

Ending the HIV Epidemic in Los Angeles County

DRAFT PLAN

Public comment period: September 16 – October 16, 2020

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Introduction

The five-year federal initiative, *Ending the HIV Epidemic: A Plan for America (EHE)*¹, focuses on four key pillars in order to reach the national goal of reducing new HIV transmissions and acquisitions in the United States by 75 percent in five years and by 90 percent in ten years. The four EHE Pillars are: (1) **Diagnose** people as early as possible, (2) **Treat** people rapidly and effectively, (3) **Prevent** new HIV transmissions, and (4) **Respond** quickly to HIV outbreaks.

Through collaboration with key stakeholders and community partners, the Los Angeles County Department of Public Health's (LACDPH), Division of HIV & STD Programs, plans to implement activities that enhance the current Los Angeles County HIV portfolio, align with the four pillars, improve HIV-related health outcomes, and prevent new transmissions. EHE is built on the premise that the right data, the right tools, and the right leadership will be the drivers in achieving a generation impacted by HIV/AIDS and will require commitment, accountability, and transformational leadership across sectors.

Today, approximately 58,000 people are living with HIV in LAC and many are effectively managing their HIV with the use of antiretroviral therapy (ART) and the availability of medical and support services. For those who are undiagnosed and are not aware of their HIV-positive status, or who have been diagnosed but are experiencing challenges with achieving and maintaining viral load suppression, getting tested and/or linking to care in a timely and supportive manner will improve health outcomes and contribute to public health efforts of ending the HIV epidemic. There is a renewed energy in the fight against HIV and AIDS, and with the resources and support from the national initiative; LAC is prepared to end the HIV epidemic, once and for all.

Section I: Epidemiologic Profile

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

Epidemiological Profile – Pillar 1: Prevent

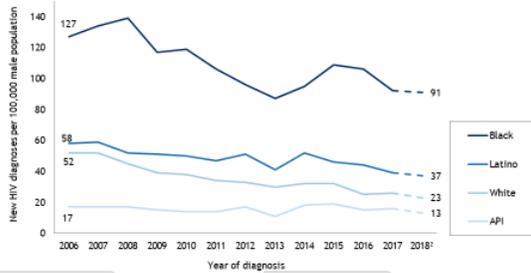
In LAC, reducing new HIV infections and improving health outcomes for people living with HIV (PLWH) remains a challenge and a priority. In 2018, 1,660 persons aged 13 years and older were newly diagnosed with HIV infection with cisgender men representing 87% of those new HIV diagnoses (N=1,445). Cisgender women (N=180, 11%) and transgender persons (N=35, 2%) represented a much lower number and proportion.² The primary mode of HIV transmission for newly diagnosed cis men was having sex with other men (MSM; 92%), followed by combination of MSM and injection drug use (IDU; 4%), and IDU alone (3%). Among cisgender women newly diagnosed with HIV the primary modes of transmission were having sex with men (75%) and IDU (25%). The percentage of persons newly

¹ <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>

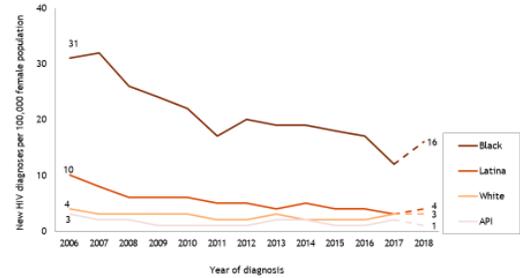
² Transgender-specific data collected has been required by CDC since May 2013, however accurate information on gender identity may not be consistently documented or reported by providers which may result in an underrepresentation or lower count of persons identifying as transgender who include transgender woman (male to female), transgender man (female to male), non-binary, and additional gender identity.

diagnosed with HIV who were unhoused at the time of diagnosis has more than doubled from 3.1% in 2010 to 7.5% in 2018. HIV diagnoses rates have also increased among persons experiencing homelessness in the past three years from 19 to 24 per 100,000. While HIV diagnoses rates have declined in general and across all racial and gender groups, key inequities persist. Black/AA cis men and cis women continue to have the highest rates of new diagnoses.³

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

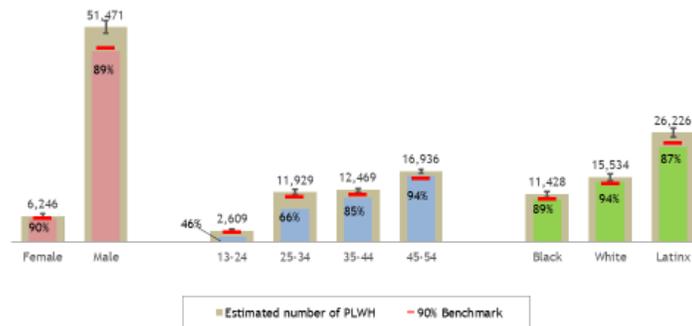


HIV diagnoses rates among females aged ≥ 13 years by race/ethnicity¹, LAC 2006-2018



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

Awareness of HIV serostatus¹ among PLWH aged ≥ 13 years by gender, age group, and race/ethnicity, LAC 2017



Diagnosis and treatment of PLWH needs to occur soon after HIV acquisition to ensure that viral suppression is achieved and sustained and to interrupt forward transmission of HIV given PLWH who maintain a suppressed viral load do not transmit HIV. While the percentage of persons presenting with AIDS, a late stage of HIV, at diagnosis in LAC has been decreasing, it has persisted at around 20%. Almost half of Latinx cisgender men (48%) and 17% of Black/AA cisgender men were diagnosed with AIDS at HIV diagnosis; compared to only 2% of White cisgender men, and 4% of Latina and Black/AA cisgender women.

Timely diagnosis requires that people at ongoing risk of HIV test regularly. Across the five Centers for Disease Control and Prevention (CDC) National HIV Behavioral Surveillance (NHBS) survey populations, the highest levels of recent HIV testing (in the past 12 months) was reported by transgender (85%) and

³ Rates for transgender persons cannot be reported due to unreliable estimates of the total population.

MSM (84%) participants. Among transgender participants, the highest levels of recent HIV testing were among Latinx (89%) and those aged 30 and younger (90%). Among MSM, 83% of Latinx, 83% Black/AA, and 90% of White MSM reported recent HIV testing. Among PWID, 55% reported recent HIV testing, with lowest levels reported among White PWID (47%). Among at-risk heterosexuals⁴, the overall level of recent HIV testing was 30% and was lowest among Latinx (27%) and cisgender men (28%).

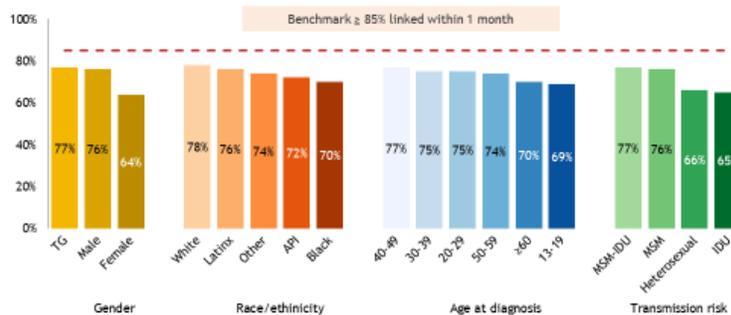
Data in Action: More work is needed to diagnose people living with HIV (PLWH) earlier or soon after HIV acquisition. Testing programs need to be scaled for groups with highest levels of undiagnosed HIV including youth between the ages of 13-34 and PWID. Latinx cisgender men are more likely to wait until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

Epidemiological Profile – Pillar 2: Treat

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

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

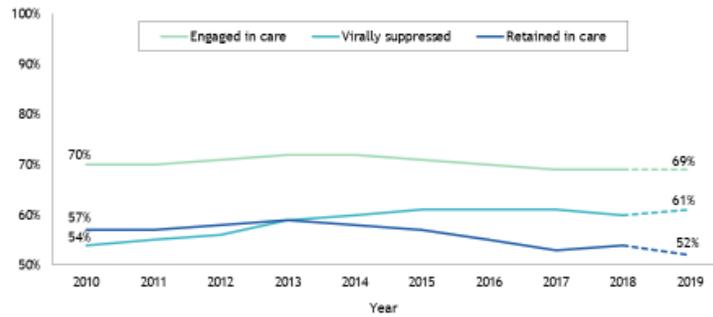
Linkage to care¹ within 1 month of HIV diagnosis among persons aged ≥ 13 years newly diagnosed with HIV by selected demographic² and risk characteristics, LAC 2018



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

⁴ As defined are persons who were born and identify as male or born as and identify as female, younger than 60 years of age, and reported vaginal or oral sex with a partner of the opposite sex in the past 12 months.

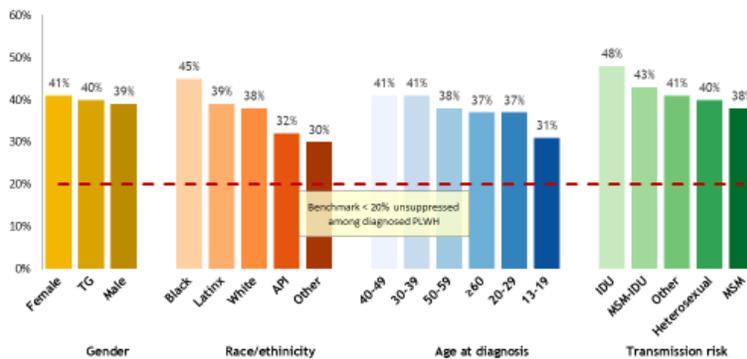
Trends in engagement, retention and viral suppression for persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019¹



People whose mode of HIV transmission was IDU had the lowest levels of engagement in care (61%), retention in care (47%), and viral suppression (52%) compared with other modes of transmission. Compared to PLWH of other race/ethnicity groups, Black/African Americans have experienced the poorest care outcomes, with the lowest levels of engagement (66%) and retention in care (48%) and viral suppression (55%). Poor outcomes persist throughout the HIV care continuum for unhoused persons compared with housed persons, with greatest disparities observed in viral suppression at 45% and 61%, respectively.

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

Unsuppressed viral load¹ by selected demographic and risk characteristics among persons aged ≥ 13 years diagnosed through 2018 and living in LAC at year-end 2019

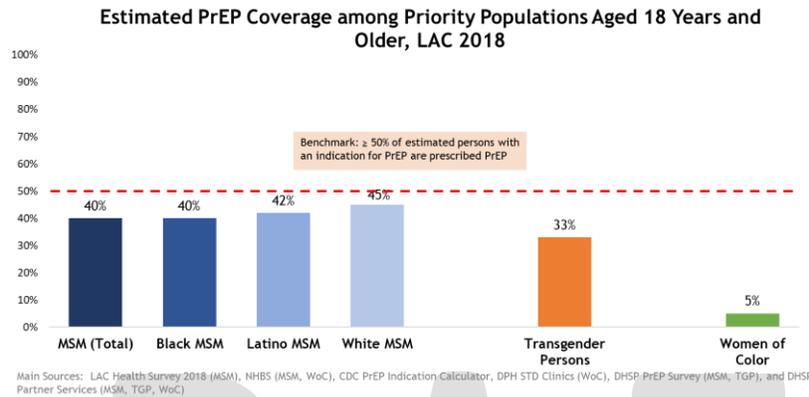


Epidemiological Profile – Pillar 3: Prevent

Ending the HIV Epidemic (EHE) Prevent Pillar focuses on preventing new HIV transmissions through proven interventions with the primary indicator to increase the proportion of persons prescribed PrEP in priority populations to at least 50%.

Pre-exposure Prophylaxis (PrEP): “PrEP coverage” is defined as the number of people aged 16 years and older prescribed PrEP divided by the number of people with an indication for PrEP, meaning that they were at elevated risk for HIV acquisition. Based on multiple data sources, an estimated 72,700 LAC residents had an indication for PrEP and approximately 25,500 had been prescribed PrEP in 2018;

representing a 35% PrEP coverage. In LAC, approximately 24% of MSM (42% of Latinx, 60% of Black/AA, and 12% White MSM), 21% of transgender persons, and 8% of cisgender women of color (WoC) had an indication for PrEP. PrEP coverage among MSM was 40% with highest coverage among White MSM (45%) followed by Latinx (42%) and Black/AA MSM (40%). PrEP coverage among transgender persons was 33% while PrEP coverage for WoC with an indication for PrEP was 5%.



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

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

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

Data in Action: Interventions to address suboptimal PrEP coverage, particularly among Black/AA MSM and cisgender women of color, are critically needed. Without intervention, increased use of injection methamphetamine and higher risk injection behaviors represent a critical and emerging outbreak risk among PWID in LAC.

Epidemiological Profile - Pillar 4: Respond

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

Data-to-Care is a data-driven approach that charges LACDPH to use HIV surveillance and other data sources to identify PLWH who are not in care, link those not in care to appropriate medical and social services, and ultimately support the HIV care continuum.⁵ Despite increased focus on direct public health interventions to improve the HIV care continuum since 2013, linkage to and engagement in HIV medical care remain suboptimal. The lowest levels of linkage to care within one month of diagnosis was among cisgender women, Black/African Americans, and PWID newly diagnosed with HIV in 2018. At the end of 2019, approximate 1 in 3 PLWH had no evidence of HIV medical care in the past 12 months with the lowest levels of engagement in care among PWID (39%), Black/African Americans (34%), heterosexuals (33%), those aged 40-49 years (33%), and cisgender women (32%).

To further identify and prioritize individuals for public health interventions, the CDC has advanced two new approaches, HIV Molecular Cluster Detection and time-space cluster analyses to complement Data-to-Care activities. In 2018, LACDPH started using the CDC's new HIV TRACE program to identify priority molecular clusters, a group of 5 or more persons whose genotype is identified as being highly similar. Because the HIV virus mutates quickly over time, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission, often by people who are unaware of their HIV status or aware of their status, but are not virally suppressed. A total of 16 priority molecular clusters are currently being monitored and prioritized for public health action including 5 clusters identified by State OA and CDC that involve LAC cases. Upon investigation, approximately 25% of all cluster members were not virally suppressed and 35% had never received Partner Services. Direct intervention at the cluster-level resulted in 75% of all cluster members being contacted and offered partner services.

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

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

⁵ <https://tinyurl.com/DataToCare>

Section II: Situational Analysis & Needs Assessment

Situational Analysis & Needs Assessment - Pillar 1: Diagnose

Diagnosis of HIV is the first important step in improving an individual's health status and reducing their likelihood of transmitting HIV to others. As mentioned previously, in LAC, only 89% of PLWH know their HIV status, meaning that approximately 6,400 people who are HIV positive are unaware of their status. To increase the proportion of people living with HIV who are diagnosed to at least 95%, LACDPH, community clinics, community partners, and other private and public entities must join together to support a robust widespread HIV testing strategy in new and innovative ways. LACDPH funds community partners to conduct HIV testing in a variety of targeted, or high risk, settings: non-clinical venues that serve the target populations, community-based HIV/sexually transmitted diseases (STD) Clinics, social and sexual network testing programs, and commercial sex venues. Overall, LACDPH supports 42 HIV testing providers with annual goals to provide over 81,603 HIV tests and diagnose over 811 individuals with HIV each year. In addition, LACDPH staff directly provides HIV testing in the LAC jails and County STD Clinics.

Routine HIV Testing

Expanding routine HIV testing within emergency departments, hospitals, federally qualified health centers (FQHCs), and other clinical settings is crucial to meet the HIV testing goal related to EHE. While targeted testing often provides the highest positivity rate, implementing routine testing in health care settings is an important component to test individuals who do not recognize their HIV risk or would otherwise not request an HIV test. Routine testing is also more sustainable as it leverages insurance and other health system programs to cover the cost of testing. Unfortunately, fostering new routine HIV testing programs in healthcare settings has been difficult in Los Angeles County. Despite a variety of policy changes that allow for reimbursement for HIV screening, other non-financial barriers continue to impede acceptance of routine HIV testing such as start-up costs, the need for technical assistance and staffing, adaptation of electronic medical records, determining appropriate and feasible linkage to care plans, provider training, and a lack of in-house dedicated "champions." In LAC, fourteen FQHCs, all part of the Community Clinic Association of Los Angeles County (CCALAC), a network of FQHCs, received EHE funding to cover start-up costs and reduce barriers in routine HIV testing and prevention within their clinics.

In the past, LACDPH has conducted provider detailing, a method of reaching providers to deliver key public health messaging, on both HIV, PrEP, and syphilis in women to influence practice patterns for established community medical providers. However, identifying and reaching out to providers across the LAC is resource and time intensive. 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 educate multiple individuals at the same time. By reaching providers 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 for the span of their medical, and the training may even result in the development of 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 adequately. Among NHBS participants, 16% of MSM and 45% of PWID had not had a test in the past 12 months; fewer with ongoing HIV risk receive HIV testing every 3 or 6 months as recommended by the CDC. With a focus on providing quick and confidential testing, LACDPH funded HIV testing agencies have not historically stressed long-term HIV prevention with clients, missing an opportunity to follow-up with

clients after the initial test. 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 would represent a significant step forward in ensuring that clients who do acquire HIV receive a timely diagnosis. In addition, many clients, particularly younger individuals, prefer digital forms of communication for the ease and confidentiality they provide.

Home Test Kits

Due to the COVID-19 pandemic, use of preventive health care services has been negatively impacted, decreasing the number of HIV tests provided in both targeted and healthcare settings. Alternative approaches are necessary to promote testing for individuals at ongoing risk who may be less inclined to seek in-person services. While current FDA approved home test kits are less sensitive than other rapid tests, they do provide a low barrier method for individuals to continue to test for HIV outside of traditional brick and mortar sites. There are potential downsides with home testing. For clients who test positive, they may not connect to HIV care, and unless the client reaches out, the public health department would be limited in the ability to assist. However, the client would be aware of their serostatus, whereas they may never have gotten tested if the home test kit were not available. Early in 2020, Building Healthy Online Communities, together with the National Association of AIDS Directors (NASTAD), launched Take Me Home, a timely and innovative HIV home test kit ordering program that centralizes advertising, data collection, and test kit distribution to clients, relieving health departments from coordinating and hiring staff to conduct these tasks. LACDPH joined the program in August 2020 with a specific focus on providing home test kits to individuals who have not been tested in the last 12 months; if demand is high, LACDPH anticipates further investment in the program. Another potential use is for LACDPH targeted testing sites to offer home test kits to individuals to perform at home remotely in three months with video or phone assistance by the test counselor. However, as mentioned, given the lower sensitivity of the current home test kit, this should be reserved as a secondary option for clients who are hesitant or unable to go to the clinic or office for testing.

Situational Analysis & Needs Assessment - Pillar 2: Treat

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

Linkage to care

Since 2011, LACDPH has incentivized timely linkage to HIV medical care for its network of community 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. While this incentive structure initially produced significant improvements in initial linkage to care, performance has generally plateaued. This is likely due to a combination of client factors, such as denial or competing life demands, and structural barriers, such as onerous financial screening requirements and administrative paperwork in place before medical care is authorized. In addition, the current system does not facilitate or support the rapid initiation of antiretroviral therapy (ART), an intervention that has been shown to improve time to viral suppression. LACDPH, together with HIV prevention and medical providers, needs to restructure its approach to linkage to care and treat new HIV diagnoses with the urgency it deserves. In addition, LACDPH can utilize its position as funder to

provide technical assistance to clinics to reduce unnecessary administrative barriers for patients and improve the client experience.

Engagement in Care and Viral Suppression

In 2013, LACDPH implemented the *Medical Care Coordination (MCC)* program in Ryan White 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. Based on these findings, LACDPH expanded MCC to additional HIV clinics in 2017. 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. LRP utilizes experienced County health navigators, who have access to a wide-range of LACDPH and County data systems; these systems provide the ability to locate and follow-up with clients who are often not well served by traditional medical and support services, including those without a cell phone or who are unstably housed. When clients are ready to engage in care, LRP staff facilitate a warm hand-off to clinics, and, when available to MCC teams.

Despite these programs, for many PLWH struggling with financial concerns, housing instability, mental health diagnoses, and substance use disorders (SUD), it is still challenging to remain in care and achieve viral suppression over long periods of time. The current safety net in LAC to address these issues is fraught and complex. In general, mental health services and SUD services, particularly for low-income persons, can be difficult to navigate; at the same time, mental health services specifically designed for PLWH remain underutilized in parts of LAC. While methamphetamine is the primary drug of use for over 20% of clients admitted for SUD treatment in the LACDPH Substance Abuse Prevention and Control (SAPC) funded programs, only 47% of clients complete treatment.⁶ To truly improve the health outcomes of PLWH who have not achieved viral suppression, disruptive programming that will improve the lives of people experiencing financial hardship, homelessness, mental illness, and SUD are greatly needed. New and unconventional programming, such as conditional financial incentives, also known as contingency management, should be explored, particularly for individuals facing the most complex life circumstances.

Situational Analysis & Needs Assessment - Pillar 3: Prevent

Pre-exposure Prophylaxis (PrEP)

Increasing the number of people who take advantage of and have access to clinical preventive services, such as PrEP, continues to be a major public health challenge. Despite widely available PrEP resources and providers in LAC, fewer than a third of persons with an indication for PrEP report taking it. In California, significant progress has been made to limit PrEP associated costs as a barrier to uptake; most health insurance plans now cover most PrEP associated health care costs, with public and private programs available to cover out-of-pocket costs based on income.⁷ Unfortunately, assistance programs require eligibility screening and paperwork, which can deter some clients. Clear and direct messaging about PrEP from the appropriate community stakeholders is greatly needed to address mistrust and combat misleading information. Health care systems must adapt to make PrEP initiation and its continued use as easy as possible so that individuals with a continued indication are retained in care.

⁶ Unpublished data, LAC DPH Substance Abuse Prevention and Control.

⁷ www.PleasePrEPMe.org/payment

Mistrust of new pharmacologic interventions and medical providers in communities of color are understandable and justifiable given the history of Black Americans mistreatment as unwilling subjects of medical research and continued biases in access to and the delivery of health care services. Unsurprisingly, the uptake of PrEP among Black and Latinx MSM has consistently been lower than among Whites. Unfortunately, this is compounded by the fact that potential side effects of PrEP have received undue and misdirected attention due to advertising by those seeking product liability lawsuits against the drug manufacturer. In addition, many individuals incorrectly believe that PrEP will be too expensive and therefore inaccessible. Community organizations, medical providers, and the public health department all have a role to play to help address misinformation and mistrust. The Commission's *Black/African American (AA) Community Task Force* has recommended increasing culturally sensitive PrEP advertising designed with input from the very communities it is attempting to reach, including Black/AA youth, cisgender women, transgender individuals, and gender nonconforming populations. In addition, voices of influential individuals through social media and marketing may help destigmatize PrEP use and could potentially activate some individuals to take action. Lastly, PrEP support groups have the potential to create social support for promote PrEP initiation and retention and may be a particularly promising strategy for younger men who do not have much experience navigating the healthcare system.

For PrEP to reach all individuals in need of it, health care providers need to not only understand the basic clinical information, but, more importantly, be mindful and comfortable enough to ask patients about their sexual behaviors in an open non-judgmental manner. The LAC PrEP Centers of Excellence were funded in 2016 with the goal of creating culturally competent access points where patients can also receive PrEP specific assistance and navigation through cost and health insurance issues. Since the FDA approval of PrEP, the number of other medical providers in Los Angeles who report being a PrEP Provider has steadily increased.⁸ Unfortunately, certain geographic areas of LAC are still low in the number of PrEP providers relative to the number of individuals at risk for HIV: eastern San Gabriel Valley near Pomona, High Desert, South Los Angeles, San Fernando Valley, and Long Beach. Recently, 14 federally qualified health centers (FQHCs) in LAC were funded directly through federal Ending the HIV Epidemic efforts to expand their PrEP and HIV prevention efforts. Recent California legislation and policy changes have further expanded access points to include pharmacies and telemedicine providers.

One major concern regarding PrEP uptake is its duration of use among individuals with continued risk. Discontinuation of PrEP is likely due to multiple factors, such as pill fatigue, administrative barriers, and competing life demands. To improve PrEP retention, current PrEP providers need to 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, 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 significant step toward further minimizing the frequency and length of time for medical visits. Many clients, especially younger individuals, prefer digital forms of communication and care, yet many community health centers still lack secure technology platforms with which to easily communicate with patients. Recent studies have demonstrated that long acting injectable PrEP options are an excellent alternative to oral daily PrEP, with the additional benefit that they may be attractive for individuals with pill fatigue or those with adherence issues.

Syringe Services Programs

Historical data in LAC have shown injection drug use (IDU) to be a consistent, but less common risk factor for HIV transmission, accounting for less than 5% of HIV cases annually. However, across the United States, and more recently in Seattle-King County, IDU based outbreaks have occurred, even in

⁸ www.PleasePrEPMe.org/find-a-provider

areas where syringe support programs are available⁹. The rise of conditions that contribute to drug use, such as economic inequality, homelessness, untreated mental illness, and opioid and methamphetamine use are pervasive in LAC, making the jurisdiction susceptible to an IDU outbreak. The most recent local National Behavior Surveillance Survey (NHBS) cycle of PWID, which included younger PWID than previous cycles, revealed higher levels of risky injection practices, methamphetamine use, exchange sex, and unstable housing.

Fortunately, syringe services programs (SSPs) are legal under California law, but programs in LAC are fragmented as they are supported by both the County and the City of Los Angeles. In addition, LACDPH funded SSPs are small in scale, including only six agencies funded at low levels through the LACDPH Substance Abuse and Prevention Control Program (SAPC). Of those six agencies, only three are funded to do HIV, STD, and hepatitis C (HCV) testing. Unfortunately, there is limited data and no existing in-depth analysis of how well the LAC SSP programs are doing with regards to linking clients to testing and other HIV prevention and care resources; given their very limited budgets, it is likely there is room for investment and enhancement.

Given increased IDU HIV outbreaks nationally, the need to assess and address gaps in the LAC PWID HIV prevention landscape has become important. In 2019, the California State legislature, recognizing the importance of SSPs and the effectiveness of a comprehensive, integrated approach to care for people who inject drugs, allocated increased funding to SSPs for expanded service provision and HCV screening. As a result, DHSP, SAPC, and the LACDPH Acute Communicable Disease Control Program (ACDC) had begun preliminary work to utilize this investment and energy to expand HCV, HIV, and syphilis screening among SSP users. Unfortunately, the COVID pandemic has put tremendous strain on all three LACDPH divisions and these plans are temporarily on hold. In addition, there may be limited bandwidth for SSP organizations to incorporate additional programming and projects during the pandemic.

Situational Analysis & Needs Assessment - Pillar 4: Respond

The use of client-level data reported to the public health department to identify and target individuals for contact tracing and linkage to services has a long precedent that continues during the current COVID pandemic. For HIV prevention and outreach, the use of client data for such activities is relatively recent. For decades, national guidelines and state laws restricted access and use of individual level surveillance data on persons diagnosed with HIV in a certain jurisdiction, to traditional surveillance functions, such as generating aggregated reports to describe population-based trends among persons living with diagnosed HIV. While well intentioned in the early days of the HIV epidemic as a way to protect privacy of PLWH, these laws severely limited the ability of public health staff to use available information to work directly with people newly diagnosed with HIV to ensure they were receiving care and treatment and to offer testing to their recent partners.

We are now 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 needed, and required by federal funders, to ensure that the HIV public health response is timely and targeted for greatest impact. These activities require real-time access to individual-level surveillance data and are expected to be carried out regularly as part of the Respond Pillar of the EHE strategy 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. LACDPH has three programmatic Respond activities: Partner Services, Linkage Reengagement Program, and HIV Molecular Cluster Detection.

⁹ MMWR Feb 2019 Seattle. <https://www.cdc.gov/mmwr/volumes/68/wr/mm6815a2.htm>.

Partner Services

The CDC describes Partner Services as a public health activity of rigorously trained staff to “identify and locate the sexual contacts of infected people and other people at risk for behavioral or other risk factors ‘contact tracing’- and then refer them for care and treatment, as appropriate.”¹⁰ In LAC, lack of data system integration, data access, and limited staffing continue to hinder the ability of LACDPH to reach all newly diagnosed persons with HIV. The latest estimate is that only two-thirds of newly diagnosed persons with HIV in LAC receive an offer of Partner Services around the time of their diagnosis.

Linkage Re-engagement Program

The Linkage Re-engagement Program (LRP) is staffed by a team of health navigators and supervised by a social worker, provides intensive case management and longitudinal support to PLWH who are out of care and often face challenging life circumstances and have multiple comorbid mental health or SUD conditions. While the majority of LRP clients are referred by their medical provider after they have fallen out of care and been lost to follow-up, others are identified through data-to-care analyses because they are at particularly high risk for poor outcomes, 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, LACDPH started using the CDC’s new HIV TRACE program to identify priority molecular clusters, which is a group of 5 or more persons whose HIV genotype is identified as being highly similar. Because the HIV virus mutates quickly overtime, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission, likely by persons who are unaware of their HIV status or know their status but are not virally suppressed.

LACDPH staff perform analysis of available surveillance and programmatic data on individuals in these molecular clusters to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from the LRP or Partner Services teams. Given that molecular cluster detection is new, LAC DPH began a process in late 2019 to engage the community regarding its use and assess potential unintended consequences. Questions and concerns from community members and misperceptions of the use of data, and the potential of legal ramifications and privacy issues arose and necessitate ongoing discussion; unfortunately, planned activities for further community dialogue have been put on hold due to the deployment of staff to the local COVID-19 response.

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

Looking forward

As we continue to move forward with EHE and elevate new partnerships with community and providers, LACDPH will continue to establish common language and understanding of the Respond Pillar strategies to support the adoption of this work, help clients in need, and prevent outbreaks. EHE work will only be successful with meaningful and extensive partnerships with LAC’s HIV medical homes, Medical Care Coordination teams, impacted communities, and a broad-based coalition of service partners. An integrated data management system for case management and surveillance data is foundational to future programmatic enhancements. LACDPH’s Informational Technology branch has plans, contingent on COVID-19 related priorities, to add HIV and STDs to its new surveillance data system for all

¹⁰ <https://www.cdc.gov/std/program/partners.htm>

communicable diseases in July 2021; the new system will offer large-scale improvements to overall data management, facilitate data linkages across diseases, and improve timely access to surveillance data for staff working with clients. Prior to the COVID-19 pandemic, there was Department wide support to expand surveillance and program staff to support full implementation and optimization of LACDPH EHE Respond activities. Since March 2020, most surveillance and program staff are reassigned to COVID-19 response, hindering the capacity to fully plan and implement new EHE Respond activities. With no current timeline for changes in the COVID-19 staffing plan, LACDPH may be forced to delay further changes and improvements.

Key Target Populations

Based on the epidemiologic profile, situational analysis and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic include: Black/African American MSM, Latinx MSM, women of color, people who inject drugs, transgender people, and youth (under 29 years).

Capacity Building & HIV Workforce

At the November 2018 Commission meeting, there was a resounding need from frontline HIV service provider staff in the community on the importance of providing the HIV workforce with the tools, resources, and support to maintain their health and wellbeing while continuing to diligently serve people affected by and living with HIV. LACDPH is interested in exploring 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 response. LACDPH is also working with the California Prevention Training Center to identify trainings to support the HIV workforce, with a particular focus on client centered approaches to care.

Even prior to COVID-19, LAC was in the midst of a massive affordable housing and homelessness crisis and also assessing how to address the disproportionate impact of HIV/AIDS in Black/African American communities in LAC. Now, with worsening economic injustice, the Black Lives Matter movement, and the COVID-19 pandemic, the emotional and physical capacity of individuals, organizations, and the HIV workforce including LACDPH are further strained. LACDPH recognizes the need to create intentional programming and services under EHE that address intersectional issues beyond HIV, support PLWH in ways that they are asking for support, while also strengthening the HIV workforce throughout the County. LACDPH plans on leveraging existing partnerships to achieve the EHE goals and will work closely with both the Long Beach Department of Health and Human Services as well as the Pasadena Public Health Department.

Section IV: Ending the HIV Epidemic Plan

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

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

EHE Plan - Pillar 1: Diagnose

Leading Indicators:

- 1) Increase the percentage of PLWH who are aware of their HIV status to 95%
- 2) Reduce annual number of HIV diagnoses

Strategy 1A: Expand or implement routine opt-out HIV screening in healthcare and other institutional settings in high prevalence communities.

- Activity 1A.1: Assess and monitor the degree HIV testing is occurring Countywide. Identify infrastructure and healthcare system issues in the era of COVID-19 to determine the feasibility of routine opt-out testing.
- Activity 1B.1: Expand the number of emergency departments and community health centers in high prevalence communities performing routine opt-out HIV screening.

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

- Activity 1B.1: Assess and monitor the degree HIV testing is occurring Countywide (see Strategy 1A). Identify infrastructure and healthcare system issues in the era of COVID-19 to determine the feasibility of a countywide rapid HIV self-test program.
- Activity 1B.2: Develop guidance on HIV home testing and assess readiness of providers to implement home testing.
- Activity 1B.3: Expand use of HIV home testing among at risk individuals unlikely to receive traditional in-person HIV testing.

Strategy 1C: Increase at least yearly re-screening of persons at elevated risk for HIV infection per CDC testing guidelines, in healthcare and non-healthcare settings.

- 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 and use of provider-to-patient communication tools among LACDPH funded HIV prevention providers.

Key Partners and HIV Workforce: FQHCs and community health centers, Emergency departments, HIV and STD Testing Providers, HIV Prevention Providers, academic medical provider training programs, Building Healthy Online Communities-NASTAD, LA County Department of Health Services, Los Angeles County Sherriff Department, and City of Long Beach and City of Pasadena Health Departments.

Outcomes:

- Increased routine opt-out HIV screenings in healthcare and other institutional settings
- Increased local availability of and accessibility to HIV testing services

- Increased HIV screening and re-screening among persons at elevated risk for HIV infection
- Increased knowledge of HIV status
- Increased HIV diagnoses

Monitoring Data Sources: DHSP HIV Surveillance (eHARS)

EHE Plan - Pillar 2: Treat

Leading Indicators:

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

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

- Activity 2A.1: Increase capacity of LACDPH to provide same-day rapid linkage to care during expanded hours and days for newly diagnosed persons throughout LAC.
Activity 2A.2: Develop network of HIV care providers committed to support same day enhanced new patient appointments and rapid ART disbursement.

Strategy 2B: Support re-engagement and retention in HIV care and treatment adherence, especially for persons who are not recipients of Ryan White HIV/AIDS Programs by addressing unmet mental health and substance use disorder (SUD) treatment needs.

- Activity 2B.1: Comprehensively assess unmet mental health and SUD needs of PLWH and identify gaps and area of improvement in the mental health and SUD treatment provider network in LAC.
- Activity 2B.2: Develop a report that summarizes critical gaps in current system and makes recommendations for improvement and investment of County and Ryan White Program funds.

Strategy 2C: Promote Ryan White HIV/AIDS Program (RWHAP) services to increase awareness, access and utilization of available services for PLWH.

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

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

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

Strategy 2E: Improve delivery of client care and customer satisfaction by addressing burnout and staff capacity to better address the needs of PLWH.

- Activity 2E.1: Conduct assessment to identify factors contributing to staff burnout and attrition as well as gaps in skills or knowledge.
- Activity 2E.2: Support programs or technical assistance in response to identified needs

Strategy 2F: Develop a new housing service to provide rental subsidies to prevent homelessness among PLWH.

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

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

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

Key Partners and HIV Workforce: Ryan White HIV service providers, HIV medical providers outside of Ryan White network, FQHCs and community health centers, HIV Service Providers, HIV and STD Testing Providers, HOPWA, County Housing for Health program, Los Angeles County Homeless Services Authority (LAHSA), LAC Department of Mental Health, LAC Department of Health Services, City of Long Beach and City of Pasadena Health Departments.

Outcomes:

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

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

EHE Plan - Pillar 3: Prevent

Leading Indicator: Increase the proportion of persons prescribed PrEP in priority populations to at least 50%.

Strategy 3A: Accelerate efforts to increase PrEP use, particularly for populations with the highest rates of new HIV diagnoses and low PrEP coverage.

- Activity 3A.1: Conduct an in-depth landscape analysis of current PrEP resources and services among primary care providers in high morbidity areas, transgender care providers, women’s health providers, and SUD providers.
- Activity 3A.2: Implement systematic and innovative strategies at LACDPH funded PrEP Centers of Excellence for client communication to promote retention in PrEP and sexual health services.
- Activity 3A.3: Increase capacity of LACDPH staff to provide more robust PrEP Navigation 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 help combat misinformation regarding PrEP cost, access, and safety.
- Activity 3A.5: Work with local stakeholders to identify the potential role for PrEP support groups or PrEP ambassadors to support new and continued PrEP use in affected communities.

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

- Activity 3B.1: Collaborate with the Los Angeles County Substance Abuse Prevention and Control Program to identify opportunities to improve the provision or linkage of SSP clients to HIV prevention and care services.
- Activity 3B.2: Explore ideas for alternate models of prevention service delivery (e.g., vouchers which can be taken to pharmacies in exchange for clean syringes and home HIV test kits).

Key Partners: FQHCs and community health centers, PrEP Centers of Excellence, HIV Service Providers, HIV and STD Testing Providers, LA County STD clinics, Los Angeles County Substance Abuse and Prevention Control Program, County and City funded SSPs, pharmacies, general practitioners, community leaders and advocates, PACE Program - Region 9 Team

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 plans, National HIV Behavioral Surveillance (NHBS).

EHE Plan - Pillar 4: Respond

Leading Indicators:

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

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

- Activity 4A.1: Develop a protocol, training materials, and standard operation plan.

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

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

- Activity 4B.1: Increase capacity of LACDPH 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 LACDPH staff for timely follow-up and Partner Services.

Key Partners: State OA, City of Long Beach and City of Pasadena Health Departments, HIV Service Providers, HIV and STD Testing Providers

Outcomes:

- Increased number of newly diagnosed people with HIV interviewed by Partner Services
- 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 (HIV Casewatch), Local HIV clusters

LACDPH Funding Sources specific to EHE: HRSA 078 Ending the HIV Epidemic (\$3,083,808), CDC Ending the HIV Epidemic (\$3,360,658), HRSA CARES Act (\$1,000,000)

Table 1: Funding Sources and Allocations

Note: Not an exhaustive list. Includes funding at the LACDPH level as well as external funding that will play an important role in EHE Plan implementation.

Funding Source	Diagnose	Treat	Prevent	Respond
HRSA Ending the HIV Epidemic		X		X
CDC Ending the Epidemic Program Implementation (Component A)	X		X	
CDC Ending the Epidemic Planning (2019-2020)	X	X	X	X
HRSA CARES		X		
HRSA Ryan White Program Part A	X	X	X	
HRSA Ryan White Program Part B		X	X	
HRSA Ryan White Program Minority AIDS Initiative		X	X	
CDC Integrated HIV Surveillance and Prevention	X	X	X	X
CDC HIV Treatment Improvement Demonstration Project		X	X	
CDC National HIV Behavioral Survey and TG Supplement			X	

CDC Medical Monitoring Project		X		
State OA HIV Surveillance	X		X	
SAPC Non-Drug Medi-Cal	X		X	
County/City of LA SSP Funding			X	
EHE funding to Federally Qualified Health Centers	X	X	X	
EHE funding to Academic Institutions/Research	X	X	X	X
EHE funding to AIDS Education and Training Centers	X	X	X	

Section IV: Engagement Process

Community engagement has always been and continues to be invaluable to the planning and development process for HIV prevention and care throughout Los Angeles County (LAC). Prior to the launch of *Ending the HIV Epidemic: A Plan for America* (EHE), LAC developed and released its own jurisdictional plan in November 2017, the *Los Angeles County HIV/AIDS Strategy for 2020 and Beyond* (LACHAS), which served as a framework of policies, strategy recommendations, and targeted outcomes that the community and key stakeholders could work together 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 in LACHAS to better align with the national EHE initiative. Through a series of listening sessions with the community stakeholders, Los Angeles County Commission on HIV (Commission) meetings; full and multi-day regional EHE planning meetings hosted by the California Department of Public Health, Office of AIDS (State OA), University of California Los Angeles Center for HIV Identification, Prevention, and Treatment Services (UCLA CHIPTS), and the Commission; local EHE Steering Committee meetings; meetings with people living with HIV/AIDS (PLWH); and meetings and site visits with multiple federal partners; LACDPH obtained input and guidance on services and activities that were necessary to LACHAS and now, that are necessary for EHE implementation.

Local Prevention and Care Integrated Planning Body

The Los Angeles County Commission on HIV (Commission) is the federally mandated, local Ryan White HIV/AIDS community planning council that provides recommendations to LACDPH on HIV prevention and care services throughout the County. The Commission is comprised of 51 members, appointed by the Board of Supervisors, who represent the diversity of LAC and communities impacted by HIV. LACDPH has a long-standing partnership with the Commission and will rely on the partnership as the key community arm in EHE efforts moving forward.

Prior to the release of LACHAS, LACDPH collaborated with a group of HIV prevention and care stakeholders on developing the initial framework of strategies the County could collectively work towards in an effort to reduce annual HIV transmissions, increase diagnoses, and increase viral suppression rates. After the release of LACHAS, DHSP continued to collaborate with the Commission to disseminate, promote, and engage the broader LAC community to build knowledge and awareness of LACHAS strategies and goals, and to recruit new partners and voices into the HIV arena. Over a dozen call-to-action meetings were held in various communities and jurisdictions across the County to increase access and the ability to participate. As a result of outreach and promotion through the Commission listserv, and special invites to stakeholders and elected officials within particular jurisdictions, over 750 community stakeholders were reached. Summary reports from the call-to-action meetings, including health district demographics, key takeaways, and top insights from the group discussions were

developed and distributed to the community¹¹. The Commission was integral in promoting LACHAS, encouraging the community to get involved, and identifying new non-traditional partners to join the movement to end the HIV epidemic. The ongoing community engagement and input conducted for LACHAS provided valuable insight on needed services and activities and helped drive the development of the subsequent EHE Plan.

In November 2019, the Commission held an all-day community meeting with over 190 participants to listen to the community response to EHE, the best way to engage the community moving forward, and to garner input on the leadership necessary to achieve EHE goals. The meeting included a panel of representatives from the State OA; LACDPH leadership; the Office of Assistant Secretary of Health, Prevention through Active Community Engagement (PACE) Team, Region 9; UCLA CHIPTS and other important HIV stakeholders from LAC. Key takeaways included the importance of multi-sector commitment to achieve EHE goals, a commitment to being disruptively innovative, ensuring transparency and accountability from partners, and lifting up voices of communities most impacted by HIV.

At the Commission's January 2020 meeting, Commissioners and members of the public participated in small group breakout sessions to discuss additional ideas related to community engagement and mobilization for EHE. With an understanding that LAC needs to be disruptively innovative to end the HIV epidemic and bring new voices to the table, participants broke out into small groups to discuss how community members can take individual action in EHE efforts, which sectors participants could mobilize, and how the development of the new EHE Steering Committee could support efforts to recruit new voices. The discussions were an important exercise for the community to self-identify opportunities to become involved in promoting and advancing EHE strategies. As a follow up to community discussions, the Commission is working to increase membership on the planning council by identifying strategies that will engage pharmaceutical companies, healthcare plans, State Medicaid, HIV private providers, and youth as part of Commission EHE efforts. LACDPH will continue to engage with the Commission to ensure EHE is responsive to the needs of the community and is also exploring activities and projects that Commissioners can champion to end the HIV epidemic.

Commission leadership continues to provide input and feedback on the content, strategies, and activities included in the EHE Plan to further inform LAC's EHE efforts. LACDPH released the plan to the LAC community for a 30-day public comment period in September 2020 and partnered with the Commission to ensure individuals and communities were aware of the opportunity and able to respond with their feedback accordingly. In addition, Commissioners were provided an opportunity to submit more in-depth feedback than the open public comment period through listening sessions facilitated by Commission staff with feedback submitted to LACDPH.

Local Community Partners

In an effort to recruit new voices and partnerships into EHE efforts, LACDPH formed an Ending the HIV Epidemic (EHE) Steering Committee to highlight new voices that could support the implementation of local strategies as well as serve as catalyst for collective action to end the HIV epidemic. LACDPH created a competitive application process via an online survey platform, distributed the application across 11 different listservs, both HIV and non-HIV related, and reached out directly to partners to share widely including the PACE team, the Center for Health Equity, and the LACDPH Regional Health Offices. A review team from LACDPH and the Commission scored over 85 applications that were received in a two-week period, and selected Committee members who reflect a broad range of perspectives beyond HIV

¹¹ <https://tinyurl.com/LACHASmeetings>

such as health equity, social justice, substance use disorder, housing, and mental health. LACDPH notified candidates in early September 2020 and will hold the first meeting on October 1, 2020. The EHE Steering Committee members will be integral in the development and the EHE Plan and will have opportunities to provide their input and expertise for the proposed strategies and activities. The Steering Committee members were announced at the Ending the HIV Epidemic Townhall on September 16, 2020.

Local community partners have also been engaged through recurring EHE updates at monthly Commission meetings as well as monthly Commission subcommittee meetings. In addition, the Commission has three official caucuses, the Consumer Caucus, Women’s Caucus, and Transgender Caucus, and one taskforce, the Black/African American Communities Taskforce, that focus on specific populations disproportionately and/or highly impacted by HIV. After the COVID-19 pandemic forced the closure of County offices in March 2020, the Commission switched all meetings to a virtual platform, allowing community partners to participate and continue the important work of the Commission. There has been an increase in community participation in meetings, including an estimated 25% increase of new voices and people who have not attended meetings in the past at Commission meetings and 50% increase of new participants at the Commission’s recent Virtual Lunch and Learn Series which promotes HIV service providers across the County. Commission staff suspects the virtual platform has allowed individuals who had not been able to attend meetings due to competing priorities, lack of or limited access to transportation, or due to the size and traffic restraints of LAC to now participate remotely.

On September 16, 2020, LACDPH held a virtual EHE Townhall to provide an overview on EHE efforts, describe how COVID-19 is impacting progress, and open a 30-day public comment period for the community to review and provide input on the EHE plan. The opportunity to provide public comment was promoted via the Townhall and distributed through the same avenues as the EHE Steering Committee recruitment process to reach a much larger and vast network than the traditional HIV channels. Through this exercise, LACDPH hopes to garner input from a diverse group of local community partners, service providers, and new voices.

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

Local Service Provider Partners

Local service providers are represented and engaged through various committees, coalitions, working groups, and networks across Los Angeles County. There is a strong network of LACDPH funded service providers that serve people living with and affected by HIV in diverse communities across the County. In addition, there are a number of public facing listservs that disseminate information for trainings, webinars, and events related to HIV and the social determinants of health that impact HIV. Service providers are also represented on the Commission, the EHE Steering Committee, and Service Provider Networks (SPNs) in specific jurisdictions across the County. There are strong coalitions and groups in LAC such as the Ending the Epidemics Statewide coalition that addresses policy and advocacy on the syndemic relationship between HIV, sexually transmitted infections (STIs), and viral hepatitis, and the LAC PrEP/PEP Working Group. By working with such groups and coalitions, LACDPH has been able to gain input and guidance on HIV prevention and care efforts. Service providers had robust participation in

the many community listening sessions and health district discussions since the development and release of LACHAS and have maintained participation in the development of the EHE Plan.

In addition to the existing service provider network, LACDPH has been working to recruit and develop new partnerships with the five LACDPH Regional Health Offices that oversee all public health issues in specific geographic service planning areas throughout the County, new partners identified through the UCLA CHIPTS Regional EHE Coordination meeting in January 2020, and the LAC Community Prevention and Population Health Task Force to inform them of EHE and request feedback on the EHE plan. The Office of the Assistant Secretary for Health (OASH) PACE Team has also been a great asset to local EHE community engagement efforts. LACDPH also works closely with the HIV Medical Advisory Committee, which includes medical leadership from Ryan White funded HIV Clinics across the County, and the Medical Care Coordination (MCC) Learning Collaborative, to obtain feedback on all HIV prevention and treatment activities including EHE goals and strategies.

Concurrence – To be determined (TBD)

The Los Angeles County Department of Public Health, Division of HIV and STD Programs values community voices in the planning, development, implementation, and evaluation of LAC HIV prevention and care efforts. Despite the COVID-19 pandemic impacting individuals and organizations across the County, LACDPH plans on working with the local community, key stakeholders, and the Commission to garner input and feedback on the EHE Plan.

The development of the EHE Plan is an iterative process to fully vet and refine the strategies and activities necessary to end the HIV epidemic in LAC. The approach for achieving concurrence will include presenting initial drafts to leadership of the Commission on HIV for review and input, subsequent drafts to the entire Commission, in addition to obtaining feedback through a 30-day open public comment period to the broader LAC community.

LACDPH will work closely with the Commission to reach concurrence on and disseminate the final plan.

Acronyms

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