-engagement to HIV care. LRP receives referrals from a broad base of countywide partners and also uses data-to-care reports to identify potential LRP clients. LRP often works to locate persons hardest to find and acts as a service of last resort after all other outreach efforts have failed. Because LRP clients are not on ART it is essential that they are located and connected to care in order to improve their health outcomes and prevent transmission of HIV. With LRP clients reaching undetectable levels, partners are less likely to contract and further

[36] One more EOP was recently funded in 2022 to bring the total to seven.

transmit HIV. Furthermore, partners are then able to receive support to get tested and take actions to address their status, whether negative or positive. LRP also supports Partner Services follow-up by taking on cases of clients who have been difficult to locate.

Services PLWH Need to Stay in HIV Care and Treatment and Achieve Viral Suppression: Once initially linked to care, it is imperative that HIV-positive persons remain engaged in care to improve their health outcomes and prevent transmission. Concerted efforts are also needed to re-engage into care PLWH who are diagnosed but not in care. The use of surveillance data to identify those who are lost to care is critical. Since the inception of the Ryan White Program, HRSA has funded a comprehensive set of medical and related services targeting low-income PLWH. Although the local utilization rates of Ryan White services don't tell us the complete picture of the needs of all PLWH, they serve as a starting point for examining needs related to engagement in care. Ryan White Program clients totaled 21,877 in Year 31 (3/1/21-2/28/22), representing 41% of all PLWDH in LA County. The services most utilized by RWP clients were Medical Outpatient (70%), Medical Care Coordination (38%), and Non-Medical Case Management (24%) (Table 7).

Table 7: Ryan White Program Services Utilization, 3/1/21-2/28/22

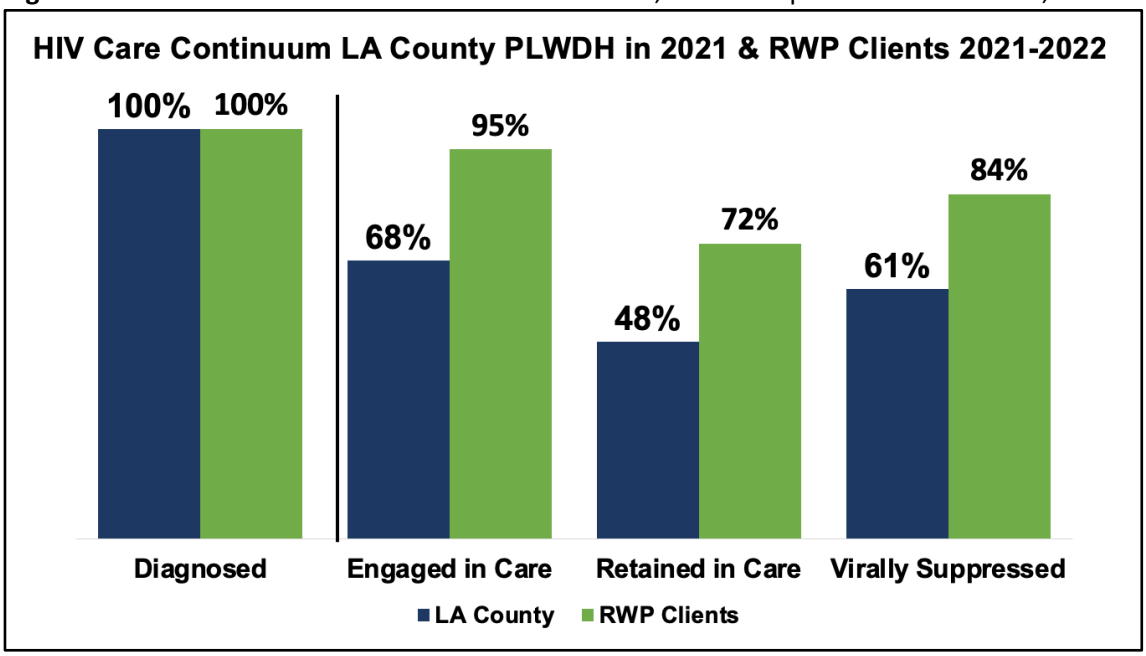
Service Category	Unique Clients	Percentage of RW Clients	Units Per Client
Total Unduplicated Clients*	21,877	--	--
Medical Outpatient	**15,272**	**69.8%**	**3**
Supplemental AOM Procedures	10,396	47.5%	25
Medical Outpatient	15,272	69.8%	3
Medical Care Coordination	**8,244**	**37.7%**	**14**
Non-Medical CM	**5,181**	**23.7%**	**4**
Benefits Specialty	4,658	21.3%	4
Transitional CM – Jails	563	2.6%	6
Oral Health Care	**4,153**	**19.0%**	**11**
General Oral Health	3,849	17.6%	7
Specialty Oral Health	3,477	15.9%	5
Nutrition Support	**1,988**	**9.2%**	**193**
Food Bank	1,582	7.2%	97
Delivered Meals	560	2.6%	410
Mental Health Services	**756**	**3.5%**	**7**
Home-Based Case Management	**280**	**1.3%**	**321**
Case Management	279	1.3%	43
Homemaker	184	0.8%	354
Nutrition	54	0.3%	108
Psychotherapy CM	70	0.3%	29
Attendant Care	20	0.1%	237
Durable Medical Equipment	4	0.02%	3
Housing Services	**237**	**1.08%**	**287**
Permanent Supportive Housing	151	0.7%	323
Residential Care Facilities for the Chronically	60	0.3%	238
Transitional Residential Care Facilities	28	0.1%	180
Substance Abuse Services – Residential	**90**	**0.4%**	**123**
Outreach Services (LRP Program)	**26**	**0.1%**	**11**

*Receiving Fundable RW Program Services

Los Angeles County is also funded through HRSA's Minority AIDS Initiative (MAI) and has selected three subpopulations of focus based on local epidemiologic and programmatic data: cisgender men of color aged 30 or older who have sex with men (MSM of color); cisgender men of color aged 18-29 years who have sex with men (YMSM of color); and transgender persons of color (Trans clients). MAI subpopulations totaled 11,721, representing 55% of clients receiving at least one RWP service in Year 31. The top four services that were disproportionately utilized (compared to their population size) by the MAI population were benefits specialty (60%), mental health (58%), non-medical case management (58%), and oral health care (56%).

As depicted in Figure 32, HIV Care Continuum outcomes for RWP patients were better than for the larger population of PLWDH. However, disparities persist among certain subpopulations, again speaking to the need to target services to these populations. Among the RWP clients in Year 31, engagement in care rates were lowest for those who were homeless (90%), recently incarcerated (91%), people aged 18-29 (92%) and African Americans (92%). Retention in care rates were lowest for those between the ages of 18-29 (59%), currently homeless (60%), recently incarcerated (65%) and African American (66%). Viral suppression rates were lowest among currently homeless (67%), recently incarcerated (70%), people who inject drugs (77%) and people aged 18-29 (77%).

Fig. 32: HIV Care Continuum Outcomes: PLWDH in LAC, 2021 Compared to RWP Clients, 2021-22



Unmet Need (Not in Care): Based on the five-year population estimate (2016-2020) of 44,090 PLWDH in LAC, 7,279 (17%) were estimated to have unmet need (not in HIV medical care) as indicated by there being no evidence of a viral load or CD4 reported in 2020 (Table 5).

- Among each of the three epicenters of HIV: 19% of PLWDH in Central, 17% of PLWDH in Hollywood-Wilshire, and 15% of PLWDH in Long Beach had unmet need.

- The majority of persons with unmet need were male (87%). Within each gender category 16% of males, 17% of females, and 17% of trans persons were aware of their HIV status and did not receive recent laboratory testing.

- Within each racial/ethnic group, Native Hawaiian/Pacific Islander Non-Hispanic had the highest percentage of PLWDH with unmet need (30%), followed by Blacks/African Americans (21%), and American Indian and Alaskan Natives (18%).

- The percentage of unmet need was highest within younger age groups; 23% of PLWDH 25-34 years, 21% of PLWDH 13-24, and 20% of PLWDH age 35-44 years.

In Care, Not Virally Suppressed (VS): Among the 36,811 PLWDH who were in care, 4,563 (12%) were not virally suppressed (viral load ≥200 copies/mL on the most recent test reported) between January 1, 2020, and December 31, 2021.

- Among the three epicenters of HIV: 17% of PLWDH in Central, 14% of PLWDH in Hollywood-Wilshire, and 10% of PLWDH in Long Beach were not virally suppressed.

- More than one out of five transgender persons (18%) were in care, but not virally suppressed compared to 12% of cisgender males and 13% of cisgender females.

- Within each racial/ethnic group, Black/African Americans had the highest percentage of PLWDH in care and not virally suppressed (16%), followed by multiracial (not Hispanic) group (14%) and Native Hawaiian/Pacific Islanders (13%).

- The percentage of unsuppressed viral load was highest within younger age groups; 18% of PLWDH 13-24 years, 16% of PLWDH 25-34 years, and 14% of PLWDH age 35-44 years.

Barriers to Services

The HIV Workforce Capacity and Service System Survey[37] respondents, both providers and community members, were asked to rank a set of barriers to accessing or remaining engaged in a variety of HIV-related services including HIV testing, PrEP and HIV care, and to add any other significant barriers not listed. Listening session participants were also asked to discuss any barriers related to diagnosing HIV and accessing HIV treatment and prevention services.

Top Five Barriers to Accessing HIV Testing

	Providers	**Community**
1	Lack of culturally appropriate services	Substance use
2	Substance use	Lack of accurate information about testing
3	Mental health	They don't believe they're at risk
4	They don't believe they're at risk	Mental health
5	Lack of accurate information about testing	Lack of culturally appropriate services

Other related barriers that respondents identified included:

- (Lack of) awareness of free services
- (Lack of) awareness of testing locations and hours
- Fear of finding out they're infected
- Isolation
- Stigma/Internalized homophobia
- PTSD

In addition to the barriers listed above, survey and listening session participants identified barriers relating to lack of urgency about HIV, not having enough testing sites, concern about HIV stigma and lack of health literacy or knowing they're at risk.

[37] Workforce Capacity and Service System Survey is described in more detail in the Approach section below.

"We should learn from COVID – they had testing on every corner. Why can't we do that with HIV?"

"I already experience stigma for being Black and Gay. I don't want to add to that by being HIV positive."

"A lot of people still don't know they can get HIV – and once they're positive, they don't understand a lot of the language. U equals U means nothing to them."

Top Five Barriers to Accessing PrEP

	Providers	**Community**
1	Mental health	Concern they won't be able to pay for PrEP
2	Substance Use	Substance use
3	Lack of culturally appropriate services	Lack of accurate information about PrEP
4	Lack of stable housing	Mental health
5	Lack of accurate information about PrEP	Trauma

Other/related barriers included:

- Lack of social support and not having role models who take PrEP
- Stigma/Internalized homophobia

PrEP Needs among Black/African American MSM, Transgender and Cisgender Women

In 2019, the Commission on HIV's Black/African American Task Force developed a set of recommendations that included developing a targeted PrEP marketing campaign for Black/African American communities, given less than optimal PrEP uptake. In response to this recommendation, a series of focus groups were held for Black/African American MSM, transwomen and cisgender women to inform the development of a PrEP campaign.[38]

Among MSM, common barriers to accessing PrEP included:

- Provider barriers – difficulty getting a provider to prescribe PrEP; not having providers close by; and not a lot of people in the clinics who "look like us"
- Miseducation and mistrust – not knowing where and how to get PrEP and not fully understanding PrEP and its side effects
- Mental fatigue – having to constantly take medication can be overwhelming; having to take medications to have sex reinforces there is shame in having sex

Among transwomen, common barriers to accessing PrEP included:

- Discrimination - trans and nonbinary people face an extreme amount of discrimination in trying to not only utilize PrEP, but in every aspect of life
- Providers/Access – poor access to facilities; lack of eligibility for PrEP/cost; lack of Black trans/nonbinary people who work at facilities.
- Side effects: physical and mental – including a recognition that even preparing to take meds is challenging
- Stigma - association of PrEP use with being promiscuous

Among cisgender women, common barriers to accessing PrEP included:

- Stigma - questions about number of partners can feel shaming; scared family or friends might find out they're taking it; they might be stereotyped for using PrEP

[38] Facilitated by *Equity & Impact Solutions*

- Access - can't afford it if it's not free; not the same availability that MSM have
- Pill Burden - taking a pill everyday can be burdensome
- Social Determinants - having to deal with poverty, housing insecurity, etc., makes it hard to focus on PrEP
- Medical Mistrust - believing the medications only work for MSM; believing only HIV+ people take medications; not understanding why PrEP takes longer to work in women than men
- Lack of Support - no PrEP support groups in LA for Black cis women
- Messaging/Marketing - not enough campaigns with Black cis women in clinics and publicly
- Lack of holistic focus - not enough focus on general well-being, access to healthcare and social support services everyone deserves

Optimizing PrEP Delivery to Immigrant Latino MSM in LAC: The Center for HIV Identification, Prevention and Treatment Services (CHIPTS) recently led a collaborative research project to understand the barriers to PrEP access, and to develop strategies to enhance PrEP delivery, among immigrant Latino MSM (LMSM) in LAC. Given that LMSM comprised the largest percentage (51%) of all new HIV infections among MSM of all racial/ethnic groups in LAC in 2019, and that nationally, since 2010, foreign born LMSM have comprised the majority of new annual HIV infections among LMSM, researchers were intent to understand any additional barriers to accessing HIV prevention services immigrant LMSM may face that are not experienced by US-born LMSM. The study included in-depth interviews with 15 Spanish-speaking and 10 English-speaking immigrant LMSM, 7 key informant in-depth interviews and a concept mapping process[39] with 19 panelists.[40] Key barriers were identified at the agency-, and client-level, including:

Agency-Level Barriers

Language

- Lack of Spanish-speaking staff and PrEP navigators
- Lack of services offered in Spanish
- Lack of properly translated Spanish language materials
- Difficulty completing English language forms
- No standardized way to talk about PrEP in Spanish

Provider bias/knowledge/comfort

- Not receptive to providing PrEP services
- Hold perception that PrEP will lead to promiscuity
- Lack knowledge of PrEP
- Not proactive about offering PrEP to this population
- Not comfortable delivering PrEP to this population

Outreach doesn't reflect population

- Lack of PrEP outreach materials or public awareness campaigns tailored for immigrant LMSM
- Outreach materials are not intentionally created for immigrant Latino MSM

[39] Concept mapping is a mixed methods approach that integrates qualitative perspectives of individuals with multivariate statistical methods to visually depict the composite thinking of the group. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5451901/

[40] Key informant and concept mapping participant inclusion criteria: Staff member from a medical care facility or community-based organization that provides PrEP services to immigrant Latino MSM; Person with experience working with or advocating on behalf of immigrant Latino MSM; Person with knowledge of issues affecting access to HIV prevention services such as PrEP among immigrant Latino MSM.

Client-Level Barriers

Lack of knowledge about PrEP and available PrEP services

- Unaware of PrEP
- Don't know that PrEP is for them
- Don't know where or how to access PrEP
- Unaware of medication assistance programs (e.g., Gilead's Advancing Access Program, PrEP-AP)

Structural/logistical barriers

- Lack of health insurance
- Cost of services not covered by assistance programs
- Lack of transportation
- Unable to get release time to attend medical appointments
- Clinic hours (i.e., no weekends or evening hours)

Language

- Difficulty communicating with non-Spanish speaking providers
- Not enough services offered in Spanish
- Unaware of where to access services in Spanish

Cultural

- Don't use healthcare services unless absolutely necessary and don't use preventive services
- Uncomfortable talking about sexual behaviors with providers
- Homophobia in the Latinx community (e.g., needing to hide sexuality)

Immigration status

- Fear that information about use of PrEP services and/or HIV testing will be reported to immigration authorities
- Fear that use of public benefits will impact immigration process
- Fear of deportation if accessing PrEP services

PrEP-related stigma

- PrEP is only for gay men or men who are promiscuous
- Fear of being outed when accessing PrEP
- Fear of family, friends, or partners finding a PrEP bottle
- Fear of being thought of as HIV-positive

Individual perceptions/beliefs

- Fear of side effects
- Don't recognize their own HIV risk
- Providers assume they are having sex with women because some immigrant LMSM identify as heterosexual

The concept mapping process was used to develop implementation strategies to enhance PrEP delivery to immigrant LMSM. After identifying a list of strategies, the top five that were determined to be most feasible and important were recommended for prioritization:

1. Provide immediate access to and enrollment in PrEP services (e.g., same-day PrEP, PrEP walk-in clinic), so that there isn't a delay in receiving services.
2. Gather testimonials from immigrant Latino MSM who have buy-in to PrEP services and are willing to showcase their stories on social media.

3. Deliver comprehensive PrEP education and training to every staff member at the clinic, from front desk staff to providers.
4. Provide support to help undocumented individuals enroll in insurance programs that cover PrEP services.
5. Develop campaigns informing people that they can access PrEP (e.g., through PrEP-AP) regardless of their current documentation status and without affecting their future chances for documentation.

Additional themes identified from survey and listening session participants related to accessing PrEP included discomfort/ unfamiliarity with taking medication when you're not sick, thinking PrEP is for other people because of lack of authentic advertising, and not being able to store the medication because of being unhoused.

"We only go to the doctor when we're sick."

"I don't see any pictures of people that look like me on those billboards that I drive by every day."

"How can I take medication every day? Where am I supposed to keep it when I'm on the street?"

Top Five Barriers to Linkage to Care

	Providers	**Community**
1	Substance use	Substance use
2	Lack of accurate information about LTC	Mental health
3	Lack of culturally appropriate services	Concern that they won't be able to pay for HIV care
4	Lack of stable housing	Lack of accurate information about LTC
5	Trauma	Lack of stable housing

Other:

- Lack of HIV-positive peers to talk to
- Need a warm hand-off and walked to services without having to wait
- Stigma
- Transportation
- Unfriendly insensitive waiting rooms
- Fear of people thinking they're gay

Survey and listening session participants expressed not wanting to access care due to bad experiences with providers in the past and not feeling comfortable in the clinic's physical space. They also expressed concern over administrative hurdles.

"I've had bad experiences with providers before. Why would I go back to be judged again?"

"When I'm in the waiting room, I feel like I'm in someone else's space."

"If it were easy to see the doctor, I think more people would do it, but I think there are too many administrative and logistic barriers. Right now, it feels like the opposite of "express" linkage."

Top Five Barriers to Remaining Engaged in Care

	Providers	Community
1	Substance use	Substance use
2	Mental health	They don't feel sick
3	Trauma	Mental health
4	Lack of stable housing	Lack of stable housing
5	Lack of accurate information about HIV care	Trauma

Other:

- Lack of appointment time options
- Don't want to take medication or go to doctor's office
- Lack of peer support and treatment advocates
- Lack of respect in waiting areas, reception for drug users, homeless and other downtrodden
- Stigma
- Transportation

Participants also identified barriers related to medical mistrust, not having providers who look like them, lack of transportation and childcare and the need for peer advocates.

"We need to have a list of providers that are people of color and LGBT and we need to have more of them."

"There are a lot of reasons why we don't remain in care – we need help with transportation and help with childcare. And I need to see a provider who gets me."

"Doctor appointments are fifteen minutes. If I want to know what my labs mean, or why I'm given a particular pill, or how to manage side effects, I go to my peer-led support group, which is not funded by the County or by my health insurance. We need peer advocates. We need treatment advocates."

Co-occurring Disorders, Social Determinants of Health and Stigma

Across all categories of service, the top two barriers identified were substance use and mental health challenges. We also recognize that HIV disparities in LA County, like the rest of the nation are fueled by stigma and social determinants, including housing instability and incarceration. Each of these is described in more detail below.

Mental Health Disorders: Mental health disorders can affect the progression of HIV disease, medication adherence and the likelihood of engaging in high-risk behaviors that may result in HIV transmission.[41] Based on 2015-2019 Medical Monitoring Project (MMP) data, between 10.4% -16.5% of PLWDH in LA County report moderate to severe depressive symptoms. Effective treatment of mental health disorders requires regular screening and diagnosis. Using a subset of RWP clients, we compared diagnosis and screening data to describe the prevalence of undiagnosed depressive disorder among Medical Care Coordination (MCC) services patients from 2013- 2019. As part of routine assessment, patients were screened for depressive symptoms using the Patient Health Questionnaire (PHQ-9) and their medical record reviewed for any depressive disorder diagnosis. Among the 9,178 MCC clients, 29% met the screener criteria for a depressive disorder and 33% had

[41] Remien RH, Stirratt MJ, Nguyen N, Robbins RN, Pala AN, Mellins CA. Mental health and HIV/AIDS: the need for an integrated response. AIDS. 2019 Jul 15;33(9):1411-1420.

been previously diagnosed. Among those with depressive symptoms, only 57% had a corresponding diagnosis. Compared to patients with depressive symptoms and a concurrent diagnosis, those with symptoms and no diagnosis were more likely to be male, younger (12-24 years compared to 24- 39 years of age), higher assessed acuity, and have unsuppressed viral load in the past six months.

Assessment of Unmet Mental Health Needs of PLWH

A recent key accomplishment under the EHE Initiative was a formal assessment of the unmet mental health needs of PLWH and the LAC mental health services and delivery system. Conducted by HMA Community Strategies, the assessment sought to identify barriers at the systems-, provider-, and client-level. Key stakeholder interviews (15 agencies), surveys (35 provider and 29 client respondents), and a review of secondary data rendered the following key findings and recommendations:

KEY FINDINGS	RECOMMENDATIONS
DATA LIMITATIONS	
•There is a lack of access to data and a lack of integrated data across the BH system – prevents comprehensive analysis of service utilization among PLWH. •Within the DMH data set, SOGIE was unknown for a slight majority of patients with both HIV and a BH diagnosis. This SOGIE data gap make it more difficult to tailor public health messaging and interventions.	•Establish a data infrastructure that enables the extraction and analysis of client-level data across county departments to identify who and which subgroups are not receiving services •Develop data sharing protocols and/or platforms that would allow patient health information to be more efficiently shared between DMH, DHS and DPH to avoid delays in data request •Add sexual orientation/gender identity and expression (SOGIE) data fields to ongoing data collection and data systems •Collect comorbid health condition data as part of the data collection to track other major life stressors of PLWH in order to provide client-centered, whole person care.
ELIGIBILITY AND SERVICE UTILIZATION	
•The increase of health care coverage and decline in aggregate HIV incidence result in a decline of the number of individuals eligible for Ryan White; fewer PLWH are eligible under current guidelines. •The current system is more successful in reaching Hispanic/Latinx population despite the prevalence of HIV being more prominent in the Black community.	•Revise regulations to allow Ryan White services to individuals who are Medi-Cal eligible •Reduce the administrative burden on providers and clients by minimizing or streamlining intake and reporting requirements •Encourage and incentivize providers to hire peers, community health workers (CHWs) or navigators to assist with insurance and paperwork
SERVICE DELIVERY AND COORDINATION	
•Linkages between MH and primary care remain an issue for many providers. •Most providers have difficulty ensuring PLWH can receive timely referrals to MH services, as well as difficulties referring clients to both psychiatric and SUD services. •Many providers reported difficulty matching PLWH to a licensed clinician on their staff with whom they identify	•Modify screening tools to enhance alignment with Trauma Informed Care and Gender Affirming Care •Improve cross agency referrals by using the Los Angeles Network for Enhanced Services (LANES) to have more accurate patient data and facilitate referral communication. •Design and convene forums that bring together providers to discuss and plan improvements (e.g.,

•Providers have difficulty coping with rules and regulations that limit how they can staff clinical care for PLWH. •Many MH service clients not currently accessing received MH services via telehealth indicated they would be interested in starting services via telehealth. •Clients often experience difficulties navigating the current MH system. •Clients lack awareness of the services available and experience long wait times and excessive paperwork to access these services.	how to strengthen implementation of "No Wrong Door"). •Develop a resource guide that provides detailed information on providers' services, capacity, and specialty services to enhance cross-agencies referrals.
FINANCE AND FUNDING	
•Many MH providers do not receive Ryan White funding, nor do they have a DMH contract to provide MH services. •Providing wrap-around services is unsustainable for most providers. •Providers are challenged by the current billing system; the opaque nature of reimbursement poses a significant barrier for service providers.	•Develop and offer training to providers intended to clarify and standardize reimbursement policies, including guidance on CPT codes, rates, and proper documentation. •Advocate for subsidizing BH services for individuals who are above the RW eligibility threshold but do not have other sources as payment of last resort.
WORKFORCE AND STAFF CAPACITY	
•Staff retention is a significant issue at both the provider and systems levels; excessive turnover and inability to recruit and retain staff is a barrier to provision of MH services to PLWH. •Nearly all providers have difficulty assessing relevant staff training resources and/or staff training opportunities. •There is a need for more professional development of the MH workforce, as well as reconsideration of the content and emphasis of training efforts.	•Leverage current efforts of the *Zeroing In: Ending the HIV* consortium and other EHE capacity building organizations to provide better quality, relevant workforce training opportunities that prioritize the following: •Models of collaborative, holistic care •Co-occurring disorders (e.g., the intersection of HIV and SUD) •SMI/high acuity mental health conditions •Advanced trauma-informed care and practices •Innovations in telehealth •Resources to improve workforce retention •Coordinate training offerings among DHSP, DMH, SAPC, and the clinical provider organizations •Explore whether LMFTs could be cross credentialed to provide services now restricted to LCSWs •Collect data on the diversity and lived experience of staff working with PLWH •Expand Spanish-language providers

STDs: Project Fierce Community Survey

Project Fierce is a community-based project funded by the CDC designed to reduce STD disparities and promote sexual health among young (18-24) cisgender and transgender women of color in LAC. As a project of Community Health Councils and WeCanStopSTDsLA, the Project Fierce Community Advisory Board implemented a community survey in 2021 to better understand the sexual health

needs of young women of color. The 27 survey respondents identified as cisgender women (82%) and transgender/gender non-conforming (18%); straight/heterosexual (63%), bisexual (19%), and pansexual/queer (13%); Latinx (70%), Black/African American (22%), Asian (7%), and American Indian/Indigenous (7%). Key findings included:

- 73% were offered an STD screening by a healthcare provided; 27% were not offered one
- 52% would be more likely to get screened for STDs if it was mailed to their home rather than walking into a clinic; 33% would be equally likely; and 15% would be less likely
- 26% would be more likely to get screened for STDs if it was offered through mobile services rather than walking into a clinic; 41% would be equally likely; and 33% would be less likely
- 33% had never been tested for STDs. Of those that were tested: 37% had previously been tested for chlamydia; 30% for HIV; 22% for gonorrhea; and 15% for HPV
- 30% reported that their healthcare provider had never educated them on STIs, associated risks, and ways to stay healthy
- 33% were not sure which questions to ask their provider during appointments
- Factors that influenced their likelihood of discussing their sexual health history and concerns with their provider included: having a consistent healthcare provider (67%); the healthcare provider's age (48%), gender identify (48%), race/ethnicity (33%), and experience (26%).
- 48% reported that they never (26%) or not very often (22%) have a consistent healthcare provider
- 52% reported that celebrities, social media, and media influencers shaped their view or understanding of sex and sexual relations
- 29% reported that they had felt/been pressured to have unprotected sex in a monogamous relationship

Substance Use Disorder (SUD) and the Meth Epidemic: In contrast to other parts of the U.S. where the HIV epidemic is driven significantly by sharing of needles and other equipment among PWID and other substances[42], the nexus between substance use and HIV in LAC centers on unprotected sex while under the influence of alcohol or other drugs. Based on MMP data (2015-2019), it is estimated that between 33.9% and 42.1% of PLWDH used non-injection drugs, and 1.9% to 4.9% used injection drugs in the past 12 months. Among a subset of 9,021 RWP clients receiving MCC services in LAC from 2013-2018 who were screened, approximately one out of five had indication of a SUD.

In LAC an estimated 18% of young adults aged 18-25 and 8.4% of adults aged 26 and older were estimated to have a SUD. Based on data from the LAC SAPC program, approximately 1 in 5 people treated for SUDs in the county are treated for meth use disorder and only 47% of these clients successfully completed treatment.

In the U.S, the increased risk of adverse outcomes associated with meth use (vs. non-use), include depression (1.3 times), HIV infection (1.5 times) and HCV infection (3.4 times). Between 2010 and 2020, meth-related overdose deaths in LAC have increased 1,185% and percent of all drug deaths has increased by 345%. Latinos made up the majority of patients with primary meth problem admitted to a treatment facility (65%), while Blacks had the highest rate (223). Patients admitted to treatment whose primary drug problem was meth had higher rates of STDs than clients with other primary drug problems. The difference was greatest with respect to syphilis, with 1.2% of those with meth as a primary problem having syphilis compared to 0.3% of those with other drugs as a primary problem – a five-fold difference.[43] The connection between meth use and syphilis is further illustrated through the analysis of Partner Services (PS) data. Between 2011 and 2019: meth use

[42] Syringes and equipment may also be shared to administer hormones, steroids and/or vitamins
[43] http://www.publichealth.lacounty.gov/sapc/MDU/MDBrief/MethBrief.pdf

among the early syphilis cases referred to PS increased among men who have sex with women, by 7 to 22%, and women who have sex with men, by 0% to 21%.

Among MSM in LAC, meth use is frequently associated with increased unsafe sexual activity. Meth-using MSM are much more likely to have multiple sexual partners and report inconsistent condom use than MSM who do not use meth. Meth users have numerous clinical challenges such as poor treatment engagement rates, high drop-out rates, high relapse rates, severe paranoia, and declining oral health. The medical and psychiatric aspects of meth dependence often exceed the capabilities of existing SUD programs, requiring significant cost for training and education for staff to improve service delivery.

Homeless/Unstably Housed: There are more than 69,000 homeless persons in LA County on any given night.[44] Since 2019, there has been a 12.7% increase in the homeless population in LA County and over 70% of the homeless were unsheltered. Nearly half (44%) of the homeless people in the county were found in areas with the highest rates of HIV/ AIDS, poverty, and uninsured. Approximately 41% percent of LA County's homeless were chronically homeless, 2% had HIV/AIDS, 26% had a SUD, and 25% had a serious mental illness. Nine percent of RWP clients in Year 31 were experiencing homelessness. Among clients enrolled in MCC services at Ryan White clinics from 2013-2019 (n=8,438), 24% reported experiencing homelessness in the past six months at enrollment. Clients who reported recent homelessness were significantly more likely to be Black/African American, recently incarcerated (in the past six months), have depressive symptoms, and have used injection drugs in the past six months compared to clients who did not report recent homelessness. In addition, those who reported recent homelessness were more likely to be male and heterosexual, live below the federal poverty level (FPL), be US natives, and have less than a high school diploma compared to clients who did not report recent homelessness. These data suggest that MCC clients experiencing homelessness were from communities disproportionately impacted by HIV (e.g., persons of Black race/ethnicity), impacted by multiple determinants of health (e.g., experience with the justice system, low educational attainment, poverty) and comorbid conditions (e.g., mental health and IDU). Of particular interest is that these clients were more likely to be non-MSM and IDU – both populations in which HIV prevalence has historically been lower but could contribute to potential HIV clusters or outbreaks.

Incarceration: Incarceration is associated with harmful effects on viral suppression, lower CD4+ T-cell counts, and accelerated disease progression.[45] HIV prevalence among men in LA County jails is estimated to be between 1% and 2% and approximately 300 PLWH are housed in the jails at any one time. Based on the MMP data from 2015-2019, between 1.1% and 3.2% of PLWDH reported being incarcerated in the past year. Among RWP clients in 2021, 8% had been incarcerated in the past two years. High percentages of these clients were living at or below FPL (85%), experiencing current homelessness (33%), MSM of color (44%), and African American (36%). These clients also had some of the lowest levels of engagement and retention in care and viral suppression.

Beyond the direct association of incarceration and poor health outcomes among PLWH, we also recognize incarceration as a force in LA and across the country that destabilizes communities, disrupts family relationships, and magnifies the accumulation of health and social disadvantage for already marginalized populations. The LA County Sheriff's Department (LASD) operates the largest municipal jail system in the US, and the US, in turn "imprisons more people than any other nation on

[44] https://www.lahsa.org/documents?id=6515-lacounty-hc22-data-summary

[45] Fuge TG, Tsourtos G, Miller ER. A systematic review and meta-analyses on initiation, adherence and outcomes of antiretroviral therapy in incarcerated people. PLoS ONE. 2020;15(5):e0233355.

Earth." [46] There are more than 250,000 people who cycle through the county justice system annually, roughly 14,500 daily, and 500 inmates classified each day. In addition to the sheer volume of people in LA County jails, there are stark racial disparities. Black/African Americans, while making up only 9% of the LA County population, represent over 29% of the jail population. The justice system is clearly ill-equipped to deal with the thousands of people it imprisons who are typically struggling with poverty, homelessness, substance use disorders and mental health challenges. As a result, people cycle in and out of jail, not able to get the care they need to live healthy and productive lives.

In 2020, LA County voters approved Measure J, which dedicated no less than ten percent of the County's locally generated unrestricted funding to address the disproportionate impact of racial injustice through community investments such as youth development, job training, small business development, supportive housing services and alternatives to incarceration.[47] As a result, the LA County Board of Supervisors adopted the Care First Community Investment spending plan[48] (aka Measure J), an unprecedented $187.7 million spending package to advance its care first, jails last vision with a series of direct community investments and funding for alternatives to incarceration—accelerating the transformative process of creating a more just and equitable Los Angeles County for all residents. The plan was developed with an equity lens with a primary focus on chronically under-resourced communities to address negative outcomes caused by racially-driven criminal justice inequities and long-term community economic disinvestment. As such, the plan supports a wide range of programs including interim and permanent supportive housing, grants to community-based organizations, and employment opportunities for adults and youth. Highlights of the funding plan include:

- $42 million to support the closure of Men's Central Jail
- $16 million for housing and related services to meet a variety of needs including for people experiencing homelessness with complex health needs and people with substance use disorder;
- $15 million to support residents returning to the community after incarceration

Stigma: Since the beginning of the epidemic, stigma in all its forms has served as a constant barrier to people being able to access HIV care and prevention services. HIV-related stigma is compounded by stigma associated with LGBTQ identities and sexual behaviors, using drugs, injecting drugs, mental health disorders, being homeless and being incarcerated. Given its pervasiveness and sometimes insidious nature, stigma is hard to pinpoint and even harder to address. A recent example of how stigma impacts the lives of PLWH and the communities most impacted by HIV is the messaging and reaction to Monkeypox. In late 2022, LA County, like many urban areas across the country, is struggling to combat the monkeypox virus as we continue to grapple with COVID-19. To date, the vast majority of the 1,836 monkeypox cases have been identified among cisgender men (97%), most of whom identify as gay/bi or other MSM. However, risk is not limited to MSM, given that available evidence suggests that those who are most at risk are those who have had close physical contact with someone with monkeypox. Unfortunately, early messaging about monkeypox may have inadvertently led to people believing they are not at risk if they are not gay or transgender identified. There is also concern locally and globally that some communications and commentary on monkeypox have used language and imagery that reinforce homophobic and racist stereotypes and

[46] https://www.lacounty.hiv/wp-content/uploads/2018/11/LACHAS2018-English.pdf
[47] https://ceo.lacounty.gov/ati/
[48] In response to recommendations put forth by the *Measure J Reimagine LA Advisory Committee,* since transformed into the *Care First and Community Investment Advisory Committee*

exacerbate stigma.[49] We recognize that such stigma and misinformation can severely undermine outbreak response. Indeed, we are reminded of the early days of the HIV epidemic when racism, homophobia, transphobia and stigma led to the failure to prioritize the communities most impacted by HIV/AIDS – gay men, people of color, trans persons and PWID - early on in the course of the epidemic. This resulted in the steady and deadly spread of HIV/AIDS most profoundly in these groups and a failure to - as of yet - end the HIV epidemic nationally.

The monkeypox outbreak creates both another health burden and another social burden for the LGBTQ population and for people living with HIV. The evolution of monkeypox remains to be seen, but even after the current wave of this particular health threat subsides, we likely will not be spared from future outbreaks, epidemics or pandemics of other infectious diseases. To protect PLWH and the communities most impacted by HIV from both the health and social burdens brought about by current and future pandemics, we urge public health leaders and elected officials to respond to outbreaks with an approach that avoids stigma and blame. To do so, we encourage the infusion of community voices and perspectives, particularly among those most impacted, in the development of such responses and messaging. We need to ensure that public health leaders and governments work with communities to find local solutions. Disproportionately impacted populations must not bear the brunt of increased stigma and discrimination as a result of any health threat or the response to it. Moving forward, we will work to ensure that these key principles[50] guide future public health responses in LA County:

- Affected communities must be actively engaged in identifying and implementing strategies in response to threats to their health and well-being.

- Stigma and fear are constant companions of infectious disease pandemics; proactive steps must be taken to minimize their negative consequences.

- To reduce health disparities, proactively identify groups and communities at disproportionate risk of developing disease or poor health outcomes and design interventions to reduce these disparities and to promote health equity.

Overall Service System and Workforce Capacity

Additional data were captured through assessment activities that pertained to the HIV service system and workforce capacity. Participants cited numerous strengths with the HIV service system in LA County, including addressing the epidemic through a social justice lens, multiple free and accessible services, and the dedication of those who work in the field.

"The HIV workforce tends to be comprised of passionate and committed workers. They feel their job is meaningful and believe in helping others to the best of their ability."

"It's beginning to acknowledge the impact of systemic racism in all aspects of care and as a driver of health disparities."

Relatedly, community members who had received HIV-related services over the past year had mostly positive feedback about the services they received:

- 98% either strongly agreed or agreed that they were treated with respect;

[49]https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2022/may/20220522_PR_Monkeypox

[50] Valdiserri, R.O., Holtgrave, D.R. Responding to Pandemics: What We've Learned from HIV/AIDS. *AIDS Behav* 24, 1980–1982 (2020). https://doi.org/10.1007/s10461-020-02859-5

- 93% either strongly agreed or agreed that they did not feel judged;
- 97% either strongly agreed or agreed that the staff made them feel welcome and comfortable
- 97% either strongly agreed or agreed that the provider met their needs and answered their questions.

Needs/Areas for Improvement

Community members appreciated when their providers treated them more holistically, but some reported frustration with having to advocate to be screened for STDs, not being able to receive whole-person care, and not receiving culturally competent services.

"My clinic screen for other issues I may have and that was important to me."

"I used to be screened for STDs every three months. Now that I see my ID doc twice a year, the tests have been added to my labs once, at my request."

"My HIV provider used to be the only doctor I saw. My current and past physician is no longer willing to treat my cholesterol or other non-HIV issues. As an older person with HIV, I'm also dealing with other comorbidities. My healthcare is siloed, I'm taking ten different medications and I only see doctors who advocate for their disease, with no one advocating for the whole person."

"The location was cyberspace, so I didn't visit the therapist's office. I took three months to see the therapist. The therapist had no experience working with gay men, HIV, or cancer survivors."

"Case managers spend more time doing paperwork than servicing clients. LA County loves data driven programs, but all that paperwork means some people are denied access to services or have to wait three months."

The majority (79%) of respondents strongly agreed or agreed that there needs to be more people living with HIV delivering HIV-related services. Among those who identified as HIV-positive, the percentage jumped to 93%. Additionally, 80% of respondents strongly agreed or agreed that "there needs to be more people who look like me delivering HIV-related services." This included 86% of respondents who identified as Black/African American and 88% who identified as Latinx.

In addition to increasing the diversity of the workforce, the greatest needs with respect to the workforce and service system included addressing provider burnout; addressing turnover that stems from a variety of issues; the need for expedited services, especially for those with complex needs; training needs; building a better pipeline for providers; and addressing administrative barriers.

"Hire more people, more staff that look like us and can relate to our needs. Don't require a Master's degree in social work. Let people with an Associate's degree take a little training. If you hire more people that are HIV and give them training, you'll get better results."

"Do they employ members of the populations in positions other than outreach? For example, do they have trans front desk staff or a gay black MA? Or do these folks only get hired to do outreach to their "target" population?"

"They (providers) are overworked / forced to wear multiple hats and many of them have unhealed trauma that directly impacts the quality of their services."

"The turnover in organizations is high due to low pay and other factors. More free training is needed that offers certification and licensing. Experience is frequently underappreciated vs college degrees."

"What we really need are housing resources, access to expedited mental health services and substance use disorder resources, linkage to care of vulnerable populations especially those experiencing homelessness."

"The greatest need is to cross train programs regarding their services and systems to connect clients to services."

"(There are) no clear pipelines or educational training programs (in colleges or in the community) to prepare for positions in the HIV field (HIV counselors, HIV prevention workers, PrEP navigators, Linkage to Care, Case Managers, Case Watch Data Managers, ADAP enrollers, Benefits Counselors, etc.)."

"At meetings, it often feels like there is adequate resource allocation especially for housing, yet as a provider, it feels that those resources are difficult to obtain or are not available in real time. There is so much red tape and ultimately, the patients suffer or there is delay in receiving care. This also applies to mental health resources."

"*(We need) one database for all services, once registered data like income can be updated and people get automatically enrolled for needed services like affordable housing."*

a. Priorities – The needs assessment process helped us to identify the following key priorities:

- Integration and streamlining of services
- Address mental health needs of PLWH and at-risk for HIV
- Address SUD, especially meth use disorder
- Address needs and gaps in the HIV workforce
- Clear marketing and messaging about services and risks to reach priority populations
- Need to increase health literacy

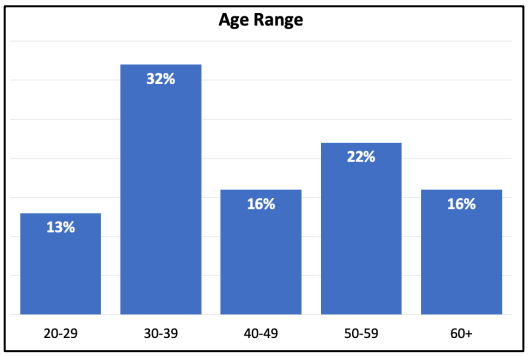
b. Actions Taken - In response to needs and barriers identified during the development of both the Integrated Plan and the EHE, LA County has undertaken a number of activities, including:

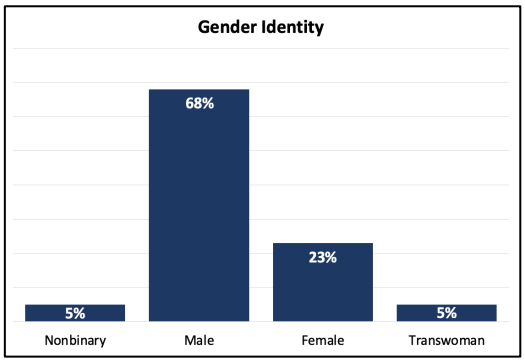
- Distributed over 15,000 HIV self-test kits
- An Assessment of Unmet Mental Health Needs of PLWH
- Assessment activities to develop PrEP campaigns in the Black/African American community
- Began initial activities for comprehensive workforce capacity assessment
- Increased Tele-PrEP capacity for PrEP/PEP Centers of Excellence
- DHSP began implementing *Addressing Implicit Bias & Medical Mistrust, and Cultural Humility* training
- Emergency Financial Assistance for PLWH – developed for clients at risk of losing housing or in need of one-time or short-term financial assistance
- Exploring ways to improve Partner Services efforts
- Development of a Cluster Detection and Response Community Advisory Board
- Community meetings and trainings on Cluster Detection and Response
- DHSP implemented EHE community mobilization project through a partnership with the AMAAD Institute, focused on highly impacted populations
- Implemented iCARE Contingency Management project
- Implemented Rapid and Ready Linkage to Care project

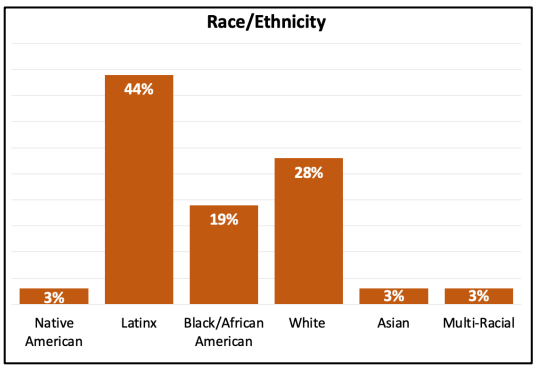
c. Approach - At the onset of planning, stakeholders expressed concern related to "over-assessing" both community members and providers, and that we should strive to utilize the data, recommendations and reports that had recently been collected and compiled through various means. For example, the recent development of the LA County EHE, the local *Act Now Against Meth* campaign; and the recommendations from the Commission's Black/African American Task Force, Women's Caucus, Transgender Caucus, Consumer Caucus, Prevention Planning Workgroup, and Aging Task Force rendered useful information for our planning purposes. In addition to the analysis of existing reports and data, we also collected primary qualitative data from priority populations, community members and providers through listening sessions, an online survey and facilitated stakeholder meetings.

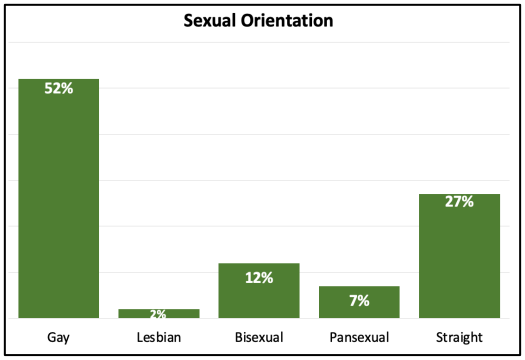
Listening Sessions: To ensure the voices and perspectives of communities most impacted by HIV were used to drive the Integrated Plan's goals and objectives, we conducted facilitated "listening sessions" with priority population groups. A total of 86 participants attended the listening sessions for Black MSM; People of Trans Experience; Cisgender Women of Color; People who Inject Drugs and their Stakeholders; PLWH 50 years of age and Older; and People Under 30 years of age. The listening sessions were 90-120 minutes long and included discussions about what the HIV service system does well; and barriers and solutions related to each pillar. Participants each received a $25 gift card for their participation.

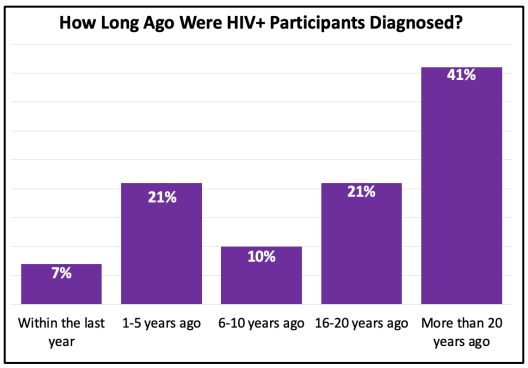
Survey: Two online surveys were also disseminated to capture perspectives from providers and community members (defined as anyone who had accessed any type of HIV-related service in LA County in the past 12 months). Community members each received a $25 gift card for completing the survey and providers had the option of entering a raffle to win one of two $50 gift cards. Both the provider and community surveys were available in English and Spanish. Fifty-one community members completed the survey, however, only 13 providers responded to the survey, which may be due to being "over-assessed" as described above. The demographic profile of community survey participants include:

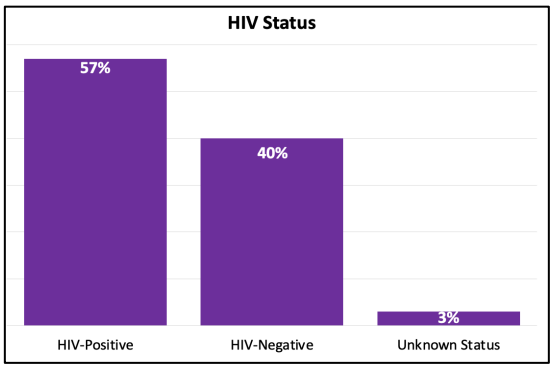












Facilitated Stakeholder Meetings: To capture feedback from key stakeholders, the planning team (PP&A leadership, Commission staff and Consultant) facilitated a number of structured discussions to ascertain how to build upon the existing EHE to develop the new Integrated Plan. Stakeholders represented the following entities and/or population groups:

- EHE Steering Committee members
- Community-based organizations serving PLWH and at-risk for HIV
- Health department staff from LA County, the CA State Office of AIDS, and the Cities of Long Beach, and Pasadena
- People living with HIV, including members of a Federally recognized Indian tribe and individuals co-infected with hepatitis C
- Members from priority population groups including Black MSM, Latinx MSM, Women of Color, Trans and nonbinary persons, PWID, people 50 and older, people under 30
- Health department epidemiologists
- HIV clinical care providers including those who represent RWHAP Part C and D
- Providers from STD clinics
- Non-elected community leaders including faith community members and business/labor representatives
- FQHC and Community Health Centers
- Substance use treatment providers
- Hospital planning agencies and health care planning agencies
- Mental health providers
- Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility
- HOPWA Coordinator
- City of Los Angeles AIDS Coordinator
- Social services providers including housing and homeless services representatives*
- Service Planning Area (SPA) 2 (San Fernando Valley) HIV and social service providers
- SPA 4 (Metro) HIV and social service providers
- Long Beach HIV Community Planning members
- City of West Hollywood HIV service coordinators/staff
- Part F/AETC

Section IV: Situational Analysis

Overall, the LA County HIV prevention and care system has many strengths and providers, advocates, consumers and community members can be proud of key achievements over the course of the HIV epidemic that have undoubtedly saved lives and improved the quality of life for those living with or at-risk for HIV. More recently, although COVID-19 has devastated Angelinos and greatly stretched the public health infrastructure, the HIV system has shown great resiliency and continues to diagnose and treat people living with HIV and prevent HIV transmission through the provision of high-quality services. Although the number of people living with HIV continues to climb, the number of annual HIV infections continue to decrease, as does the HIV death rate. Unfortunately, HIV-related disparities persist across race/ethnicity, gender identity, sexual orientation and age group. These disparities are driven largely by structural and systemic issues including housing status, poverty, recent incarceration, and co-morbid conditions such as STD coinfection, substance use disorders and mental health disorders. Our commitment to ending HIV means we must also be committed to confronting harmful practices and oppressive systems that fuel these disparities.

a. Diagnose all People with HIV as early as Possible: An HIV diagnosis as close to the period of infection as possible is a crucial first step to achieving optimal HIV-related health outcomes and reducing the likelihood of HIV transmission. In LA County, an estimated 6,800 people or 11% of all people living with HIV, are undiagnosed and therefore unaware of their status. Additionally, one out of five people who were newly diagnosed with HIV in 2020 were diagnosed in the “late stage” of the disease, increasing the risk of transmission and poorer health outcomes. To increase the proportion of people living with HIV who are diagnosed to at least 95%, and to increase the timeliness of diagnosis, LA County 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. Critical in this effort is increasing the number of testing services access points to meet clients where they are in their readiness to engage in testing services in clinical, non-clinical and other community settings.

LA County DPH supports a cross-section of organizations to conduct HIV testing in a variety of settings, including non-clinical venues that serve priority populations, community-based HIV/STD clinics, social and sexual network testing programs, and commercial sex venues. Overall, 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 county jails and 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.

Routine HIV Testing: Expanding routine HIV testing within emergency departments, hospitals in highly HIV impacted geographic areas, FQHCs, and other clinical settings is crucial to meet HIV testing goals. 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. Given the co-occurrence of HIV and other STDs and substance use, it is essential that we continue to promote HIV testing as a part of routine STD screenings and at substance use disorder treatment facilities and SSPs. 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."

Primary Care Clinics: As part of the national EHE initiative, since 2020 39 FQHCs and community health clinics were funded directly by HRSA's Bureau of Primary Health Care to adopt routine HIV screening, increase PrEP provision, and implement other HIV prevention services within their clinics. LA County DHSP works with the funded clinics in partnership with the Community Clinic Association of Los Angeles County to support these efforts.

Emergency Departments (EDs), Urgent Care Centers and Hospitals: EDs are entry points into healthcare services for many individuals, including people living with diagnosed and undiagnosed HIV. Thus, EDs, urgent care settings, and hospitals are important locations to offer HIV testing, especially for those who don't access primary care. Routine HIV screening in these settings is also conducive to the identification of persons with acute HIV infection and high linkage to care rates. In 2020, DPH received HIV case reports for a total of 2,338 new HIV diagnoses, and 2,006 cases were matched to a reporting health care facility. Approximately three out of every five new diagnoses were identified at one of the top eight HIV diagnosing hospitals or outpatient clinics.

Sexual & Reproductive Health Clinics: Screening sexually active persons for HIV when they present for STD testing is imperative, particularly given that HIV and other STDs often co-occur. Sexual health providers in LA County include community and DPH STD clinics, family planning providers, and HIV PrEP clinics. DPH currently operates 11 STD clinics and funds four community-based LGBT focused STD clinics that provide no-cost specialized STD and HIV services in a confidential, non-judgmental setting. Family planning providers include Planned Parenthood as well as a network of many smaller clinics. These providers have and continue to provide comprehensive STD and family planning services to patients of all genders for uninsured or underinsured persons. Since 2012, the number of clinics offering PrEP either in a separate PrEP focused clinic or integrated into their regular services has increased. Increased PrEP use results in increased HIV testing given CDC guidelines that clients prescribed PrEP should be tested for HIV every three months. The top six sexual and reproductive health clinics diagnosed nearly one-third (30%) of all new diagnoses in 2020.

In the past, DHSP has conducted Public Health Detailing (a method of targeting and reaching providers who will benefit from a short, focused 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 develop 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 (e.g. CDC recommendation of at least once per year). Among CDC's NHBS participants, 15% of transwomen, 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 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.

Self-Test Kits: 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 HIV self-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, LA County DHSP joined the multi-jurisdictional Take Me Home initiative. Take Me Home is a timely and innovative HIV self-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, DHSP has also made available HIV self-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. TakeMeHome is working to expand its reach and diversify its users by implementing active social media strategies and partnering with local credible messengers to increase the recognition of and trust in the program. Providing the opportunity for no-cost self-test kits is a strategy to increase access to HIV testing services with minimal staff support. Since January 2021, Public Health has distributed over 15,000 kits to contracted HIV prevention agencies, other community partners, and through community events. DPH plans to expand self-test kit distribution through programs that serve people who inject drugs, transitional aged youth, and people experiencing homelessness. LA County is also pursuing distribution options through non-traditional partners such as barbershops, religious institutions, mutual aid groups, as well as through large scale community events.

In addition to HIV self-testing, the “I Know” program (dontthinkknow.org), first developed by LAC DPH in 2009, was the second free home STD testing program in the U.S. offered by a public health agency, and the very first to offer clients online access to test results. The program offers free testing for chlamydia and gonorrhea to females and trans males in LAC ages 12-24, using the Aptima Combo 2 vaginal swab. Chlamydia and gonorrhea together cause more than 25,000 infections in young women in LA County annually. Most of these infections are asymptomatic, making routine testing essential to timely treatment and preventing further transmission. "I Know" expands testing by removing common barriers to clinic-based testing, including time, stigma, and lack of nearby facilities. Re-launched in April 2022 on a new more powerful software platform, “I Know” has now also expanded to six other CA counties, with support from CA Department of Public Health.

The County welcomes traditional and non-traditional 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 “syndemic” testing that includes viral hepatitis and STDs. DHSP 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.

b. Treat People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression: By leveraging a combination of federal, state, and local funds, LA County supports a network of HIV providers and more than 30 DHSP funded HIV medical homes, where referrals, linkage assistance, medical care, and medications are available regardless of insurance status. For years, DHSP, the Commission and a network of providers have worked to reduce barriers to care so that PLWDH can be readily linked to and be retained in HIV medical care. Despite these efforts, at the end of 2020, linkage to care, engagement in care, and viral suppression rates remain far below targets for a significant subset of patients.

Linkage to care: Since 2011, DHSP 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. Only 76% of persons who were newly diagnosed in 2020 were linked to HIV care within one month and only 54% were linked to HIV care within one week. 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. DHSP, 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, DHSP will utilize its position as funder to provide technical assistance to clinics to reduce unnecessary administrative barriers for patients and improve the client experience. An exciting LTC project recently launched by DHSP is the Rapid and Ready program focusing on same-day linkage to care which has received 52 referrals to date, of which, 50% have been linked to care.

Engagement and Retention in Care: In 2013, LAC DHSP 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, and then 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 DHSP-based health navigators, who have access to a wide-range of LA 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.

In August of 2022, a contingency management program known as iCARE (Incentives for Care, Adherence, Retention, and Engagement) was launched. iCARE is an incentive-based program that seeks to support engagement in care and viral suppression among youth and young people under the age of 30 using principles of contingency management, an evidence-based behavioral intervention. This pilot program consists of two cohorts (youth under 30 years and women from DHSP's Linkage and Re-engagement Program).

It is clear that despite the availability of these programs, many PLWH struggling with financial concerns, housing instability, mental health diagnoses, and SUDs, also struggle to not only access care, but remain in care and achieve viral suppression over long periods of time.

Cal-AIM[51]*:* The California Department of Health Care Services (DHCS) has recently begun rolling out a multi-year initiative to improve the quality of care provided to Medi-Cal members by implementing broad delivery system, program, and payment reform across the Medi-Cal Program. The goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative are to identify and manage member risk and need through whole-person care approaches and addressing social determinants of health; move Medi-Cal to a more consistent and seamless systems by reducing complexity and increasing flexibility; and improve quality outcomes, reduce health disparities and drive delivery systems transformation and innovation through value-based initiatives, modernization of systems, and payment reform. Under CalAIM, Enhanced Care Management (ECM) is a care coordination benefit for the highest need and/or high-cost members. This new Medi-Cal managed care plan benefit would provide intensive care management for both medical and non-medical needs for high-need Medi-Cal members. Eligible populations include people experiencing homelessness, people at risk of institutionalization and people transitioning from incarceration with complex health needs. Because a key focus of CalAIM is addressing the challenges facing people with complex and unmet needs, we are hopeful that CalAIM will help support the needs of PLWH who have fallen out of care or are at risk of falling out of care. For these reasons, we will carefully monitor the roll-out of the new initiative and work to ensure the system supports the needs of PLWH.

Addressing the Meth Epidemic: In LA County, the 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. 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 LA County 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 developed the Los Angeles County Platform Addressing the Meth Epidemic. The platform includes a list of recommendations for meth prevention, treatment, and policy, some of which we have folded into our goals and objectives. 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 actively participates in both the Prevention and Treatment Committees of the Meth

[51] https://www.dhcs.ca.gov/calaim

Task Force.

Aging with HIV: As we enter the fifth decade of the HIV epidemic, those who are aged 50 and older make up an increasingly larger percentage (51%) of PLWDH, with people 50-59 years old making up 30% of all PLWHD and people 60 and older making up 21%. By comparison, people 50 and older make up only 33% of LA County's general population. It is estimated that by 2030, people 50 and older will comprise 70% of all PLWH. Additionally, among new HIV diagnoses in 2020, 34% of people aged 50-59 and 31% of people 60 and over were diagnosed at Stage 3 of HIV disease, indicative of late HIV disease (compared to 20% among all diagnoses).

Advances in treatment have greatly improved the health and well-being of all PLWH. As HIV treatments continue to improve and the general population continues to age, the number of older PLWH will continue to increase. Relatedly, according to a recent modeling project,[52] by 2030, over 25% of people taking HIV treatment will be over the age of 65; over half will be over the age of 53; and 36% of people taking ART are expected to have multimorbidity – at least two physical co-morbidities in addition to HIV. A recent study finds that accelerated aging occurs within just two to three years of infection.[53] With age and the cumulative effects of HIV, older PLWH and some long-term survivors experience exacerbated age-related health vulnerabilities and comorbid conditions. Older PLWH face a range of challenges to their physical and mental health, in addition to the usual effects of aging, even when HIV disease is well-controlled.[54, 55]

Physical challenges may include exacerbation of widespread, chronic inflammation associated with normal aging; multimorbidities and their interactions, and side effects of ART and other medications. Mental challenges and challenges to overall well-being may include HIV-associated neurocognitive disorders; depression; trauma and loneliness.

As the needs of older PLWH and long-term survivors come more into focus and grow more urgent, it is imperative that our service system adapts to ensure strategies for long-term viral suppression, continuous access to ART, and prevention and care for comorbid physical and mental conditions. In 2020, the Commission on HIV's Aging Task Force (now Caucus) developed a set of recommendations to address the broad health needs of those over 50 years old living with HIV and long-term survivors. The Task Force is currently revisiting the recommendations to better respond to the aging needs of long-term survivors under 50 and individuals who acquired HIV perinatally. Aligned with these recommendations, as well as California's Master Plan on Aging, DHSP has begun to develop plans to address the needs of those PLWH 50 and older, as reflected in our goals and objectives.

The current safety net in LAC to address the needs of PLWH with multiple health and/or life circumstances (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 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 education, emotional support, trauma informed care and 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,

[52] Kasaie P et al. *Multimorbidity in people with HIV using ART in the US: projections to 2030.* Conference on Retroviruses and Opportunistic Infections, abstract 102, 2021.

[53] Crabb Breen, et al. *Accelerated aging with HIV begins at the time of initial HIV infection.* Published: 6/30/22 DOI: https://doi.org/10.1016/j.isci.2022.104488

[54] https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv

[55] https://www.medicalnewstoday.com/articles/growing-old-with-hiv

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.

c. Prevent New HIV Transmissions by Using Proven Interventions, Including PrEP/PEP & SSPs

PrEP/PEP: 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, less than four in ten persons with an indication for PrEP report taking it. 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. Unfortunately, assistance programs require eligibility screening and paperwork, which can deter some clients. Clear and direct messaging about PrEP from 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 mistreatment of Black Americans, Native Americans, and other people of color, 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 and transgender persons has consistently been lower compared to their White counterparts. 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*[56] recommended increasing culturally sensitive PrEP advertising designed with input from the very communities it is attempting to reach, including Black/African American cisgender women, transgender individuals and MSM. 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.

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 to discussing sexual behaviors with patients, ideally in an open non-judgmental manner. The network of LAC PrEP Centers of Excellence (COEs) 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] Recently, 39 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. Additionally, recent California legislation and policy changes have further expanded PrEP access points to include pharmacies[57] and telemedicine providers.

[56] Now the Black/African American Caucus of the LA County Commission on HIV

[57] With the passing of California's Senate Bill 159, pharmacists are now allowed to directly provide PrEP and post exposure prophylaxis (PEP).

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.

DHSP and stakeholders must continue to promote all PrEP access points to further increase uptake. Studies have demonstrated that the "2-1-1" PrEP regimen[58] (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, recent increases in opioid and methamphetamine use via both injection drug use and non-injection drug use is concerning. Additionally, the rise of conditions that contribute to drug use, such as economic inequality, homelessness and untreated mental illness are pervasive in LAC, increasing our susceptibility to an IDU outbreak. 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 nine agencies funded at modest levels through the DPH SAPC program. Of the nine currently funded EOP agencies, only two currently 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. LAC has recently increased our investment in this area and we plan to continue to enhance the SSP service portfolio to ensure clients are linked to HIV prevention and treatment services and allow for more robust data collection. Despite recent legislative setbacks, we will also continue to support the creation of supervised drug consumption sites and services. Supervised Consumption Sites (SCS) are designated sites where people can use pre-obtained drugs under the safety and support of trained personnel. SCS have been implemented across over 200 sites in countries around the world and have been proven to save lives.[59]

[58] There is scientific evidence that the "2-1-1" schedule provides effective protection for cisgender MSM when having anal sex without a condom, however, to date, we don't know how "on-demand" PrEP works for heterosexual cisgender men and women, people who inject drugs, and transgender persons.

[59] Gostin LO, Hodge JG, Gulinson CL. Supervised injection facilities: legal and policy reforms. *JAMA*. 2019; 321(8):745-746.

d. Respond Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People who Need Them: The use of client-level data reported to the public health department to identify and target PLWH for contact tracing and linkage to services has a long precedent that continues today. 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 PLWDH. While these limits on the use of surveillance data in the early days of the HIV epidemic as a way to protect the 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 find 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 targeted and timely, and has the greatest impact. These activities require real-time access to client-level surveillance data and will be carried out regularly 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.

Partner Services: The CDC describes Partner Services as a continuum of clinical evaluation, counseling, diagnostic testing, and treatment designed to increase the number of infected persons brought to treatment and to reduce transmission among sexual networks.[60] Partner services is a key strategy for identifying people with HIV infection—those with undiagnosed infection and those with diagnosed infection who are not receiving HIV medical care—and helping them access care and treatment. All persons with newly diagnosed HIV infection should receive Partner Services to help them identify sex and needle-sharing partners who may also be infected or may be at very high risk for becoming infected. These partners can then be notified of their potential exposure and offered HIV testing. Those who test positive for HIV can then be linked to HIV medical care and other services. Those who test negative can then be linked to PrEP, SSP and other prevention services.

DPH employs Public Health Investigators (PHI, aka Disease Intervention Specialists) to implement both HIV and STD Partner Services (PS) activities. Currently, LAC's integrated HIV/STD disease investigation and PS program is implemented by staff who work within two separate divisions within the Department of Public Health: DHSP and Community and Field Services (CFS). DHSP PHIs, based at a centralized office, focus on syphilis and HIV partner services while CFS PHIs, based in 12 district offices throughout LAC, focus on HIV/STD and other communicable diseases assigned by the DPH.

While the Partner Services program in LAC has been mostly 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 DHSP to reach all newly diagnosed persons with HIV. The latest estimate suggests that 73% of newly diagnosed persons with HIV in LAC receive an offer of Partner Services around the time of their diagnosis, but only 46% of those newly diagnosed are interviewed and only 10% name contacts. 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.

[60] https://www.cdc.gov/std/treatment-guidelines/clinical-partnerServices.htm

In response to the steady increase of syphilis cases and the increasingly scarce human and financial resources available to aggressively investigate all cases and interrupt the transmission of new infections, DPH has employed and implemented a priority setting process to further improve local disease investigation efforts, in particular HIV partner services. The three-point plan to improve HIV partner services includes HIV surveillance system improvements, organizational restructuring and enhanced HIV training for PHIs.

In 2021, DHSP hired seven new Public Health Investigator Trainees. The County will also hire additional PHIs to move closer towards meeting the large needs based on the high HIV and syphilis rates. Key to expanding and improving the local infrastructure is updating the existing training curriculum and adding more mentoring and hands-on training to provide better disease intervention for the very complex, high priority HIV and syphilis cases. Additional improvements are planned in quality improvement and epidemiological analysis to inform the current needs and practices as well as to inform incident trends; ultimately, to use data-to-care/action strategies in real time to detect, intervene, and prevent new cases. One other important upgrade is a new data management system, IRIS, which will enhance the workflow and case management system in comparison to the current system, STD Casewatch. IRIS will also integrate data systems that allows for efficiencies in conducting searches in HIV surveillance and other key databases.

Linkage Re-engagement Program: At DHSP, the Linkage and 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 PLWDH 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 DHSP 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 DHSP 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. Planned activities for further community dialogue were put on hold due to the deployment of staff to the local COVID-19 response, however they have recently resumed. As a part of continued community engagement and awareness on molecular cluster detection and the monitoring of cluster outbreaks, DHSP will develop a communication strategy for community members and organizations in 2022 and beyond.

More recently, LAC DHSP 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.

As we continue to move forward with EHE and develop new or strengthen existing partnerships with community stakeholders and service providers, LAC DHSP 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 has begun to add HIV and STDs to its new surveillance data system for all communicable diseases; 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. We are hopeful that 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.

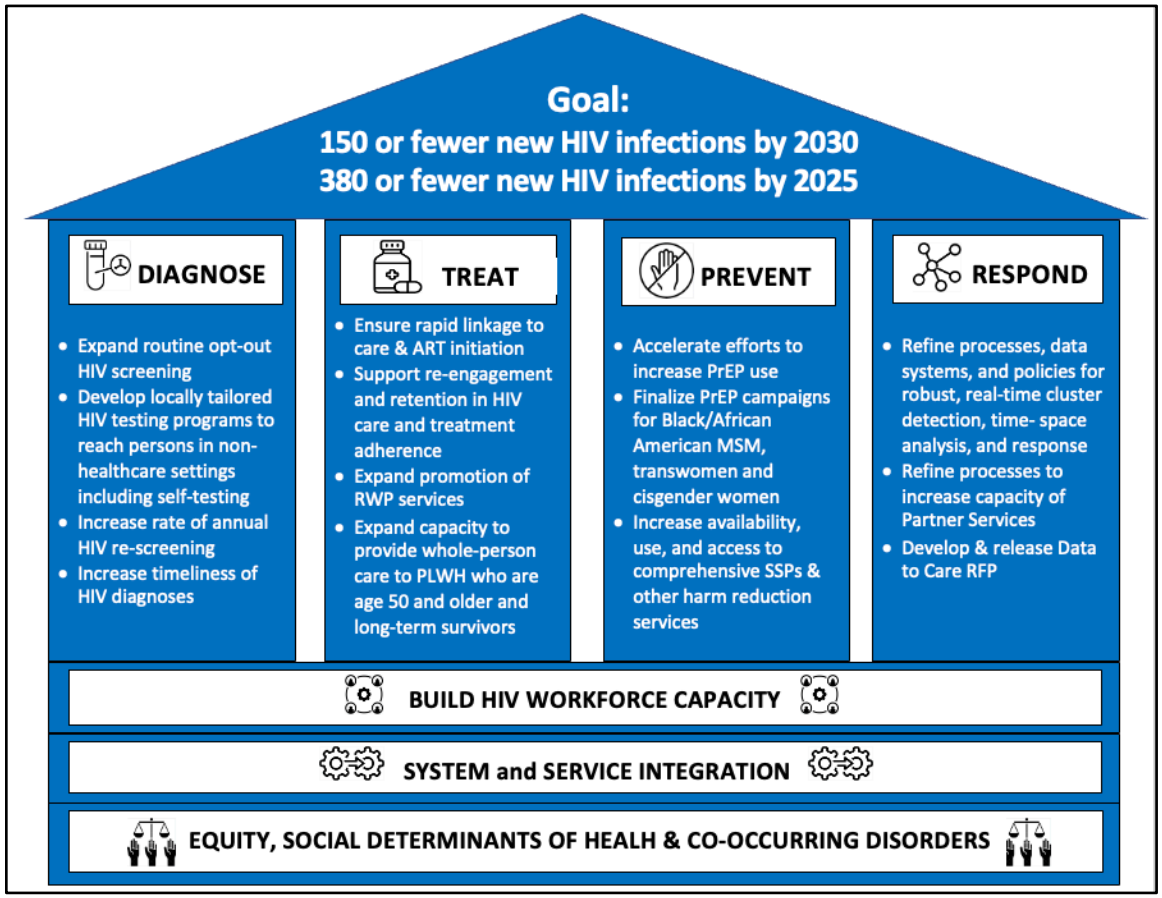
Priority Populations: Based on epidemiologic and needs assessment data, the priority populations for the Integrated Plan are: Black/African American MSM, Latinx MSM, women of color, people who inject drugs, transgender persons, youth under 30 years of age and PLWH aged 50 and older. These populations are inclusive of the priority populations in the EHE with the addition of the 50 and older population group. Although these populations will be prioritized, the County's 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 experiencing unstable housing or homelessness, among others.

Capacity Building & HIV Workforce: For many years, there has been a resounding call from frontline HIV service providers and others to provide 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. The jurisdiction 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 HIV response. LAC DHSP will continue to work with the AETCs and the California Prevention Training Center to identify trainings to support the HIV workforce, with a particular focus on client-centered and trauma-informed approaches to HIV care. Given recent events and persistent social injustices, including COVID-19, a housing crisis, and worsening economic, racial and social injustice, the emotional and physical capacity of individuals, organizations, and the HIV workforce continues to be strained and tested. We recognize 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 HIV workforce. We will continue to encourage organizations to diversify the HIV workforce by hiring diverse employees to promote cultural competency, mirror the populations most impacted by the HIV epidemic, and combat systemic racism as we operationalize all Pillars.

Section V: Goals and Objectives

The EHE Plan forms the core of the Integrated Plan's goals, objectives and strategies. In addition to the four pillars: diagnose, treat, prevent and respond, we have added key foundational and cross-pillar elements that are essential to supporting each pillar's strategies and activities and our broader HIV-related goals. As depicted in Figure 33, these foundational elements include Building Workforce Capacity; System and Service Integration; and Equity, Social Determinants of Health and Co-Occurring Disorders.

Figure 33: Four Key Pillars and a Strong Foundation Necessary to Achieve HIV-Related Goals



Pillar I: Diagnose

Goal: Diagnose all people with HIV as early as possible
Objectives: 1. By 2025, increase the percentage of PLWH who are aware of their status to 95%, from a baseline of 89%. 2. By 2025, reduce the number of undiagnosed PLWH from an estimated 6,800 to an estimated 3,067.[61] 3. By 2026, decrease the proportion of people newly diagnosed with HIV who are in the late stage[62] of HIV disease at time of diagnosis from 20% to 15%.
Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other settings, such as emergency departments (EDs) and community health centers (CHCs) 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 EDs and CHCs 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/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 self-testing, including linkage to care and prevention services, a quality assurance protocol, and assess readiness of providers to implement self-testing.
Activity 1B.3: Assess Take Me Home self-testing initiative utilization, barriers and facilitators and make improvements as necessary.
Activity 1B.4: Expand use of HIV self-testing among at risk individuals unlikely to receive traditional in-person HIV testing by developing and expanding other types of self-testing (in addition to Take Me Home) to ensure equitable access.
Strategy 1C: Increase the rate of annual HIV re-screening among persons at elevated risk for HIV in both healthcare & non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening & increase ways of maintaining communication with clients.
Activity 1C.1: Develop provider-to-patient communication tools to support providers in identifying 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 & use of provider-to-patient communication tools among LAC DHSP funded HIV prevention providers.

[61] Estimated based on 59,400 PLWH in 2021 and assuming 4,450 new infections and 2,500 deaths by 2025 = ~61,350 x 5% = 3,067 Undiagnosed PLWH in 2025

[62] Late stage is Stage 3 HIV disease, the criteria being either CD4 < 200 cells/µL within 90 days of HIV diagnosis or a diagnosis of an opportunistic illness within 90 days of HIV diagnosis

Activity 1C.4: Explore the use of client incentives to maintain re-screening adherence.
Strategy 1D: Increase the timeliness of HIV diagnoses from point of infection by increasing access to testing and increasing awareness of risk
Activity 1D.1: Increase integration of HIV testing/screening with other STDs and HCV
Activity 1D.2: Increase the number of STD & HIV express clinics in LAC, especially in Health Districts disproportionately impacted by HIV
Activity 1D.3: Increase community awareness of HIV testing options through advertising and promotional events in multiple languages
Activity 1D.4: Work with SAPC to ensure that all syringe service programs (SSPs) provide integrated testing/screening (HIV, STDs, HCV) and linkage to care
Activity 1D.5: Explore utilizing a Promotores/Community Health Worker model to increase sexual health literacy and awareness of HIV risk in priority populations
Activity 1D.6: Increase the capacity of Partner Services and Cluster Detection and Response to quickly identify and contact people who may be at risk of HIV/STD/HCV and direct them to testing services (see Respond Pillar activities)
Key Partners: FQHCs & Community Health Centers, Emergency Departments, HIV & STD testing providers, HIV prevention providers, private providers, academic medical provider training programs including colleges and universities, LAC Dept. of Health Services (DHS), LAC Dept. of Mental Health (DMH), LAC Sherriff's Department, homeless service providers, City of Long Beach and City of Pasadena Health Departments, LAC DPH Substance Abuse Prevention and Control Program (SAPC) and other DPH programs and divisions.
Potential Funding Resources: CDC EHE Program Implementation; HRSA RWP Part A; CDC Integrated HIV Surveillance and Prevention; State OA HIV Surveillance; SAPC Non-Drug Medi-Cal; EHE funding to FQHCs, Academic Institutions/Research, and AIDS Education and Training Centers
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 • Improved timeliness between HIV infection and diagnosis
Monitoring Data Source: DHSP HIV Surveillance (eHARS)
Expected Impact on HIV Care Continuum: Increase the percentage of PLWH who know their HIV status by 6% (89% to 95%).
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☐ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

Pillar II: Treat

Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression
Objectives: 1. By 2025, increase the proportion of people diagnosed with HIV who are linked to HIV care[63] within one month of diagnosis from 76% to 95%. 2. By 2026, increase the proportion of people diagnosed with HIV who are linked to care within 7 days from 54% (2020) to 65%. 3. By 2025, increase the proportion of PLWDH who are virally suppressed from 61% 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
Activity 2B.1: Expand the use and capacity of peer navigators and/or community health workers for PLWH to increase health literacy, access services and address social determinants of health (housing, food insecurity, etc.)
Activity 2B.2: Increase knowledge & awareness among both providers & community members about long acting injectables and other biomedical advances
Activity 2B.3: Create and distribute list of clinical providers of color and LGBTQ culturally competent providers
Activity 2B.4: Create and expand medical and supportive services for cisgender women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare, and substance abuse
Activity 2B.5: Create and expand medical and supportive services for transgender persons living with HIV/AIDS
Activity 2B.6: 2B.6: Advocate for appropriate allocation and maintenance of funding for the Trans, Gender Nonconforming and Intersex (TGI) Equity Fund created by the passage of AB-2521
Strategy 2C: 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, persons with substance use disorders, and unhoused persons.
Activity 2C.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 2C.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 2C.3: 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.

[63] Linked to HIV care is defined as ≥ 1 CD4/VL/Genotype test reported

Activity 2C.4: Leverage and monitor CalAIM to ensure their programs are appropriate and effective for PLWH
Activity 2C.5: Develop transitional case management programs that help PLWH transition from Ryan White Program into Medi-Cal, Medicare and CalAIM, and develop case management services that can monitor if care and support services are meeting the needs of PLWH post-transition.
Activity 2C.6: Expand the use of street medicine for unhoused PLWH and at-risk for HIV
Strategy 2D: 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 2D.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 2E: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH
Activity 2E.1: Determine processes and program operations for housing assistance that are aligned with federal funding guidance and restrictions
Activity 2E.2: Identify potential housing partners positioned to serve PLWH and implement an expanded housing program.
Strategy 2F: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH
Activity 2F.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 2F.2: Identify potential clinical sites, train staff on pilot processes, and implement program
Activity 2F.3: Develop a robust evaluation plan to determine continued use of financial incentives and potential for expansion to other populations
Strategy 2G: RFP: EHE Priority Populations Interventions
Activity 2G.1: Develop and release RFP to fund 7-10 contracts for identified interventions
Strategy 2H: Expand capacity to provide whole-person care to PLWH who are age 50 and older and long-term survivors[59]
Activity 2H.1: Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services[64]
Activity 2H.2: Identify and implement best practices related to addressing psychosocial and behavioral health needs of older PLWH and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation[59]
Activity 2H.3: Review/update diagnostic screenings to include age-related conditions (i.e. screen for loneliness, ACEs, depression, anxiety, experiences of discrimination), using LA County Commission on HIV's Aging Task Force recommendations as a guide
Activity 2H.4: Screen patients for comprehensive benefits analysis and financial screening; and assess access to caregiving support

[64] Adapted from the NHAS, 2022-2025

Activity 2H.5: Review Home-Based Case Management service standards for alignment with OT and PT assessments
Key Partners: RWP-supported HIV service providers, HIV medical providers outside of RWP network, FQHCs and Community Health Centers, HIV and STD Testing Providers, HOPWA, CA Dept. of Healthcare Services; LAC DHS Housing for Health program, LAC Homeless Services Authority (LAHSA), additional housing and homeless service providers, immigrant rights groups, public and private health plans, LAC DMH, LAC DHS, and City of Long Beach and City of Pasadena Health Departments.
Potential Funding Resources: HRSA EHE; HRSA CARES; HRSA RWP Part A; HRSA RWP Part B; HRSA RWP Minority AIDS Initiative; CDC Medical Monitoring Project; EHE funding to FQHCs, Academic Institutions/Research, and AIDS Education and Training Centers.
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 capacity to serve PLWH 50 and older and long-term survivors • Increased utilization of RWP core services among PLWH • Increase viral suppression among PLWH
Monitoring Data Source: HIV Casewatch, DHSP HIV Surveillance (eHARS), Medical Monitoring Project (MMP)
Expected Impact on HIV Care Continuum: Increase the percentage of PLWDH who are linked to HIV care within 90 days by 19% & and who are linked to HIV care within 7 days by 11%. Increase viral suppression rate by 34% (from 61% to 95%).
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☐ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

Pillar III: Prevent

Goal: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs)
Objectives: 1. By 2025, increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50%, from a 2022 baseline of 39%. 2. By 2025, increase the proportion of Black/African American persons prescribed PrEP with an indication for PrEP to at least 50%, from a 2022 baseline of 25%. 3. By 2025, increase the proportion of Latinx persons prescribed PrEP with an indication for PrEP to at least 50%, from a 2022 baseline of 38%. 4. By 2026, increase the percentage of EOPs and SSPs that provide HIV/STD testing and HCV screening from 20% to 80%.
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; and promoting recent innovations
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 DHSP-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, how to access PrEP/PEP under SB 159,[65] 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.
Activity 3A.6: Finalize PrEP campaigns for Black/African American MSM, transwomen and cisgender women, per the LA County Commission on HIV's Black/African American Community Task Force's Recommendations.
Activity 3A.7: Increase knowledge & awareness among both providers & community members about long acting injectables and other biomedical advances (See 2.B.2).
Activity 3A.8: Help build the capacity of pharmacies to prescribe PrEP/PEP and create a directory of pharmacies that have capacity to prescribe PrEP/PEP under SB159, potentially to be integrated into the GetPrEPLA website.
Activity 3A.9: Develop a public health detailing campaign to expand the number of oral PrEP prescribers in LAC.

[65] SB 159 authorizes pharmacists to furnish PrEP and PEP without a physician prescription and prohibits insurance companies from requiring prior authorizations in order to obtain PrEP coverage.

Strategy 3B: Increase availability, use, and access to comprehensive syringe services programs (SSPs) and other harm reduction services.
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 HIV self-test kits).
Activity 3B.3: Distribute information about the efficacy of SSPs to increase the health literacy of HIV providers and community members
Activity 3B.4: Destigmatize syringe services/needle exchange and further integrate SSP providers into HIV-related work
Activity 3B.5: Promote safe consumption/injection sites
Key Partners: FQHCs and Community Health Centers, PrEP Centers of Excellence, HIV and STD Testing Providers, LAC STD clinics, LAC SAPC; 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.
Potential Funding Resources: CDC EHE Program Implementation; HRSA RWP Part A; HRSA RWP Part B; HRSA RWP Minority AIDS Initiative; CDC National HIV Behavioral Survey & TG Supplement; CDC Integrated HIV Surveillance and Prevention; State OA HIV Surveillance; SAPC Non-Drug Medi-Cal; County/City of LA SSP Funding; EHE funding to FQHCs, Academic Institutions/Research, and AIDS Education and Training Centers.
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.
Expected Impact on HIV Care Continuum: Increase the percentage of people with an indication for PrEP who access PrEP by 11%.
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☐ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☐ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

Pillar IV: Respond

Goal: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them
Objectives: 1. By 2026, provide/disseminate at least 5 educational trainings/workshops or educational materials to increase awareness/knowledge related to cluster and outbreak detection and response 2. By 2025, increase the total proportion of persons newly diagnosed with HIV who are assigned for Partner Services (PS) to 95% from a 2021 baseline of 73% 3. By 2025, increase the total proportion of persons newly diagnosed with HIV who are interviewed for PS to 75% from a 2021 baseline of 46%
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.
Activity 4A.4: Educate HIV providers about the use and effectiveness of cluster detection
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 DHSP 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.
Activity 4B.3: Educate HIV providers about the use and effectiveness of Partner Services
Activity 4B.4: Explore increased use of community-embedded Partner Services
Strategy 4C: Data to Care RFP
Activity 4C.1: Develop and release RFP to fund up to 5 contracts for Data to Care activities.
Key Partners: California Office of AIDS, City of Long Beach and City of Pasadena Health Departments, HIV and STD Service Providers; CBA
Potential Funding Resources: HRSA EHE; CDC Integrated HIV Surveillance and Prevention; EHE funding to Academic Institutions/Research
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
Expected Impact on HIV Care Continuum: Increase the number of people in networks affected by rapid transmission who know their HIV status, are linked to HIV medical care, and who are virally suppressed, and/or who are engaged in appropriate prevention services.
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☐ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

Workforce Capacity

Goal: Increase the capacity of the HIV workforce to diagnose and treat PLWH, prevent new HIV infections and reduce HIV-related disparities
Objectives: 1. By 2024, conduct a comprehensive assessment of the HIV workforce identifying strengths, needs and potential solutions, including an assessment of the true costs of services and how those services might the financed. 2. By 2026, implement training, technical assistance and necessary policy changes to increase workforce capacity as outlined in assessment findings and guided by the strategies below.
Strategy 5A: Increase the diversity and capacity of the workforce that delivers HIV prevention, care and supportive services to optimally reflect and serve the populations most impacted by HIV
Activity 5A.1: Conduct an assessment of Black/African American led agencies providing HIV services to identify training/technical assistance (TA) needs
Activity 5A.2: Provide TA and/or training for Black/African American led agencies to provide a more equitable playing field to successfully compete for solicitations, based on assessment findings
Activity 5A.3: Increase inclusion of peers/paraprofessionals in the workforce through training, mentorship, certification, supervision, reimbursement, and team functioning to assist with HIV, STD, HCV, and mental health and SUD service provision[59]
Activity 5A.4: Develop inventory of both formal and informal pipeline programs to prepare workers to work in the HIV/health field
Activity 5A.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations[59]

Activity 5A.6: Based on results of workforce capacity assessment, review and revise service standards as necessary
Activity 5A.7: Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV
Strategy 5B: Ensure that the workforce is adequately prepared to deliver high-quality services in a culturally responsive manner
Activity 5B.1: Include harm reduction principles and the provision of trauma-informed care across provider trainings
Activity 5B.2: Provide gerontology training to Ambulatory Outpatient Medical, Oral Health, Medical Care Coordination and Mental Health services providers to improve awareness and understanding of age-related inequities in care and treatment
Activity 5B.3: Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or who experience risk for HIV, including LGBTQI+ people, immigrants, people who use drugs, and people involved in sex work[59]
Activity 5B.4: Identify and make available succession planning and leadership development trainings/programs
Key Partners: AETC; CBAs; FQHCs and Community Health Centers, HIV and STD Testing Providers, HIV prevention providers, private providers, academic medical provider training programs including colleges and universities, LAC DHS, LAC DMH, LAC SAPC.
Potential Funding Resources: CDC, HRSA, SAMHSA
Outcomes: • Increased capacity to provide culturally responsive services to PLWH and people at-risk for HIV
Expected Impact on HIV Care Continuum: Increased number of PLWH who know their status; Increased number of PLWDH that are linked to care within 30 days, retained in care and virally suppressed.
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☒ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

System and Service Integration

Goal: Integrate systems and services to address the syndemic of HIV, STDs, viral hepatitis, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence[59]
Objectives: 1. By 2026, the LA County Division of HIV and STD Programs (DHSP) and/or the Commission on HIV (COH) will implement at least three internal (within LAC system) efforts to advance system and service integration 2. By 2026, DHSP and/or the COH will implement at least three external efforts to advance system and service integration
Strategy 6A: Increase cross-training and TA opportunities across fields/disciplines
Activity 6A.1: Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs[59]
Activity 6A.2: Expand opportunities and mechanisms for information sharing and peer-to-peer technical assistance amongst HIV/STD/MH/SUD/Housing providers[59]
Activity 6A.3: Support training for housing service providers on needs of PLWH and LGBTQI persons to improve cultural competencies among staff
Activity 6A.4: Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services[59]
Activity 6A.5: Increase capacity of FQHCs that provide HIV-related services to screen for and treat HCV / Increased integration of HIV and HCV services
Strategy 6B: Leverage the Alliance of Health Integration initiative to integrate services within LA County publicly funded care systems.
Activity 6B.1: Strive to align strategic planning efforts on HIV, STIs, viral hepatitis, substance use disorders, and mental health care across national, state, and local partners[59]
Activity 6B.2: Optimize RWP, Medicaid, Medicare, and other health systems to ensure they are used in a manner to deliver the highest quality of care for PLWH.

Key Partners: RWP, Medi-Cal, Medicare, LAC Acute Communicable Disease Control (ACDC); LAC DHS, DMH, SAPC and other DPH programs
Potential Funding Resources: CDC, HRSA, SAMHSA
Outcomes: • Increased system and service integration
Expected Impact on HIV Care Continuum: Increased number of PLWH who know their status; Increased number of PLWDH that are linked to care within 30 days, retained in care and virally suppressed.
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☒ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

Equity, Social Determinants of Health and Co-Occurring Disorders

Goal: Achieve health equity by addressing social determinants of health, stigma, & co-occurring disorders that fuel the HIV epidemic and HIV disparities
Objectives: 1. By 2026, increase the number of services and programs available to address meth use disorder by at least 25% 2. By 2026, increase the availability of mental health services for PLWH and at-risk for HIV by at least 25% 3. By 2026, reduce the rates of syphilis, gonorrhea, chlamydia and HCV in LA County by at least 25% 4. By 2026, reduce the rates of syphilis, gonorrhea, chlamydia and HCV among Black/African Americans in LA County by at least 25% 5. By 2026, increase the number of evidence-based or evidence-informed practices/programs that address SDH by at least 20%.
Strategy 7A: Advocate for an effective countywide response to SUDs, especially methamphetamine disorder
Activity 7A.1: Assess providers' ability to recognize and address meth use disorder
Activity 7A.2: Advocate for services and programs associated with methamphetamine use and HIV transmission
Activity 7A.3: Expand and enhance mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.
Activity 7A.4: Support the building of community-based mental health services.
Strategy 7B: Advocate for an effective countywide response to the Sexually Transmitted Disease (STD) epidemic
Activity 7B.1: LA County Commission on HIV Public Policy Committee (PPC) will submit a letter to the Board of Supervisors (BOS) that will outline priorities/recommendations to improve the countywide STD response (based on a DPH report previously submitted to the BOS)
Activity 7B.2: The PPC will request a formal letter of support from the BOS to support the EHE budget request to the State of California
Strategy 7C: Address social determinants of health and stigma
Activity 7C.1: Create funding opportunities that specifically address social & structural drivers of health as they relate to BIPOC communities

Activity 7C.2: Implement effective, evidence-based and evidence-informed interventions that address stigma and SDHs among PLWH or at risk for HIV
Activity 7C.3: Work with communities to reframe HIV services and HIV-related messaging so that they do not stigmatize people or behaviors.[59]
Activity 7C.4: Ensure that the voices/perspectives of PLWH and people at-risk for HIV are represented in pandemic planning and response (
Activity 7C.5: Monitor and advocate for policies that support the following: • **7C.5a:** Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through redistribution of funding for policing and incarceration. • **7C.5b**: Improve systems, strategies and proposals that prevent homelessness, expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS, especially LGBTQ people • **7C.5c:** Promote family housing and emergency financial assistance as a strategy to maintain housing • **7C.5d:** Increase coordination among housing agencies to include intergenerational housing options • **7C.5e:** Blend funding to support housing and rental assistance for seniors living with HIV • **7C.5f:** Advocate for women's bodily autonomy in all areas of health care services including and not limited to full access to abortions, contraception, fertility/infertility services and family planning • **7C.5g:** Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g., Commercial Sex Work).
Strategy 7D: Identify root causes and directly call-out systematic racist practices that have adversely affected Black/African American communities.
Activity 7D.1: Standardize the collection of race-based stratified program evaluation data
Activity 7D.2: Disseminate analysis of race-based stratified data via presentations and informational materials
Activity 7D.3: Implement cultural humility training among healthcare providers
Activity 7D.4: Address social and structural barriers with evidence-based interventions
Activity 7D.5: Build the capacity of Black-led organizations (see 5A.1 and 5A.2)
Strategy 7E: Add Quality of Life (Q of L) Indicators for PLWH to the Integrated Plan by 2023
Activity 7E.1: Examine the newly released Q of L Indicators for PLWH included in NHAS 2022-2025 Implementation Plan and decide which ones are applicable to LAC
Activity 7E.2: Identify baseline data for each QoL indicator from local MMP data and determine performance metrics to be added to Integrated Plan

Key Partners: FQHCs and Community Health Centers, HIV and STD Testing Providers, HIV prevention providers, private providers, academic medical provider training programs including colleges and universities, LAC DHS, LAC DMH, homeless service providers, and City of Long Beach and City of Pasadena Health Departments, LAC SAPC; Act Now Against Meth Coalition (ANAM).
Potential Funding Resources: CDC, HRSA, SAMHSA
Outcomes: • Increase the number of services and programs available to address meth use disorder • Increase the availability of mental health services for PLWH and at-risk for HIV • Reduce the rates of syphilis, gonorrhea, chlamydia and HCV in LA County • Reduce the rates of syphilis, gonorrhea, chlamydia and HCV among Black/African Americans in LA County • Increase the number of evidence-based or evidence-informed practices/programs that address SDH
Monitoring Data Source: DHSP HIV Surveillance (eHARS)
Expected Impact on HIV Care Continuum: Increase the number of PLWH who know their HIV status; who are linked to HIV care within 90 days; who are retained in care and who are virally suppressed.
Alignment with NHAS Goals: ☒ Prevent New HIV Infections ☒ Improve HIV-Related Health Outcomes for PLWH ☒ Reduce HIV-Related Disparities & Health Inequities ☒ Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners & Interested Parties

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up Integrated Planning Approach

a. Implementation: To ensure that the Integrated Plan's goals and objectives are achieved, a detailed implementation plan has been developed which includes performance measures, responsible parties, and a timeline related to each activity (see Appendix 2). In addition to DHSP and the COH there are many key partners that will need to be engaged if the County's ambitious goals are to be reached. These partners include various departments and programs within the LAC system (e.g. DHS, DMH, SAPC, Sherriff's Department, etc.) as well as entities that are external to the LAC system (e.g. HIV service providers, academic institutions, FQHCs, AETC, CBA, HOPWA, etc.). Community members across the County, especially PLWH and people from priority populations also play a key role in the implementation and monitoring of the Integrated Plan. COH and DHSP will work together to coordinate the efforts of these partners by maintaining open lines of communication, information sharing, and closely monitoring progress towards achievement of activities.

The Integrated Plan provides guidance and direction to *all* stakeholders across the County that are invested in ending the HIV epidemic, regardless of the source(s) of funding that supports their work. Thus, the Plan's goals, objectives, strategies and activities can and should be utilized by all stakeholders to coordinate services and programs and align agency-specific plans.

b. Monitoring: The Commission on HIV, in collaboration with DHSP, will be responsible for monitoring progress towards achieving the Plan's goals and objectives. Specifically, the COH's Planning, Priorities and Allocations (PP&A) Committee will take the lead in monitoring progress, trouble-shooting barriers and leading the process for updating the Plan as needed. The COH has a dedicated staff person who will lead these efforts with PP&A. Two PP&A meetings every year will include a formal update on progress towards goals and objectives. In addition, the COH and DHSP will monitor progress yearly using the targets outlined in Table 8. This progress will be used to inform the annual update of the plan.

As noted, the Integrated Plan has been built upon the LAC EHE plan to ensure coordination and no duplication of efforts. DHSP provides regular EHE updates to the COH and also communicates EHE progress and updates through the use of a listserv. To facilitate the monitoring of both the EHE and the Integrated Plan, these activities will continue for the next five years.

c. Evaluation: To evaluate progress on the Integrated Plan's goals and objectives, the COH will carefully monitor each performance measure listed in Table 8 in addition to key data related to the SMART objectives. Analysis of the performance measures will be conducted twice per year by PP&A and findings will be presented to the Commission on HIV and community stakeholders at public meetings twice per year.

Table 8: Yearly Performance Measure

GOALS & OBJECTIVES	2022	2023	2024	2025	2026
Diagnose all people with HIV as early as possible					
Increase the percentage of PLWH who are aware of their status to 95% by 2025. **2021 Baseline: 89%**	90%	92%	94%	95%	95%
Reduce the number of undiagnosed PLWH from an estimated 6,800 to an estimated 3,067 by 2025. **2021 Baseline: 6,800**	5,867	4,934	4,001	3,067	3,067
Decrease the proportion of people newly diagnosed with HIV who are in the late stage of HIV disease at time of diagnosis from 20% to 15% by 2026. **2020 Baseline: 20%**	19%	18%	17%	16%	15%
Treat people with HIV rapidly and effectively to reach sustained viral suppression					
Increase the proportion of people diagnosed with HIV who are linked to HIV care w/in 1 month of diagnosis from 76% to 95% by 2025. **2020 Baseline: 76%**	83%	87%	91%	95%	95%
Increase the proportion of people diagnosed with HIV who are linked to care within 7 days from 54% (2020) to 65% by 2026. **2020 Baseline: 54%**	57%	59%	61%	63%	65%
Increase the proportion of diagnosed PLWH who are virally suppressed from 61% to 95% by 2025. **2021 Baseline: 61%**	66%	73%	83%	95%	95%
Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs					
Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% by 2025. **2022 Baseline: 39%**	39%	42%	46%	50%	50%
Increase the proportion of Latinx persons prescribed PrEP with an indication for PrEP to at least 50% by 2025. **2022 Baseline of 38%.**	39%	42%	46%	50%	50%
Increase the proportion of Black/African American persons prescribed PrEP with an indication for PrEP to at least 50% by 2025. **2022 Baseline of 25%.**	30%	35%	40%	45%	50%
Increase the percentage of EOPs and SSPs that provide HIV/STD testing and HCV screening to 80%. **2022 Baseline: 20%**	25%	35%	50%	75%	80%
Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them					
Provide/disseminate at least 5 educational trainings/workshops or educational materials to increase awareness/knowledge related to cluster and outbreak detection and response.	1	1	1	1	1

By 2025, increase the total proportion of persons newly diagnosed with HIV who are assigned for Partner Services (PS) to 95%. **2021 Baseline: 73%.**	77%	83%	89%	95%	95%
By 2025, increase the total proportion of persons newly diagnosed with HIV who are interviewed for PS to 75%. **2021 Baseline: 46%.**	53%	60%	67%	75%	75%
Increase the capacity of the HIV workforce to diagnose and treat PLWH, prevent new HIV infections and reduce HIV-related disparities					
By 2024, conduct a comprehensive assessment of the HIV workforce identifying strengths, needs and potential solutions, including an assessment of the true costs of services and how those services might the financed.			Assessment Completed		
By 2026, implement training, technical assistance and necessary policy changes to increase workforce capacity as outlined in assessment findings.			Activities implemented per assessment		
Integrate systems and services to address the syndemic of HIV, STDs, HCV, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence					
By 2026, the LA County Division of HIV and STD Programs (DHSP) and/or the Commission on HIV (COH) will implement at least three internal efforts to advance system and service integration		1 effort	1 effort	1 effort	
By 2026, DHSP and/or the COH will implement at least three external efforts to advance system and service integration		1 effort	1 effort	1 effort	
Achieve health equity by addressing social determinants of health, stigma, and co-occurring disorders that fuel the HIV epidemic and HIV disparities					
By 2026, increase the number of services and programs available to address meth use disorder by at least 25%	5%	10%	15%	20%	25%
By 2026, increase the availability of mental health services for PLWH and at-risk for HIV by at least 25%	5%	10%	15%	20%	25%
By 2026, reduce the rates of syphilis, gonorrhea, chlamydia and HCV in LA County by at least 25%	5%	10%	15%	20%	25%
By 2026, reduce the rates of syphilis, gonorrhea, chlamydia and HCV among Black/African Americans in LA County by at least 25%	5%	10%	15%	20%	25%
By 2026, increase the number of evidence-based or evidence-informed practices/programs that address SDH by at least 20%	5%	10%	15%	20%	20%

d. Improvement: The Integrated Plan is meant to be a working document that is responsive to emerging issues in the field and data that reflect current realities. The COH, in collaboration with DHSP, will use the most current data as they become available to monitor progress and make improvements to the plan as necessary. CDC and HRSA program officers will be informed of any issues that may require revisions and plans to make improvements/adjustments will be vetted by them. In addition, the COH and DHSP will continuously seek feedback from community stakeholders, especially PLWH and those who represent priority populations to guide any proposed revisions.

PP&A will lead the process to update the Plan. Suggestions for revisions will be discussed at the two PP&A meetings dedicated to the Plan's review. The final decisions to update the Plan will be made by the Executive Committee, full COH planning body, and DHSP.

e. Reporting and Dissemination: The Commission on HIV meets monthly, which includes an annual meeting in the fall/winter. As all meetings are open to the public, they will be one of the primary vehicles through which Commissioners and community stakeholders, including PLWH, are updated on the progress of the plan. Formal updates will be scheduled at least two times per year, which will include progress on achieving the goals and SMART objectives outlined in the Integrated Plan, noting any barriers or facilitators to implementing planned activities.

As part of the regular Commission on HIV meetings, there are often presentations from our research partners which are opportunities for additional education for Commissioners. Every year, the Commission on HIV will use a minimum of two research presentations to focus on key aspects of the plan's implementation (e.g., PrEP uptake, street medicine, etc.). Individuals attending the presentations will be asked to complete a presentation evaluation form, which will include at least one question on the information presented regarding the plan. COH staff will collate the responses from these evaluations and present to the PP&A and Executive committees for review. This feedback will inform the annual update of the plan.

In addition to these meetings, the Commission on HIV has a website which will be used for updates on the plan. The COH will post any presentation materials from the updates. They will also maintain a link to the progress report, reflecting progress towards achieving the SMART objectives outlined in the plan. This will be updated as progress is reported, twice per year. Throughout the implementation and monitoring process, the COH and DHSP will work in tandem to coordinate activities with the EHE Steering Committee and the EHE Plan.

Section VII: Letter of Concurrence

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave, 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

December 1, 2022

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:

The Los Angeles County Commission on HIV (Commission), the integrated prevention and care HIV planning council for the Los Angeles County Eligible Metropolitan Area (EMA), concurs with the following submission by the Department of Public Health, Division of HIV and STD Programs (DHSP) in response to the guidance set forth for health departments and HIV planning groups funded by the Centers for Disease Control and Prevention's (CDC's) Division of HIV/AIDS Prevention (DHAP) and Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, locally referred to as the Comprehensive HIV Plan (CHP).

The Los Angeles County Integrated HIV Prevention and Care Plan, 2022-2026 is Los Angeles County's third integrated HIV services plan. Led by the Los Angeles County Commission on HIV's Priorities, Planning and Allocations (PP&A) Committee, this plan was developed in partnership with DHSP and a vast array of community and organizational partners. The plan is developed in response to the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022 and as such presents a blueprint for HIV services along the entire spectrum of HIV prevention and care. LA County's Integrated Plan was also developed to align with the California statewide integrated plan, and The National HIV/AIDS Strategy (2022–2025), and Ending the HIV Epidemic Plan for Los Angeles County, 2020-2025 (EHE Plan). The Commission concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements described in the CDC/HRSA Integrated HIV Prevention and Care Plan Guidance.

The Commission has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA and affirms that it enumerates the populations most impacted by HIV, describes co-occurring conditions and social determinants that drive the HIV epidemic, and articulates local objectives and activities that align with the overarching goals of the National HIV/AIDS Strategy and the Ending the HIV

Epidemic federal initiative.

To develop the plan, planning steps were integrated into the overall work of the Commission. Integrated planning began in July of 2021 with a presentation at the Commission on HIV monthly meeting. Between July 2021 and November 2022, diverse community stakeholders were engaged in plan development through individual consultations, online surveys, focus groups, and various meetings with Commission subgroups and community coalitions such as the Service Provider Network meetings and the Long Beach HIV Planning Group, to name a few. In addition, the plan underwent a public comment period to harness feedback from the community at large. Moving forward, the tracking and monitoring of the plan will be led by the PP&A Committee, with an annual report developed to highlight successes and challenges.

We appreciate this opportunity to express our concurrence with the local planning efforts and activities and we look forward to continued collaboration to end the HIV epidemic.

Sincerely,

Bridget Gordon
Bridget Gordon, Co-Chair

Danielle Campbell
Danielle Campbell, Co-Chair

Luckie Alexander Fuller
Luckie Alexander Fuller, Co-Chair Elect

Appendix 1: CY 2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section I: Executive Summary of Integrated Plan and SCSN	*Purpose:* To provide a description of the Integrated Plan, including the SCSN and the approach the jurisdiction used to prepare and package requirements for submission Tips for meeting this requirement 1. Be sure to write the summary with enough detail to ensure the reader understands how you have met Integrated Plan requirements. 2. If you are using a combination of new and existing materials, be sure to describe how submitted materials relate to each other.		
1. Executive Summary of Integrated Plan and SCSN	Provide an overall description of the Integrated Plan, including the SCSN, and the extent to which previous/other plans/SCSNs inform this plan/SCSN, or provide an overall description of an existing plan/SCSN that meets all requirements and includes the information below.	New material submitted	

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Approach	Describe approach to preparing the Integrated Plan submission (e.g., updated previously submitted plan, integrated sections of existing plans or other documents, developed an entirely new plan, etc.).	New material submitted	
b. Documents submitted to meet requirements	List and describe all documents used to meet submission requirements, including existing materials and newly developed materials used for each requirement.	New material submitted	2
Section II: Community Engagement and Planning Process	*Purpose:* To describe how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. Review of the HIV National Strategic Plan and the updated HIV strategy, when released. 2. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. 3. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The community engagement process should reflect the local demographics. 5. The planning process should include key stakeholders and broad-based communities that include but are not limited to: people with HIV, funded-service providers, and stakeholders, especially new stakeholders, from disproportionately affected communities. See *Appendix 3* for required and suggested examples of stakeholders to be included. 6. Explain how the jurisdiction will build collaborations among systems of prevention and care relevant to HIV in the jurisdictions (e.g., behavioral health and housing services). 7. Include community engagement related to "Respond" and support of cluster detection activities.		
1. Jurisdiction Planning Process	Describe how your jurisdiction approached the planning process. Include in your description the steps used in the planning process, the groups involved in implementing the needs assessment and/or developing planning goals and how the jurisdiction incorporated data sources in the process. Describe how planning included representation from the priority populations. This may include sections from other plans such as the EHE plan. Please be sure to address the items below in your description	New material submitted	2

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Entities involved in process	List and describe the types of entities involved in the planning process. Be sure to include CDC and HRSA-funded programs, new stakeholders (e.g., new partner organizations, people with HIV), as well as other entities such as HOPWA-funded housing service providers or the state Medicaid agency that met as part of the process. See *Appendix 3* for list of required and suggested stakeholders	New material submitted	6
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state-only plans)	Describe the role of the RWHAP Part A Planning Council(s)/Planning Body(s) in developing the Integrated Plan.	New material submitted	6
c. Role of Planning Bodies and Other Entities	Describe the role of CDC Prevention Program and RWHAP Part B planning bodies, HIV prevention and care integrated planning body, and any other community members or entities who contributed to developing the Integrated Plan. If the state/territory or jurisdiction has separate prevention and care planning bodies, describe how these planning bodies collaborated to develop the Integrated Plan. Describe how the jurisdiction collaborated with EHE planning bodies. Provide documentation of the type of engagement occurred. EHE planning may be submitted as long as it includes updates that describe ongoing activities.	New material submitted	6

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
d. Collaboration with RWHAP Parts – SCSN requirement	Describe how the jurisdiction incorporated RWHAP Parts A-D providers and Part F recipients across the jurisdiction into the planning process. In the case of a RWHAP Part A or Part B only plan, indicate how the planning body incorporated or aligned with other Integrated Plans in the jurisdiction to avoid duplication and gaps in the service delivery system.	New material submitted	7
e. Engagement of people with HIV – SCSN requirement	Describe how the jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives. Describe how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan.	New material submitted	7
f. Priorities	List key priorities that arose out of the planning and community engagement process.	New material submitted	7
g. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. How the jurisdiction uses annual needs assessment data to adjust priorities. 2. How the jurisdiction incorporates the ongoing feedback of people with HIV and stakeholders. 3. Any changes to the plan as a result of updates assessments and community input. 4. Any changes made to the planning process as a result of evaluating the planning process.	New material submitted	8

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
Section III: Contributing Data Sets and Assessments	*Purpose:* To analyze the qualitative and quantitative data used by the jurisdiction to describe how HIV impacts the jurisdiction; to determine the services needed by clients to access and maintain HIV prevention, care and treatment services; to identify barriers for clients accessing those services; and to assess gaps in the service delivery system. This section fulfills several legislative requirements including: 1. SCSN 2. RWHAP Part A and B planning requirements including those requiring feedback from key stakeholders and people with HIV 3. CDC planning requirements Tips for meeting this requirement 1. This requirement may include submission of portions of other submitted plans including the EHE plan submitted as a deliverable for PS19-1906. *Please ensure that if using a previously developed plan that the data included describes the entire jurisdiction and not just a subsection of the jurisdiction such as an EHE priority county*. 2. Be sure to provide adequate detail to confirm compliance with legislative and programmatic planning requirements. 3. Include both narrative and graphic depictions of the HIV-related health disparities in the area including information about HIV outbreaks and clusters.		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	4. The data used in this section should inform both the situational analysis and the goals established by the jurisdiction. 5. *Appendix 4* includes suggested data resources to assist with this submission including the Epidemiologic Snapshot.		
1. Data Sharing and Use	Provide an overview of data available to the jurisdiction and how data were used to support planning. Identify with whom the jurisdiction has data sharing agreements and for what purpose.	New material submitted	8
2. Epidemiologic Snapshot	Provide a snapshot summary of the most current epidemiologic profile for the jurisdiction which uses the most current available data (trends for most recent 5 years). The snapshot should highlight key descriptors of people diagnosed with HIV and at-risk for exposure to HIV in the jurisdiction using both narrative and graphic depictions. Provide specifics related to the number of individuals with HIV who do not know their HIV status, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons with newly diagnosed HIV, all people with diagnosed HIV, and persons at-risk for exposure to HIV. This snapshot should also describe any HIV clusters identified and outline key characteristics of clusters and cases	New material submitted	9

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	linked to these clusters. Priority populations for prevention and care should be highlighted and align with those of the HIV National Strategic Plan. Be sure to use the HIV care continuum in your graphic depiction showing burden of HIV in the jurisdiction.	New material submitted	

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
3. HIV Prevention, Care and Treatment Resource Inventory	Create an HIV Prevention, Care and Treatment Resource Inventory. The Inventory may include a table and/or narrative but must address **all** of the following information in order to be responsive: • Organizations and agencies providing HIV care and prevention services in the jurisdiction. • HRSA (must include all RWHAP parts) and CDC funding sources. • Leveraged public and private funding sources, such as those through HRSA's Community Health Center Program, HUD's HOPWA program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration programs, and foundation funding. • Describe the jurisdiction's strategy for coordinating the provision of substance use prevention and treatment services (including programs that provide these services) with HIV prevention and care services. • Services and activities provided by these organizations in the jurisdiction and if applicable, which priority population the agency serves. • Describe how services will maximize the quality of health and support services available to people at-risk for or with HIV.	New material submitted	33

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
a. Strengths and Gaps	Please describe strengths and gaps in the HIV prevention, care and treatment inventory for the jurisdictions. This analysis should include areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts.	New material submitted	38
b. Approaches and partnerships	Please describe the approaches the jurisdiction used to complete the HIV prevention, care and treatment inventory. Be sure to include partners, especially new partners, used to assess service capacity in the area.	New material submitted	38

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
4. Needs Assessment	Identify and describe all needs assessment activities or other activities/data/information used to inform goals and objectives in this submission. Include a summary of needs assessment data including: 1. Services people need to access HIV testing, as well as the following status neutral services needed after testing: a. Services people at-risk for HIV need to stay HIV negative (e.g., PrEP, Syringe Services Programs) – Needs b. Services people need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis - Needs 2. Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression – Needs 3. Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service – Accessibility	New material submitted	46
a. Priorities	List the key priorities arising from the needs assessment process.	New material submitted	68

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
b. Actions Taken	List any key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process.	New material submitted	68
c. Approach	Please describe the approach the jurisdiction used to complete the needs assessment. Be sure to include how the jurisdiction incorporated people with HIV in the process and how the jurisdiction included entities listed in *Appendix 3*.	New material submitted	69
Section IV: Situational Analysis	Purpose: To provide an overview of strengths, challenges, and identified needs with respect to several key aspects of HIV prevention and care activities. This snapshot should synthesize information from the Community Engagement and Planning Process in Section II and the Contributing Data sets and Assessments detailed in Section III. Tips 1. New or existing material may be used; however, existing material will need to be updated if used. 2. This section not only provides a snapshot of the data and environment for goal-setting but meets the RWHAP legislative requirement for the SCSN. 3. Jurisdictions may submit the Situational Analysis submitted as part of their EHE Plan to fulfill this requirement. *However, it must include information for the entire HIV prevention and care system and not just the EHE priority area or service system.* If using EHE plans to fulfill this		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	requirement, be sure to include updates as noted below.		
1. Situational Analysis	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, provide a short overview of strengths, challenges, and identified needs with respect to HIV prevention and care. Include any analysis of structural and systemic issues impacting populations disproportionately affected by HIV and resulting in health disparities. The content of the analysis should lay the groundwork for proposed strategies submitted in the Integrated Plan's goals and objective sections. The situational analysis should include an analysis in each of the following areas: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them	New material submitted	71

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	Please note jurisdictions may submit other plans to satisfy this requirement, if applicable to the entire HIV prevention and care service system across the jurisdiction.		
a. Priority Populations	Based on the Community Engagement and Planning Process in Section II and the Contributing Data Sets and Assessments detailed in Section III, describe how the goals and objectives address the needs of priority populations for the jurisdiction.	New material submitted	81
Section V: **2022-2026 Goals and Objectives**	*Purpose:* To detail goals and objectives for the next 5 years. Goals and objectives should reflect strategies that ensure a unified, coordinated approach for all HIV prevention and care funding. Tips for meeting this requirement: 2. *Recipients may submit plans (e.g., EHE, Getting to Zero, Cluster and Outbreak Detection and Response plan) for this requirement as long as it sets goals for the entire HIV prevention and care delivery system and geographic area.* 3. Goals and objectives should be in SMART format and structured to include strategies that accomplish the following: a. Diagnose all people with HIV as early as possible b. Treat people with HIV rapidly and effectively to reach sustained viral suppression c. Prevent new HIV transmissions by using proven interventions, including pre-exposure		

Requirement	Requirement Detail	Please indicate whether the jurisdiction created new material and/or the Title/File Name of any existing material attached to meet requirement	Page(s) Where Requirement is Addressed
	prophylaxis (PrEP), post-exposure prophylaxis (PEP) and syringe services programs (SSPs) d. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them. 4. The plan should include goals that address both HIV prevention and care needs and health equity.		
1. Goals and Objectives Description	List and describe goals and objectives for how the jurisdiction will diagnose, treat, prevent and respond to HIV. Be sure the goals address any barriers or needs identified during the planning process. There should be at least 3 goals and objectives for each of these four areas. See *Appendix 2* for suggested format for Goals and Objectives. *Please note jurisdictions may submit other plans to satisfy this requirement as long as they include goals that cover the entire HIV prevention and care service delivery system and geographic area.*	New material submitted	82
a. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe any changes made as a result of analysis of data.		N/A

Section VI: **2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up**	*Purpose:* To describe the infrastructure, procedures, systems, and/or tools that will be used to support the key phases of integrated planning. In this section jurisdictions will detail how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: 1. Implementation 2. Monitoring 3. Evaluation 4. Improvement 5. Reporting and Dissemination Tips for meeting this requirement 1. This requirement may require the recipient to create some new material or expand upon existing materials. 2. Include sufficient descriptive detail for each of the 5 key phases to ensure that all entities understand their roles and responsibilities, and concur with the process. 3. If you are submitting portions of a different jurisdictional plan to meet this requirement, you should include updates that describe steps the jurisdiction has taken to accomplish each of the 5 phases.		
1. 2022-2026 Integrated Planning Implementation Approach	1. Describe the infrastructure, procedures, systems or tools that will be used to support the 5 key phases of integrated planning to ensure goals and objectives are met	New material submitted	97

a. Implementation	2. Describe the process for coordinating partners, including new partners, people with HIV, people at high risk for exposure to HIV, and providers and administrators from different funding streams, to meet the jurisdictions Integrated Plan goals and objectives. Include information about how the plan will influence the way the jurisdiction leverages and coordinates funding streams including but not limited to HAB and CDC funding.	New material submitted	97
b. Monitoring	3. Describe the process to be used for monitoring progress on the Integrated Plan goals and objectives. This should include information about how the jurisdiction will coordinate different stakeholders and different funding streams to implement plan goals. If multiple plans exist in the state (e.g., city-only Integrated Plans, state-only Integrated Plans), include information about how the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision. Be sure to include details such as specific coordination activities and timelines for coordination. *Note: Recipients will be asked to provide updates to both CDC and HRSA as part of routine monitoring of all awards.*	New material submitted	97
c. Evaluation	4. Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.	New material submitted	97

d. Improvement	5. Describe how the jurisdiction will continue to use data and community input to make revisions and improvements to the plan. Be sure to include how often the jurisdiction will make revisions and how those decisions will be made.	New material submitted	100
e. Reporting and Dissemination	6. Describe the process for informing stakeholders, including people with HIV, about progress on implementation, monitoring, evaluation and improvements made to the plan.	New material submitted	100
f. Updates to Other Strategic Plans Used to Meet Requirements	If the jurisdiction is using portions of another local strategic plan to satisfy this requirement, please describe: 1. Steps the jurisdiction has already taken to implement, monitor, evaluate, improve, and report/disseminate plan activities. 2. Achievements and challenges in implementing the plan. Include how the jurisdiction plans to resolve challenges and replicate successes. 3. Revisions made based on work completed.	New material submitted	100
Section VII: Letters of Concurrence	Provide letters of concurrence or concurrence with reservation. Each letter should specify how the planning body was involved in the Integrated Plan development. Include a letter of concurrence for each planning body in the state/territory or jurisdiction. See *Appendix 6* for a sample Letter of Concurrence.		101
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)		New material submitted	101
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)		New material submitted	101

3. RWHAP Part B Planning Body Chair or Representative		N/A	
4. Integrated Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.	N/A	
5. EHE Planning Body	If submitting an EHE plan, please ensure that the EHE planning body concurs.	N/A	

Appendix 2: Implementation Plan

Pillar I: Diagnose

Goal: Diagnose all people with HIV as early as possible

Objectives:

1. By 2025, increase the percentage of PLWH who are aware of their status to 95%, from a baseline of 89%.
2. By 2025, reduce the number of undiagnosed PLWH from an estimated 6,800 to an estimated 3,067.[66]
3. By 2026, decrease the proportion of people newly diagnosed with HIV who are in the late stage[67] of HIV disease at time of diagnosis from 20% to 15%.

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	Responsible Party	Performance Measure	Timeframe
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.	DHSP	Written report/ documentation	By 2023
1A.2: Expand the number of emergency departments and community health centers in high prevalence communities performing routine opt-out HIV screening.	DHSP; EDs; FQHCs	Number of EDs and CHC's performing routine opt-out HIV screening	By 2026
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.	DHSP	Written report/ documentation	By 2023

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

Activity	Responsible Party	Performance Measure	Timeframe
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.	DHSP	Written report/ documentation	By 2023
1B.2: Develop guidance on HIV self-testing, including linkage to care and prevention services, a quality assurance protocol, and assess readiness of	DHSP	Written guidance	By 2023

[66] Estimated based on 59,400 PLWH in 2021 and assuming 4,450 new infections and 2,500 deaths by 2025 = ~61,350 x 5% = 3,067 Undiagnosed PLWH in 2025

[67] Late stage is Stage 3 HIV disease, the criteria being either CD4 < 200 cells/µL within 90 days of HIV diagnosis or a diagnosis of an opportunistic illness within 90 days of HIV diagnosis

providers to implement self-testing.			
1B.3: Assess Take Me Home self-testing initiative utilization, barriers & facilitators	DHSP	Written documentation	By 2023
1B.4: Expand use of HIV self-testing among at risk individuals unlikely to receive in-person HIV testing by promoting other types of self-testing (in addition to Take Me Home), as available and appropriate, to ensure equitable access.	DHSP	Report/ documentation	By 2023
Strategy 1C: Increase the rate of annual HIV re-screening among persons at elevated risk for HIV in both healthcare & non-healthcare settings. Implement technology to help providers identify clients due for HIV re-screening & increase ways of maintaining communication with clients.			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
1C.1: Develop provider-to-patient communication tools to support providers in identifying at risk clients who are due for HIV re-screening and increase systematic ways of maintaining communication with clients.	DHSP; HIV prevention providers	Number of provider-to-patient communication tools	By 2023
1C.2: Develop a plan for evaluating impact of the provider-to-patient communication tools on client re-screening.	DHSP; HIV prevention providers	Evaluation Plan	By 2023
1C.3: Expand implementation & use of provider-to-patient communication tools among LAC DHSP funded HIV prevention providers.	DHSP; HIV prevention providers	Number of HIV prevention providers using new tools	By 2024
Activity 1C.4: Explore the use of client incentives to maintain re-screening adherence.			
Strategy 1D: Increase the timeliness of HIV diagnoses from point of infection by increasing access to testing and increasing awareness of risk			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
1D.1: Increase integration of HIV testing with STD and HCV screening	DHSP	Number of CBOs/clinics that have integrated testing	By 2026
1D.2: Increase the number of STD & HIV express clinics in LA County, especially in Health Districts disproportionately impacted by HIV	DHSP; HIV clinics	Number & location of STD/HIV express clinics	2022-2026
1D.3: Increase community awareness of HIV testing options through advertising and promotional events in multiple languages	DHSP; HIV/STD testing providers	Number & type of advertisements and promotional events by languages	2022-2026
1D.4: Work with SAPC to ensure that all syringe service programs (SSPs) provide integrated testing/screening (HIV, STDs, HCV) and rapid linkage to care	DHSP; SAPC	Number of SSPs that provide integrated testing and LTC rate	2022-2026

	1D.5: Explore utilizing a Promotores/Community Health Worker model to increase sexual health literacy and awareness of HIV risk in priority populations	DHSP; COH	Documentation of efforts	By 2023
	1D.6: Increase the capacity of Partner Services and Cluster Detection and Response to quickly identify and contact people who may be at risk of HIV/STD/HCV and direct them to testing services (see Respond Pillar activities)	DHSP	Number of people reached through PS and CDR	By 2026

Pillar II: Treat

Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression			
Objectives: 1. By 2025, increase the proportion of people diagnosed with HIV who are linked to HIV care[68] within one month of diagnosis from 76% to 95%. 2. By 2026, increase the proportion of people diagnosed with HIV who are linked to care within 7 days from 54% (2020) to 65%. 3. By 2025, increase the proportion of PLWDH who are virally suppressed from 61% to 95%.			
Strategy 2A: Ensure rapid linkage to HIV care and antiretroviral therapy (ART) initiation for all persons newly diagnosed with HIV.			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
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.	DHSP - Quality Improvement Group	Number of people provided with same-day rapid LTC	By 2026
2A.2: Develop a network of HIV care providers who offer same day appointments with rapid ART disbursement.	DHSP	Established network	By 2023
Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
2B.1: Expand the use and capacity of peer navigators and/or community health workers for PLWH to increase health literacy, access services and address social determinants of health (housing, food insecurity, etc.)	DHSP; Service Providers	Number of agencies reporting increased use of PNs/CHW	By 2026
2B.2: Increase knowledge & awareness among both providers & community members about long acting injectables and other biomedical advances	AETC; DHSP; Providers	Number of trainings & educational materials	By 2026
2B.3: Create and distribute list of clinical providers of color and LGBTQ culturally competent providers	COH	Documented list	By 2023
2B.4: Create and expand medical and supportive services for cisgender women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare, and substance abuse	DHSP; COH; Providers	Number of services for cisgender women	By 2026

[68] Linked to HIV care is defined as ≥ 1 CD4/VL/Genotype test reported

2B.5: Create and expand medical and supportive services for transgender persons living with HIV/AIDS	DHSP; COH; Providers	Number of services for trans persons	By 2026
2B.6: Advocate for appropriate allocation and maintenance of funding for the Trans, Gender Nonconforming and Intersex (TGI) Equity Fund created by the passage of AB-2521	COH-Public Policy Committee & Trans Caucus	Meeting minutes	2022-2026
Strategy 2C: 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, persons with substance use disorders, and unhoused persons.			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
2C.1: Comprehensively assess unmet mental health needs of PLWH and identify gaps and areas of improvement in the mental health provider network in LAC.	DHSP; DMH	Report on Unmet Mental Health needs	By 2022
2C.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.	DHSP; SAPC	Number & type of partnerships & capacity-building efforts	2022-2026
2C.3: 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.	DHSP	Written Report	By 2023
2C.4: Leverage and monitor CalAIM to ensure their programs are appropriate and effective for PLWH	DHSP & COH	Documentation of efforts to leverage and monitor	2022-2026
2C.5: Develop transitional case management service standards that help PLWH transition from RWP into Medi-Cal, Medicare and CalAIM, and develop case management service standards that can monitor if care and support services are meeting the needs of PLWH post-transition.	COH- Aging Caucus	Documented service standards	2022-2026
2C.6: Expand the use of street medicine for unhoused PLWH and those at-risk for HIV	DHSP	Street medicine units of service	2022-2026
Strategy 2D: 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	**Responsible Party**	**Performance Measure**	**Timeframe**
2D.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	DHSP	Documentation of assessment findings	By 2023
Strategy 2E: Develop and fund a housing service portfolio that provides rental subsidies to prevent homelessness among PLWH			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**

	Activity 2E.1: Determine processes and program operations for housing assistance that are aligned with federal funding guidance and restrictions	DHSP	Written findings	By 2023
	Activity 2E.2: Identify potential housing partners positioned to serve PLWH and implement an expanded housing program.	DHSP	Number of partners identified	By 2023
Strategy 2F: Explore the impact of conditional financial incentives to increase adherence to treatment for high acuity out-of-care PLWH				
	Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
	2F.1: Develop processes and program operations for a pilot program that is acceptable to clients and is aligned with federal funding guidance and restrictions	DHSP	Written processes & program operations	By 2023
	2F.2: Identify potential clinical sites, train staff on pilot processes, and implement program	DHSP	Documentation of pilot program	By 2023
	2F.3: Develop a robust evaluation plan to determine continued use of financial incentives and potential for expansion to other populations	DHSP	Evaluation Plan	By 2023
Strategy 2G: RFP: EHE Priority Populations Interventions				
	Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
	2G.1: Develop and release RFP to fund 7-10 contracts for identified interventions	DHSP	Number of contracts	By 2023
Strategy 2H: Expand capacity to provide whole-person care to PLWH who are age 50 and older and long-term survivors[4]				
	Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
	2H.1: Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services[4]	DHSP; COH Aging Caucus	Written findings	By 2023
	2H.2: Identify and implement best practices related to addressing psychosocial and behavioral health needs of older PLWH and long-term survivors including substance use treatment, mental health treatment, and programs to decrease social isolation[4]	DHSP; research partners; providers	Identification of best practices and efforts to implement	2022-2026
	2H.3: Review/update diagnostic screenings to include age-related conditions (i.e. screen for loneliness, ACEs, depression, anxiety, experiences of	Providers; Clinics; COH Aging Caucus	Screening tools developed and utilized	By 2024

[4] Adapted from the NHAS, 2022-2025

discrimination), using Commission on HIV's Aging Task Force recommendations as a guide			
2H.4: Screen patients for comprehensive benefits analysis and financial screening; and assess access to caregiving support	Providers; Clinics; COH Aging Caucus	Screening tools developed and utilized	By 2024
2H.5: Review Home-Based Case Management service standards for alignment with OT and PT assessments	COH – SBP Committee	Documented review	By 2023

Pillar III: Prevent

Goal: Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs)

Objectives:

1. By 2025, increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50%, from a 2022 baseline of 39%.
2. By 2025, increase the proportion of Black/African American persons prescribed PrEP with an indication for PrEP to at least 50%, from a 2022 baseline of 25%.
3. By 2025, increase the proportion of Latinx persons prescribed PrEP with an indication for PrEP to at least 50%, from a 2022 baseline of 38%.
4. By 2026, increase the percentage of EOPs and SSPs that provide HIV/STD testing and HCV screening from 20% to 80%.

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; and promoting recent innovations

Activity	Responsible Party	Performance Measure	Timeframe
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.	DHSP	Report on landscape analysis	By 2023
3A.2: Implement systematic and innovative strategies at LAC DHSP-funded PrEP Centers of Excellence for enhanced client communication to promote retention in PrEP and sexual health services.	DHSP; PrEP COEs	Documentation of strategies implemented	2022-2026
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.	DHSP	Increased capacity	2022-2026
3A.4: Disseminate simple fact-based social marketing PrEP messaging to increase knowledge and awareness of PrEP, alternatives to daily PrEP, how to access PrEP/PEP under SB 159, and help combat misinformation regarding cost, access, and safety.	DHSP; PrEP COEs and providers	Number of SM tools developed and disseminated	2022-2026

3A.5: Work with local stakeholders to identify potential role for PrEP support groups/PrEP ambassadors to support new & continued PrEP use in affected communities.	DHSP; COH; PrEP COEs	Number of PrEP support groups and ambassadors	2022-2026
3A.6: Finalize PrEP campaigns for Black/African American MSM, transwomen and cisgender women, per the Commission on HIV's Black/African American Community Task Force's Recommendations.	DHSP; COH-B/AA TF	Development of PrEP campaigns	By 2023
3A.7: Increase knowledge & awareness among both providers & community members about long acting injectables & other biomedical advances (See 2.B.2)	CBA; DHSP; PrEP providers	Number of trainings, TA; educational materials	2022-2026
3A.8: Help build the capacity of pharmacies to prescribe PrEP/PEP and create a directory of pharmacies that have capacity to prescribe PrEP/PEP under SB159, potentially to be integrated into the GetPrEPLA website.	DHSP; CBAs	Number pharmacies provided with assistance	2022-2026
3A.9: Develop a public health detailing campaign to expand the number of oral PrEP prescribers in LAC.	DHSP	Number of oral PrEP providers in LAC	2023-2026
Strategy 3B: Increase availability, use, and access to comprehensive syringe services programs (SSPs) and other harm reduction services.			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
3B.1: Collaborate with the LAC SAPC Program to identify opportunities to increase the capacity of SSPs, improve the provision or linkage of SSP clients to HIV, STD and HCV prevention and treatment services, and expand the availability of contingency management services to persons with substance use disorder, including meth use.	DHSP; SAPC	Documented efforts to increase capacity of SSPs and expand contingency mngmt.	2022-2026
3B.2: Explore ideas for alternative models of prevention service delivery (e.g., vouchers which can be taken to pharmacies in exchange for clean syringes and HIV self-test kits).	DHSP; COH SAPC	Number of alternative models	2022-2026
3B.3: Distribute information about the efficacy of SSPs to increase the health literacy of HIV providers and community members	DHSP; SAPC; providers	Educational materials developed	2022-2026
3B.4: Destigmatize syringe services/needle exchange and further integrate SSP providers into HIV-related work	DHSP; SAPC; providers	Documented efforts	2022-2026
3B.5: Promote safe consumption/injection sites	DHSP; SAPC; COH; providers	Documented efforts	2022-2026

Pillar IV: Respond

Goal: Respond quickly to potential HIV outbreaks to get vital prevention and treatment services to people who need them

Objectives:

1. By 2026, provide/disseminate at least 5 educational trainings/workshops or educational materials to increase awareness/knowledge related to cluster and outbreak detection and response
2. By 2025, increase the total proportion of persons newly diagnosed with HIV who are assigned for Partner Services (PS) to 95% from a 2021 baseline of 73%
3. By 2025, increase the total proportion of persons newly diagnosed with HIV who are interviewed for PS to 75% from a 2021 baseline of 46%

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

Activity	Responsible Party	Performance Measure	Timeframe
4A.1: Develop a protocol, training materials, and standard operation plan (SOP).	DHSP	Written protocol, curricula and SOP.	By 2023
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.	DHSP	Number of community engagement efforts	2022-2026
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.	DHSP	Expansion of routine epidemiological analysis	2022-2026
4A.4: Educate HIV providers about the use and effectiveness of cluster detection	DHSP	Number of trainings/ educational materials developed	2022-2026

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	Responsible Party	Performance Measure	Timeframe
4B.1: Increase capacity of LAC DHSP to provide Partner Services to all newly diagnosed persons in LAC	DHSP	Number of PS staff; training of PS staff	2022-2026
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	DHSP	New STD surveillance system	2023
4B.3: Educate HIV providers about the use and effectiveness of Partner Services	DHSP; CBA	Number of trainings & educational materials	2022-2026

4B.4: Explore increased use of community-embedded Partner Services	DHSP	Documented efforts	2023
Strategy 4C: Data to Care RFP			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
4C.1: Develop & release RFP to fund up to 5 contracts for Data to Care activities.	DHSP	Number of contracts	By 2023

Workforce Capacity

Goal: Increase the capacity of the HIV workforce to diagnose and treat PLWH, prevent new HIV infections and reduce HIV-related disparities			
Objectives: 1. By 2024, conduct a comprehensive assessment of the HIV workforce identifying strengths, needs and potential solutions, including an assessment of the true costs of services and how those services might the financed. 2. By 2026, implement training, technical assistance and necessary policy changes to increase workforce capacity as outlined in assessment findings and guided by the strategies below.			
Strategy 5A: Increase the diversity and capacity of the workforce that delivers HIV prevention, care and supportive services to optimally reflect and serve the populations most impacted by HIV.			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
5A.1: Conduct an assessment of Black/African American led agencies providing HIV services to identify training/technical assistance (TA) needs	COH-Black/AA Task Force	Assessment report	By 2023
5A.2: Provide TA and/or training for Black/African American led agencies to provide a more equitable playing field to successfully compete for solicitations, based on assessment findings	DHSP, in collaboration w/ Black/AA TF	Number of Black/AA led agencies that receive TA/trainings	By 2023
5A.3: Increase inclusion of peer/paraprofessionals[69] in the workforce through training, mentorship, certification, supervision, reimbursement, and team functioning to assist with HIV, STD, HCV, and MH and SUD service provision[4]	DHSP, AETC, COH-SBP Committee	Increased # of peer/ paraprofessionals in the workforce.	By 2026
5A.4: Develop inventory of both formal and informal pipeline programs to prepare workers to work in the HIV/health field	AETC	Report	By 2023
5A.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly	CBOs; AETC; Universities/med. & dental schools	Number of people trained/in training	2022-2026

[69] Peer/paraprofessionals defined as people who reflect the population(s) being served (e.g. PLWH, people of color, trans persons, etc.) and who may not have formal education/licensure.

from underrepresented populations[4]			
5A.6: Based on results of workforce capacity assessment, review and revise service standards as necessary	COH-SBP Committee	Revised standards	2022-2026
5A.7: Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV	CBOs; DHSP; COH	Number of PLWH & people from priority pops in leadership positions	2022-2026

Strategy 5B: Ensure that the workforce is adequately prepared to deliver high-quality services in a culturally responsive manner

Activity	Responsible Party	Performance Measure	Timeframe
5B.1: Include harm reduction principles and the provision of trauma-informed care across provider trainings	DHSP; AETC; CBA; SAPC	Number of curricula that include harm reduction & trauma-informed care	2022-2026
5B.2: Provide gerontology training for Ambulatory Outpatient Medical, Oral Health, Medical Care Coordination and Mental Health service providers to improve awareness and understanding of age-related inequities in care and treatment	DHSP	Number of providers trained on gerontology	By 2025
5B.3: Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or who experience risk for HIV, including LGBTQI+ people, immigrants, people who use drugs, and people involved in sex work[4]	DHSP; DHS; AETC; CBA	Number of providers trained on listed topics	2022-2026
5B.4: Identify and make available succession planning and leadership development trainings/programs	AETC; CBA; DHSP; COH	Number of providers trained on topics	2022-2026

System and Service Integration

Goal: Integrate systems and services to address the syndemic of HIV, STDs, HCV, and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence[4]			
Objectives: 1. By 2026, the LA County Division of HIV and STD Programs (DHSP) and/or the Commission on HIV (COH) will implement at least three internal (within LAC system) efforts to advance system and service integration 2. By 2026, DHSP and/or the COH will implement at least three external efforts to advance system and service integration			
Strategy 6A: Increase cross-training and TA opportunities across fields/disciplines			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
6A.1: Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs[4]	DHSP; DHS; SAPC	Number of trainings provided	2022-2026
6A.2: Expand opportunities and mechanisms for information sharing and peer-to-peer technical assistance amongst HIV/STD/MH/SUD/Housing providers[4]	DHSP; COH; SAPC; DMH	Number and type of info sharing/TA	2022-2026
6A.3: Support training for housing service providers on needs of PLWH and LGBTQI persons to improve cultural competencies among staff	HOPWA; COH; DHSP; LAHSA	Number of trainings provided	2022-2026
6A.4: Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services[4]	Dept. on Aging; COH; SAPC	Number and type of service providers reached	2022-2026
6A.5: Increase the integration of HIV and HCV services including increasing the capacity of FQHCs that provide HIV-related services to screen for and treat HCV	ACDC; DHSP FQHCs	Number of integration mtgs held	2022-2026
Strategy 6B: Leverage the Alliance of Health Integration initiative to integrate services within LA County publicly funded care systems			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
6B.1: Strive to align strategic planning efforts on HIV, STIs, HCV, substance use disorders, and mental health care across national, state, and local partners[4]	COH	Number of strategic plans reviewed	2022-2026
6B.2: Optimize RWP, Medicaid, Medicare, and other health systems to ensure they are used in a manner to deliver the highest quality of care for PLWH.	DHS; DHSP	Documentation of efforts	2022-2026

Equity, Social Determinants of Health and Co-Occurring Disorders

Goal: Achieve health equity by addressing social determinants of health, stigma, and co-occurring disorders that fuel the HIV epidemic and HIV disparities

Objectives:

1. By 2026, increase the number of services and programs available to address meth use disorder by at least 25%
2. By 2026, increase the availability of mental health services for PLWH and at-risk for HIV by at least 25%
3. By 2026, reduce the rates of syphilis, gonorrhea, chlamydia and HCV in LA County by at least 25%
4. By 2026, reduce the rates of syphilis, gonorrhea, chlamydia and HCV among Black/African Americans in LA County by at least 25%
5. By 2026, increase the number of evidence-based or evidence-informed practices/programs that address SDH by at least 20%.

Strategy 7A: Advocate for an effective countywide response to SUDs, especially methamphetamine disorder

Activity	Responsible Party	Performance Measure	Timeframe
7A.1: Assess providers' ability to recognize and address meth use disorder	DHSP; SAPC	Assessment completed	By 2023
7A.2: Advocate for improved and additional services and programs associated with methamphetamine use and HIV transmission	COH; CBOs; ANAM	Documentation of efforts taken	2022-2026
7A.3: Expand and enhance mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.	DMH; DHS; DHSP; COH; CBOs	Number of mental health services available	2022-2026
7A.4: Support the building of community-based mental health services.	DMH; COH-Consumer Caucus; CBOs	Number of community-based mental health services	2022-2026

Strategy 7B: Advocate for an effective countywide response to the Sexually Transmitted Disease (STD) epidemic

Activity	Responsible Party	Performance Measure	Timeframe
7B.1: Commission on HIV Public Policy Committee (PPC) will submit a letter to the Board of Supervisors (BOS) that outlines priorities/recommendations to improve the countywide STD response (based on a DPH report previously submitted to the BOS)	COH-PPC	Submitted Letter to BOS	By 2023
7B.2: The PPC will request a formal letter of support from the BOS to support the EHE budget request to the State of California	COH-PPC	Request	By 2023

Strategy 7C: Address social determinants of health and stigma

Activity	Responsible Party	Performance Measure	Timeframe

7C.1: Create funding opportunities that specifically address social and structural drivers of health as they relate to BIPOC communities		DHSP	Number of funding opportunities that address SDH in BIPOC communities	2022-2026
7C.2: Implement effective, evidence-based and evidence-informed interventions that address stigma and SDHs among PLWH or at risk for HIV		DHSP; HIV service providers	Number of evidence-based /evidence-informed interventions implemented	2022-2026
7C.3: Work with communities to reframe HIV services and HIV-related messaging so that they do not stigmatize people or behaviors.[4]		DHPS; Providers	Documented efforts	2022-2026
7C.4: Ensure that the voices/perspectives of PLWH and people at-risk for HIV are represented in pandemic planning and response (e.g., Monkeypox messaging)		DPH	Documented efforts	2022-2026
7C.5: Monitor and advocate for policies that support the following:				
	7C.5a: Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through redistribution of funding for policing and incarceration.	COH – Public Policy Committee (PPC)	Documented efforts and PPC meeting minutes	2022-2026
	7C.5b: Improve systems, strategies and proposals that prevent homelessness, expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS, especially LGBTQ people			
	7C.5c: Promote family housing and emergency financial assistance as a strategy to maintain housing			
	7C.5d: Increase coordination among housing agencies to include intergenerational housing options			
	7C.5e: Blend funding to support housing and rental assistance for seniors living with HIV			
	7C.5f: Advocate for women's bodily autonomy in all areas of health care services including and not limited to full access to abortions, contraception, fertility/infertility services and family planning			
	7C.5g: Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g., Commercial Sex Work).			

Strategy 7D: Identify root causes and directly call-out systematic racist practices that have adversely affected Black/African American communities.			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
7D.1: Standardize the collection of race-based stratified program evaluation data	HIV service providers; DHSP	Standardized evaluation measures	2022-2026
7D.2: Disseminate analysis of race-based stratified data via presentations and informational materials	DHSP; Cities of Long Beach, Pasadena, W. Hollywood	Number of presentations/materials that include race-based analysis	2022-2026
7D.3: Implement cultural humility training among healthcare providers	DHSP; AETC	Number of trainings provided	2022-2026
7D.4: Address social and structural barriers with evidence-based interventions	DHSP; Research Partners; CBOs	Number of interventions implemented	2022-2026
7D.5: Build the capacity of Black/African American-led organizations (see 5A.1 and 5A.2)	DHSP	Number of Black/African American led agencies that access training/TA	2022-2026

Strategy 7E: Add Quality of Life (Q of L) Indicators for PLWH to the Integrated Plan by 2023			
Activity	**Responsible Party**	**Performance Measure**	**Timeframe**
7E.1: Examine the newly released Q of L Indicators for PLWH included in NHAS Implementation Plan and decide which ones are applicable to LAC	COH; DHSP	Documented efforts	2023
7E.2: Identify baseline data for each QoL indicator from local MMP data and determine performance metrics to be added to Integrated Plan	COH; DHSP	Performance measures created	2023

Appendix 3: Glossary & Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AIAN	American Indian and Alaska Native
ART	Antiretroviral therapy
COVID-19	Coronavirus Disease 2019
CDC	Centers for Disease Control and Prevention
DHSP	Division of HIV and STD Programs
EHARS	Enhanced HIV/AIDS Reporting System
EHE	Ending the HIV Epidemic
FQHC	Federally Qualified Health Center
HET	Heterosexuals at increased risk for HIV
HIV	Human Immunodeficiency Virus
HUD	U.S. Department of Housing and Urban Development
IDU	Injection drug use
LAC	Los Angeles County
MHS	Molecular HIV Surveillance
MSM	Men Who Have Sex with Men
NB	Non-Binary
NHPI	Native Hawaiian and Pacific Islander
OMB	Office of Management and Budget
PEP	Post-Exposure Prophylaxis
PLWH	Persons Living with HIV
PLWDH	Persons Living with Diagnosed HIV
PrEP	Pre-Exposure Prophylaxis
PWID	Persons who Inject Drugs
SPA	Service Planning Area
TG	Transgender Persons
US	United States
VL	Viral load

Epidemic – an increase above the usual or expected occurrence of a disease within a population

Prevalence - the total number of cases of disease existing in a population.

Incidence – total number of new infections in a given period of time (usually one year).

Diagnosed Cases – number of cases reported to DHSP or the state. This may contain reports or results that were previously reported.

Number of People Living with HIV in LA County – total number of cases in a given period of time who have HIV and have a Los Angeles County address, and who are not deceased.

Rate – the number of new cases of a disease that occur during a specified period of time in a population at risk for developing the disease. Usually calculated per 100,000 people. Rates take the size of the population into account and are used in order to make comparisons.
# of new cases during a specified period of time/# of persons who are at risk for the disease during that same period of time, multiplied by 100,000

95% confidence interval – a lower and upper range of values for a measure/variable of interest which contains the true value of the variable 95% of the time.