LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE
Virtual Meeting
Tuesday, January 17, 2023
1:00PM-3:00PM (PST)

Agenda and meeting packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Planning-Priorities-and-Allocations-Committee

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/2p835a9w

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1-213-306-3065 US Toll Access code: 2599 144 7878

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PUBLIC COMMENTS

Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission.

To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS.

All Public Comments will be made part of the official record.

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LOS ANGELES COUNTY
COMMISSION ON HIV

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

PLANNING, PRIORITIES, AND ALLOCATIONS COMMITTEE

TUESDAY, January 17, 2023|1:00 – 3:00 PM

To Join by Computer:

https://lacountyboardofsupervisors.webex.com/lacountyboardofsupervisors/j.php?MTID=me7c29867f8ac99dedfcd161b0e0fefe5

**Link is for non-committee members only*

To Join by Phone: 1-213-306-3065 US Toll

Access code: 2599 144 7878

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Al Ballesteros, MBA, Co-Chair	Felipe Gonzalez	Joseph Green
Karl T. Halfman, MS	William King, MD, JD	Miguel Martinez, MPH, MSW	Anthony M. Mills, MD
Derek Murray	Jesus "Chuy" Orozco	LaShonda Spencer, MD	Michael Green, PhD
Reverend Redeem Robinson			
QUORUM:	7		

AGENDA POSTED: January 10, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx.

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. All Public Comments will be made part of the official record.

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

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours' notice before the meeting date. To arrange for these services, please contact Commission on HIV at (213) 738-2816 or via email at hivcomm@lachiv.org.
Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Comisión en HIV al (213) 738-2816 (teléfono), o por correo electrónico á hivcomm@lachiv.org, por lo menos 72 horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

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

Call to Order | Roll Call | Statement – Conflict of Interest 1:00 PM – 1:02 PM

I. ADMINISTRATIVE MATTERS 1:02 PM – 1:04 PM

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

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

II. PUBLIC COMMENT 1:04 PM – 1:14 PM

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

III. COMMITTEE NEW BUSINESS 1:14 PM – 1:19 PM

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

IV. REPORTS

5. EXECUTIVE DIRECTOR'S/STAFF REPORT 1:19 PM – 1:25 PM

6. CO-CHAIR REPORT 1:25 PM – 1:40 PM

a. Co-chair Elections
b. Committee 2023 Workplan
c. Eliminating Congenital Syphilis in LA County 2020 Report

7. DIVISION OF HIV AND STD PROGRAMS (DHSP) 1:40 PM - 1:55 PM

a. Ryan White Program Expenditures and Programmatic Updates
b. Ryan White Program Updated Unmet Need Refresher

V. DISCUSSION

8. Letter from Aging Caucus to Consider Reallocation of Funds 1:55 PM – 2:15 PM

VI. NEXT STEPS 2:15 PM – 2:25 PM

9. Task/Assignments Recap

10. Agenda Development for the Next Meeting

a. Strategize for Better Integration of Prevention Planning Workgroup in PP&A
b. AOM/MCC Provider feedback

VII. ANNOUNCEMENTS 2:25 PM – 2:30 PM

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

VIII. ADJOURNMENT 2:30 PM

12. Adjournment for the Meeting of January 17, 2023.

PROPOSED MOTION(s)/ACTION(s):	
MOTION #1:	Approve the Agenda Order, as presented or revised.
MOTION #2:	Approve meeting minutes as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 1/10/23

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

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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL	**Danielle**	UCLA/MLKCH	Oral Health Care Services
			Medical Care Coordination (MCC)
			Ambulatory Outpatient Medical (AOM)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Ambulatory Outpatient Medical (AOM)
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	Part C Provider
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FINDLEY	**Felipe**	Watts Healthcare Corporation	Transportation Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Oral Health Care Services
			Biomedical HIV Prevention
			STD Screening, Diagnosis and Treatment
FRAMES	**Arlene**	Unaffiliated consumer	No Ryan White or prevention contracts
FULLER	**LUCKIE**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
			Nutrition Support
GATES	**Jerry**	AETC	Part F Grantee
GONZALEZ	**Felipe**	Unaffiliated consumer	No Ryan White or Prevention Contracts
GORDON	**Bridget**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Joseph**	Unaffiliated consumer	No Ryan White or prevention contracts
GREEN	**Thomas**	APAIT (aka Special Services for Groups)	HIV Testing Storefront
			Mental Health
			Transportation Services
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MARTINEZ	**Eduardo**	AIDS Healthcare Foundation	Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Medical Care Coordination (MCC)
			Mental Health
			Oral Healthcare Services
			STD Screening, Diagnosis and Treatment
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
			Medical Subspecialty
			HIV and STD Prevention Services in Long Beach
MARTINEZ (PP&A Member)	**Miguel**	Children's Hospital Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
MILLS	**Anthony**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	Southern CA Men's Medical Group	Biomedical HIV Prevention
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Sexual Health Express Clinics (SHEx-C)
			Transportation Services
MORENO	**Carlos**	Children's Hospital, Los Angeles	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			STD Screening, Diagnosis and Treatment
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transitional Case Management - Youth
			Promoting Healthcare Engagement Among Vulnerable Populations
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
			Oral Healthcare Services

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Health Education/Risk Reduction, Native American
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
ROBINSON	**Mallery**	We Can Stop STDs LA (No Affiliation)	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (No Affiliation)	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SAN AGUSTIN	**Harold**	JWCH, INC.	HIV Testing Storefront
			HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV)
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Mental Health
			Oral Healthcare Services
			Transitional Case Management
			Ambulatory Outpatient Medical (AOM)
			Benefits Specialty
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Transportation Services
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			Medical Care Coordination (MCC)
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

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Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

September 27, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	P
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	EA
Joseph Green	P	Derek Murray	P
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	EA
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Lizette Martinez, Sonja Wright, AJ King			
DHSP STAFF			
Pamela Ogata, Victor Scott, Sona Oksuzyan			

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

Meeting agenda and materials can be found on the Commission's website. Click HERE.

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST

Kevin Donnelly, Co-Chair, called the meeting to order at approximately 1:05 PM, welcomed attendees, and led introductions.

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda

MOTION #1: Approve the Agenda Order ***(✓Passed by Consensus)***

2. Approval of Meeting Minutes

MOTION #2: Approval of Meeting Minutes ***(✓Passed by Consensus)***

II. PUBLIC COMMENT

3. **Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.** *There were no public comments.*

III. COMMITTEE NEW BUSINESS

4. **Opportunity for Committee members to recommend new business items for the full body or a committee-level discussion on non-agendized matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.** *There were no committee new business items.*

IV. REPORTS

5. **Execute Director/Staff Report**
   Cheryl Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the Board of Supervisors had their first in-person meeting on September 27th. The Commission on HIV (COH) will vote for in-person vs continuing virtual meetings during October's full-body (COH) meeting. If resume in person meetings, safety protocols will be in place.

   a. **Staffing Update -** C. Barrit introduced new Commission staff, Lizette Martinez, who will be lead staff for the Planning, Priorities and Allocations Committee and Prevention Planning Workgroup.

6. **Co-Chair Report**
   a. **Committee Workplan Review -** K. Donnelly provided an overview of the revisions to the PP&A 2022 Workplan, which can be found in the meeting packet. K. Donnelly identified the reallocations of RWP Part A and MAI funds as high priority item.
   b. **Prevention Planning Workgroup (PPW) | Updates –** Miguel Martinez thanked COH members who completed the Prevention Knowledge, Attitudes, and Beliefs (KAB) survey. PPW will be reviewing the results of the survey during their next meeting on September 28th and will identify key opportunities around prevention planning efforts within the COH.
   c. **Sexually Transmitted Infections (STI) Letter to the Board of Supervisors**
      - COH sent Thank You letter to BOS regarding BOS response for funding to address STIs in LA county. See meeting packet for details.
      - Al Ballesteros inquired if the letter including language for additional funding. C. Barrit commented that the Public Policy Committee is writing a letter to articulate the need for more funding based on data from DHSP. Lee Kochems recommended the letter be broad and should also be sent to the State.

- Katja Nelson stated the BOS should be well aware of lack of adequate funding for STI prevention and treatment within the County.
- Dr. Michael Green informed the PP&A Committee that the County will be receiving an additional $3 million/year from the State for STI prevention/treatment. Funding is guaranteed for 5 years but the state budget is only approved for 3 years. Award is expected in late February/early March.
- A. Ballesteros inquired if there is a way to encourage private sectors, community clinics, and health departments to lean on Medi-Cal and employer-based insurance to pay for services. He also inquired if the Medicare and Medicaid systems allow for STI service providers to access funding for clients. Dr. M. Green responded that DHSP is not aware of uncompensated costs within the private sector. He also noted clients seeking care are not being turned away from clinics. A. Ballesteros commented more attention may be needed on prevention versus treatment efforts.
- Felipe Gonzalez commented that efforts should be focused on education and prevention. He recommended informing the BOS that it is more expensive to treat STIs than to prevent them through education.

d. Letter of Assurance FY 2023 Non-Competing Continuation Progress Report – C. Barrit provided an overview of the Letter of Assurance for FY 2023 and informed the PP&A Committee that it was submitted to the Health Resources and Services Administration (HRSA) on October 3rd. HRSA requires a non-competing continuation progress report describing annual planning process, member involvement, service category rankings, training, and resource allocations.

7. Division of HIV and STD Programs (DHSP)

a. Fiscal and Program Updates – Victor Scott provided an overview of RWP Part A, Minority AIDS Initiative (MAI) and Part B expenditures for PY 32. Part A award for PY 32 is $42,142,230; MAI award for PY 32 is $3,780,205; MAI carry over from PY 31 to PY 32 is $1,747,329. Current estimates show an approximate $4 million surplus that needs to be reallocated and spent. Must spend MAI carryover from PY 31 plus 10% administrative fees first. Can shift MAI expenditures to Part A to carry over to PY 33 but not the 10% administrative costs.

i. Ryan White Program (RWP) Service Utilization Report

- Dr. Sona Oksuzyan presented RWP Year 31 Care Utilization Summary. See meeting packet for presentation slides.
- Data report includes data from HIV Casewatch, Linkage Re-engagement Program (LRP), eHARS and DHSP Expenditure Reports
- In PY 31, 21,877 RWP clients received at least one core or supportive RWP service
- 2 in every 5 people living with diagnosed HIV (PLWDH) in LA County used RWP services
- Overall, RWP recipients have better health outcomes than non-recipients
- Latinx and Black clients continue to represent the largest percentage of RWP clients.
- The majority of RWP clients continue to be cisgender men.
- From Year 27 to Year 31, the proportion of RWP clients aged 60 years and older has continued to increase.

ii. **Net County Cost (NCC) Funds Used to Support HIV Services –** See packet for NCC funds used to support HIV services.

8. City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report

a. Housing Services | Updates

i. Service Utilization, Costs and Gaps

ii. Available Housing Inventory for PLWH

iii. Waiting Lists

No HOPWA Report was provided. Staff will reach out again to Chuy Orozco, HOPWA Representative, to have data available for the October meeting.

V. DISCUSSION

9. Strategies for Reallocations of Ryan White Funds

- C. Barrit shared Funding Allocations by Program Directives document and highlighted which service category each directive would fall under. See meeting packet for materials.
- DHSP has begun looking at ways to maximize funding to spend out surplus and carry over
- Dr. M. Green announced DHSP will be providing response to the program directives during next month's PP&A Committee meeting.
- A. Ballesteros suggested looking at ways to address gaps in care for AOM providers and potential to use RWP funds to augment areas that Medi-Cal does not cover. Dr. M. Green agreed it would be a good exercise and will coordinate a meeting with AOM service providers to gather information.

10. Comprehensive HIV Plan 2022-2026

- AJ King provided an overview of the draft Comprehensive HIV Plan 2022-2026. C. Barrit reminded PP&A Committee a draft was sent to the group for review and feedback is due to AJ King by October 3rd.
- AJ King suggested to narrow target population of people over 50 to people living with HIV over 50.
- Derek Murray suggested adding language and data that RWP client have better outcomes than the general population of people living with HIV.

VI. NEXT STEPS

11. Task/Assignments Recap

- AJ King will revise the Comprehensive Plan based on PP&A committee/staff feedback and resend for review by full-body COH and public comment.
- C. Barrit will update Funding Allocations by Program Directives document to add new ideas.
- DHSP to schedule a meeting with AOM service providers to identify gaps in Medi-Cal funds where RWP funds can be utilized.
- The PP&A Committee will continue working on the reallocation of $5-6 million of RWP funds.

12. Agenda Development for the Next Meeting

a. DHSP response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34.

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

14. Adjournment for the Meeting of September 27, 2022.

The meeting was adjourned by K. Donnelly at 4:10pm

LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

October 18, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	A
Al Ballesteros, MBA, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	P	Anthony M. Mills, MD	A
Joseph Green	P	Derek Murray	P
Michael Green, PhD, MHSA	EA	Jesus "Chuy" Orozco	A
Karl T. Halfman, MS	EA	LaShonda Spencer, MD	EA
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Lizette Martinez, Sonja Wright, AJ King			
DHSP STAFF			
Pamela Ogata, Victor Scott, Wendy Garland			

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CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST

Kevin Donnelly, Co-Chair, called the meeting to order at approximately 1:05 PM, welcomed attendees, and led introductions. Kevin noted last minute changes to the agenda.

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda

MOTION #1: Approve the Agenda Order **(Quorum was not reached; no vote was held.)**

2. Approval of Meeting Minutes

MOTION #2: Approval of Meeting Minutes **(Quorum was not reached; no vote was held.)**

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS

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

There were no committee new business items.

IV. REPORTS

5. Execute Director/Staff Report

- Cheryl Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the Commission voted to continue virtual meetings for the month of November during the October full-body Commission on HIV (COH) monthly meeting. The (COH) Annual Meeting will be Nov. 10th from 9am-4pm and will also be virtual. See https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/6e5e4d51-19a4-4d21-97f3-8ffca2bb1e5c/COH%20Annual%20Meeting%202022_FINAL.pdf for meeting details.
- C. Barrit also reminded the committee that co-chair nominations will take place during the November PP&A meeting and elections will be held in December's PP&A meeting.
- Derek Murray inquired about continuing to vote on COH virtual meetings each month until the Governor's public health emergency order ends in February. C. Barrit confirmed monthly voting will continue until the emergency order is lifted and is seeking further clarification with County Counsel regarding virtual meetings beyond the end of the public health emergency order.

6. Co-Chair Report

a. Committee Workplan Update - K. Donnelly provided an overview of the revised PP&A 2022 Workplan, which can be found in the meeting packet.

b. Prevention Planning Workgroup (PPW) | Updates – Miguel Martinez reported the PPW finalized their workplan and identified 4 key priorities to focus efforts. K. Donnelly stated only 1-2 items focusing on harm reduction and increasing HIV/STD testing strategies would be priority this year and the group will revisit other items at the beginning of the year to make a full, year-long workplan. Felipe Gonzalez agreed with the priority areas and stressed the need to focus on prevention.

c. **Division of HIV and STD Programs (DHSP) Ryan White Program Utilization Report Frequency –** Lizette Martinez reviewed draft utilization report infographics summary. K. Donnelly confirmed the Ryan White Program Utilization Report is only needed once per year. Any other reports will be requested on an as needed basis. Wendy Garland stated DHSP is looking at ways to incorporate some RWP utilization along with expenditure reports to assist in planning and reallocation efforts.

7. Division of HIV and STD Programs (DHSP) Response to COH Program directives

P. Ogata provided responses to COH Program Directives; responses provided for directives 1-4. P. Ogata stated that a final document listing DHSP's responses to the directives will be provided to PP&A after Dr. Green's review.

1. Directive #1: Across all prevention programs and services, use a status-neutral approach in service delivery models and create a connected network of services that promote access to PrEP, ongoing preventive care, mental health, substance use, and housing services. A status-neutral approach considers the steps that can lead to an undetectable viral load and steps for effective HIV prevention (such as using condoms and PrEP). The status- neutral approach uses high-quality, culturally affirming care and empowers PLWH to get treatment and stay engaged in care. Similarly, high-quality preventive services for people who are at risk of HIV exposure help keep them HIV-negative. A status-neutral approach to HIV care means that all people, regardless of HIV status, are treated the same way, with dignity and respect, and with the same access to high-quality care and services.

   DHSP Response:
   - DHSP's EHE Outreach and Education team developed HIV Testing palm cards that are status neutral. One side of the palm card has resources for persons diagnosed with HIV, and the other side of the card contains resources for persons who are HIV negative.
   - DHSP recently released a new RFP (through Heluna Health) to fund mini projects that will improve linkage to care, diagnoses, or engagement in care. The RFP recommends the use of a status-neutral approach and is available at https://www.helunahealth.org/news/rfp-la-county-department-of-public-health-ending-the-hiv-epidemic-mini-grant-program-short-version-
   - All DHSP prevention contracts are status-neutral
   - Under vulnerable population contracts, at least four provide housing vouchers and three provide mental health services
   - Persons at risk for HIV should have access to substance use prevention and treatment if they have any private health insurance or through Medi-Cal
   - Identification of a funding source for housing services for persons at risk of HIV has been a challenge. DHSP will advocate with CDC and HRSA to allow more flexibility with funding in order to support the status neutral approach

- P. Ogata noted that new RFPs use blended CDC and HRSA Ending the HIV Epidemic (EHE) funding.

2. Directive #2: Across all funding sources for prevention and care, prioritize investments in populations most disproportionately affected and in health districts with the highest disease

burden and prevalence, where service gaps and needs are most severe. To determine populations and geographic areas most affected by HIV, request DHSP to provide data on the following:

a. HIV and STD surveillance
b. Continuum of care
c. PrEP continuum
d. Data on low service utilization in areas with high rates of HIV
e. Viral suppression and retention rates by service sites
f. and other relevant prevention and care data

Priority populations are those groups defined in the Los Angeles County Ending the HIV Epidemic plan. "Based on the epidemiologic profile, situational analysis, and needs assessment in Los Angeles County, the key populations of focus selected for local Ending the HIV Epidemic activities to reduce HIV-related disparities include Black/African American

DHSP Response:

- DHSP has developed HIV and STD dashboards which present current data and trends. Health district and SPA results are available. The dashboards can be accessed at http://publichealth.lacounty.gov/dhsp/Dashboard.htm
- DHSP has and will continue to provide responses to COH data requests. HIV and STD surveillance, RWP Utilization, NHBS, HIV testing, and MMP data were presented during 2021 and 2022. Data were also provided and included in the Comprehensive Prevention Plan.
- DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.

3. Directive #3: Integrate telehealth across all prevention and care services, as appropriate.

DHSP Response:

- DHSP augmented some biomedical contracts to purchase telehealth software
- RWP AOM, MCC, MH, Transitional Case Management (TCM) and Home-Based Case Management (HBCM) services have had the capacity to deliver services via telehealth since March 2020, and will continue using telehealth (phone)
- Prevention programs used Zoom, Facebook and phone and will continue to use these telehealth modalities and a hybrid approach.
- DHSP will continue to monitor and evaluate telehealth usage in the RWP
- New services such as the Spanish language mental health services will require both on-site and telehealth options

- K. Donnelly inquired if DHSP foresees any impediments to expanding the aforementioned prevention and care services. P. Ogata noted that she unaware of impediments but will consult with Paulina Zamudio.

4. Directive 4: Continue the implementation of the recommendations developed by the

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

a. Directive 4a: Require contracted agencies to complete training for staff on cultural competency and sensitivity, implicit bias, medical mistrust, and cultural humility. DHSP should work with the Black/African American community as subject matter experts in developing training materials and curriculum, monitoring, and evaluation.

DHSP Response:

- DHSP developed a training that addresses issues of cultural humility and implicit bias last year. Three hundred people have been trained so far and this work is ongoing.

- K. Donnelly stated that he will ask the Black Caucus to weigh in on DHSP responses to the directives once a final document is received.

b. Directive 4b: In collaboration with the Black/African American community, conduct a comprehensive needs assessment specific to all subsets of the Black/African American population with a larger sample size. Subgroups include MSM, transgender masculine and feminine communities, and women. Integrate needs assessment objectives and timelines in the 2022-2026 Comprehensive HIV Plan.

DHSP Response:

- DHSP has collaborated with Ranya to obtain perspectives and feedback from the Black/African American community to develop a social marketing strategy
- Black/African American Taskforce will conduct key informant interviews with service providers including workforce development needs
- Conducting LACHNA is extremely labor intensive and time-consuming activity. The NHBS data can be used for prevention planning and the Medical Monitoring Project (MMP) can be used to understand HIV care needs.
- A more targeted needs assessments should be completed by COH and AJ as part of the CHP development

c. Directive 4c: Assess available resources by health districts by order of high prevalence areas.

DHSP Response:

- DHSP will update analyses to better understand geographic diversity of the HIV epidemic and will share the results with the COH.
- DHSP will help improve the response of local HIV efforts to address epidemic among Blacks and African Americans by enlisting new providers and working with other county departments to help make the county contracting process easier to

navigate and more inclusive.

- K. Donnelly noted that there appears to be a lack of data sharing across independent health jurisdictions (i.e., Cities of Long Beach and Pasadena). W. Garland stated that Long Beach and Pasadena do submit surveillance data to Los Angeles County but also submits other data directly to the CDC. She noted that there may be challenges due to delay in reporting from providers.

d. Directive 4d: Conduct a study to identify out-of-care individuals, and populations who do not access local services and why they do not.

DHSP Response:

- DHSP staff are currently analyzing data from the Linkage and Re-Engagement Program (LRP) as well as other Data-to-Care activities to identify out of care individuals and better understand their service needs.

- P. Ogata stated that data collection is an ongoing DHSP activity.

e. Directive 4e: Fund mental health services for Black/African American women that are responsive to their needs and strengths. Maximize access to mental services by offering services remotely and in person. Develop a network of Black mental health providers to promote equity and reduce stigma and medical mistrust.

DHSP Response:

- Under the HRSA EHE grant, DHSP has secured a contractor who has conducted a Mental Health Needs Assessment. This assessment includes three levels of inquiry: systems, providers, and clients/consumers. Fifteen keyholder interviews were conducted, and surveys were collected from 35 providers and 29 consumers.
- The consultant presented preliminary findings at the October COH meeting and the final report will be available before the end of 2022.
- Based on the results of the Needs Assessment, DHSP will determine next steps to increase availability of mental health services for Black/African American women.
- Three RFPs for Black/African American or Latino MSM, Black/African American cisgender women, and Black/African American transgender were recently released (October 2022)
- To fully accomplish this goal, reform in the educational and reimbursement systems are needed which is outside DHSP's scope.

- P. Ogata noted that 3 out of the 5 RFPs mentioned are for the African American community. A. Ballesteros inquired if there gaps in AOM services (and other RW services) and coverage not picked up the Medi-Cal that RW could potentially pick-up? Theoretically, DHSP could go back to the earlier period of the current program year to recoup those costs. What areas are not covered by insurance?
- A. Ballesteros noted that he has been reaching out to other providers and has compiled a list of ideas. For instance, he indicated that providers feel that there is a disconnect between AOM and MCC services and identifying service gaps could help improve care while also maximizing grant funds. He noted that it is his understanding that P. Zamudio is also asking providers the same question. A. Ballesteros indicated that he will send his list to P. Ogata and

COH staff.

8. City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report

a. Housing Services | Updates

i. Service Utilization, Costs and Gaps

ii. Available Housing Inventory for PLWH

iii. Waiting Lists

No HOPWA Report was provided. Staff will reach out again to Chuy Orozco, HOPWA Representative, to have data available for the November meeting.

V. DISCUSSION

9. Comprehensive HIV Plan Update

- AJ King provided an update on the Comprehensive HIV Plan. Revisions are being made and the 2nd draft of the plan will be available for review by all committee members and available for public comment at the beginning of November.
- AJ King suggested changing one priority population from everyone age 50+ to people who are living with HIV age 50 and older. M. Martinez agreed with the proposed change.
- AJ King also suggesting adding quality of life (QoL) indicators outlined in the National AIDS Strategy and begin to incorporate into objectives. W. Garland voiced concerns over how data on quality-of-life indicators would be tracked and collected and the data manipulation needed to reflect the Ryan White Program (RWP) population. AJ King reiterated the focus would be to assess how the COH can address those indicators for RWP clients. White House Office of National AIDS Policy (ONAP) Director, Harold Phillips, stated at the PACHA meeting that the QoL indicators were derived from the Medical Monitoring Project.
- F. Gonzalez asked if quality of life indicators included unemployment and training. AJ King confirmed the indicators do include a measure focused on employment/unemployment.
- Al Ballesteros commented a contributing issue to unemployment is the Federal government's lack of a process or program to transition clients off Supplemental Security Income (SSI) benefits and into the workforce. Benefits are often tied to housing and other resources. The potential loss of benefits is a major issue for older adults living with HIV and are afraid to lose their housing.
- Alasdair Burton commented this is an issue for the general population as well and resource is needed to help both the HIV population and general population navigate transitioning off SSI and other benefits.

  Pamela Ogata asked if the PP&A Committee will be meeting in December. K. Donnelly suggested discussing the December PP&A meeting during the November meeting.

VI. NEXT STEPS

8. Task/Assignments Recap

- Nominations/Elections
- Continue discussion of DHSP response to COH program directives
- City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report

- Discussion on gaps in care and cost recuperation allowable using RWP funds
- DHSP expenditure updates

9. Agenda Development for the Next Meeting

a. DHSP response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34.

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

11. Adjournment for the Meeting of October 18, 2022.

The meeting was adjourned by K. Donnelly at 2:57pm

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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

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

PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

November 15, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	William King, MD, JD	P
Al Ballesteros, MBA, Co-Chair	EA	Miguel Martinez, MPH, MSW	P
Felipe Gonzalez	EA	Anthony M. Mills, MD	EA
Joseph Green	EA	Derek Murray	A
Michael Green, PhD, MHSA	P	Jesus "Chuy" Orozco	A
Karl T. Halfman, MS	P	LaShonda Spencer, MD	P
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Jose Rangel-Garibay, Lizette Martinez			
DHSP STAFF			
Pamela Ogata, Victor Scott			

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

Meeting agenda and materials can be found on the Commission's website. Click HERE.

CALL TO ORDER-INTRODUCTIONS-CONFLICT OF INTEREST

Kevin Donnelly, Co-Chair, called the meeting to order at approximately 1:05 PM, welcomed attendees, and led introductions. K. Donnelly noted that staff did not hear from J. Orozco regarding his attendance, hence the HOPWA report will be deferred until confirmation from J. Orozco is secured.

I. ADMINISTRATIVE MATTERS

1. Approval of Agenda

MOTION #1: Approve the Agenda Order **(Quorum was not reached; no vote was held.)**

2. Approval of Meeting Minutes

MOTION #2: Approval of Meeting Minutes **(Quorum was not reached; no vote was held.)**

II. PUBLIC COMMENT

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

There were no public comments.

III. COMMITTEE NEW BUSINESS

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

There were no committee new business items.

IV. REPORTS

5. Execute Director/Staff Report

- Cheryl Barrit informed the Planning, Priorities and Allocations (PP&A) Committee that the Comprehensive HIV Plan is complete and available for public comment until Nov. 21st.
- C. Barrit shared that there were approximately over 135 attendees at the Commission on HIV Annual Meeting and that evaluations pending. A summary of evaluations will be available at the next Executive Committee meeting on Dec. 7th.
- C. Barrit also noted the presentation made by Wendy Garland from the Division of HIV and STD Programs (DHSP) on Ryan White Program (RWP) Unmet Needs Framework and recommended the PP&A Committee agendize revisiting the updated framework in early 2023 and plan action steps to maximize RWP award for the next program year.

6. Co-Chair Report

- **Co-chair Nominations –** Kevin Donnelly was nominated for PP&A co-chair for 2023 by Miguel Martinez with a second from Dr. William King. K. Donnelly accepted the nomination. M. Martinez inquired about co-chair eligibility. C. Barrit reminded attendees eligibility for co-chair is at least one year of service on the Commission. There is also a goal to have at least one co-chair as a RWP consumer, if possible, to ensure equal representation between consumer and provider perspectives. Dr. LaShonda Spencer was nominated by M. Martinez but declined the nomination. Al Ballesteros was nominated by Dr. King. C. Barrit will notify A. Ballesteros of his nomination. Elections will be held at the next PP&A meeting.
- **Committee Workplan Update –** Work plan has been revised to note updates made on tasks. (see meeting packet).
- **Prevention Planning Workgroup (PPW) Workplan Updates** - M. Martinez reported PPW finalized their workplan at their last meeting (see meeting packet for PPW workplan). PPW will be meeting Wednesday, Nov. 16th and there will be a presentation from DHSP as well as a review

of the remaining portion of the Knowledge, Attitudes and Beliefs (KAB) survey. K. Donnelly commented that PPW activities will be incorporated into future PP&A Committee meetings/discussions in 2023.

- **Holiday Meeting Schedule (December 20, 2022) –** December PP&A Committee meeting was cancelled. Regular PP&A Committees will resume on January 17th, 2023.
- **Comprehensive HIV Plan 2022-2026 Updates** – K. Donnelly noted AJ King provided a brief overview of the Comprehensive HIV Plan during the Commission on HIV annual meeting and the plan is currently out for public comment and will be submitted to Health Resources and Services Administration (HRSA) in December.
- **Sexually Transmitted Diseases (STI) Crisis** – K. Donnelly noted that during the Nov. Executive Committee meeting A. Ballesteros recommended PP&A Committee discuss options for recommendations to the Board of Supervisors on addressing the STI crisis in LA County. K. Donnelly stated that this discussion will be agendized in early 2023.

7. City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report

a. Housing Services | Updates

a. Service Utilization, Costs and Gaps

b. Available Housing Inventory for PLWH

c. Waiting Lists

No HOPWA Report was provided. Staff will reach out again to Chuy Orozco, HOPWA Representative, to have data available for the January meeting.

8. Division of HIV and STD Programs (DHSP)

•Ryan White Program Expenditures

- Victor Scott provided an overview of current RWP expenditures for Program Year (PY) 32 as of Nov 2022.
- There is an estimated carryover of approximately $2.3 million in Minority AIDS Initiative (MAI) funds. Ten percent of administrative costs must be spent and cannot be carried over into PY 33.
- C. Barrit inquired if DHSP would need to return to the Committee before the end of PY 32 for any potential recommendations on reallocations to maximize the award and match areas where the Commission on HIV (COH) may not have allocated enough funding for a particular service. Dr. Michael Green responded that DHSP did not anticipate the need to return back to the COH. DHSP has the authority to expand contracts if expenditures allow. Dr. Green did confirm DHSP will continue to provide regular updates that will include information on how resources are spent to the COH for the remainder of the program year.
- K. Donnelly inquired if the allocation of funds will need to be reallocated at the end of each program year with the new RWP 3-year cycle. Dr. Green responded by saying the COH [planning council] has already allocated funds for each year of the 3-year cycle but has the liberty of reviewing and redistributing allocations at any point throughout the 3-year cycle. He also confirmed there is a requirement to certify the allocations being reported [to HRSA] are synchronized with allocations at the beginning of each term

year.

- K. Donnelly inquired if DHSP is currently using RWP funds to cover gaps in services (such as Mental Health) for those covered by Medi-Cal given the recent Medi-Cal expansion and proposed further expansion to those aged 18-49 in 2024. Dr. Green commented that the current largest expenditure in LAC RWP funds is Medical Care Coordination (MCC), but the largest concern is the potential for shifts in Ambulatory/Outpatient Medical (AOM) costs. Dr. Green commented that anticipated shifts in AOM costs resulting from the Medi-Cal expansion have yet to be seen and is unsure if expenditures will increase when Medi-Cal is expanded to ages 18-49 in 2024. He also noted Mental Health services and Housing are areas where investments can increase but noted a lack of capacity at the agency level to serve more clients. A solid understanding of the housing needs of PLWHA is unknown at the moment as HOPWA housing services have yet to be reported.
- Dr. King expressed concern with clients transitioning from RWP to Medicaid and inability to access specialists (e.g., cardiologists) as he has noted many providers do not accept Medicaid. He inquired if any modeling has been done regarding access to services for people transitioning from RWP to Medicaid and where these individuals would receive care. Dr. Green noted DHSP does not have this information and the questions would need to be addressed by the state Department of Health Care Services. He also noted DHSP relies on the Medical Advisory Committee (MAC) that is comprised of physicians from DHSP-funded agencies for transparency on any challenges physicians are facing in providing medical services within LA County. DHSP has asked the MAC numerous times if there are issues with providing specialty services and the MAC has consistently expressed that it is not a problem. DHSP does not currently have a contract for medical specialty services as they have had in the past. No agency applied for medical specialty care services funding and DHSP is unaware of how clients access specialty care.
- Dr. LaShonda Spencer commented that clients at Oasis Clinic over 50 years of age recently transitioned to DHS Medi-Cal and did not have a disruption in service and were able to keep the same provider. She noted she was not aware of how the transition was managed on the back end.
- Dr. King inquired about reimbursement rates for specialty services. Dr. Green noted Medi-Cal rates are lower than Medicaid rates, but reimbursement rates are individually calculated for each federally qualified health center (FQHC). Dr. Spencer added the level of care may also very across providers. Dr. Green noted the gaps in care provided thru DHSP-funded agencies present an opportunity to supplement services.

V. DISCUSSION

9. DHSP Response/feedback to the Comprehensive Program Directives for PY 32, 33, and 34

- Pamela Ogata presented DHSP responses to the Comprehensive Program Directives. See meeting packet for the directives document.
- K. Donnelly inquired if Heluna Health was a contracted agency. P. Ogata confirmed Heluna Health is contracted with DHSP and will subcontract with other agencies to provide services for

target populations. M. Martinez inquired if DHSP will no longer be moving forward with RFPs directly with the County. P. Ogata stated contracting with Heluna Health to subcontract to other agencies would be one mechanism for contracting with agencies for services and that DHSP will also continue with the traditional RFP process to contract directly with the County.

- M. Martinez inquired if the contract amount result in less money being allocated for direct services due to distribution through two agencies versus one. Dr. Green commented there is a 10% administrative cap, and this method of contracting does not impact the allocation amount for direct services.
- K. Donnell inquired if street medicine is being considered as part of nonmedical case management. P. Ogata confirmed DHSP is currently working on developing the street medicine program and DHSP is currently in contract deliberations.
- Karl Halfman inquired if the new RWP data system be an "off the shelf" system or if DHSP will be building their own system. Dr. Green responded that the new system will be customized from an existing product with a goal to go live by March 2024.

10. Gaps in services allowable for reimbursement under Ryan White Program

- C. Barrit reminded the Committee this is a follow-up from a previous meeting where A. Ballesteros suggested reaching out to providers to identify potential gaps in services that can be augmented with RWP funds. P. Ogata stated DHSP has not received any concrete requests but will follow up with colleagues. C. Barrit suggested hosting a listening session for providers around MCC and AOM at a future PP&A Committee meeting. K. Donnelly agreed and suggested hosting the listening session in February or March of 2023.

VI. NEXT STEPS

11. Task/Assignments Recap

- Review Unmet Needs Framework
- City of Los Angeles Housing Opportunities for People Living with AIDS (HOPWA) Report
- Planning for provider listening session regarding using RWP funds to augment gaps in services

12. Agenda Development for the Next Meeting

a. Co-chair elections
b. Addressing the STI Crisis
c. Prevention Planning Workgroup

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

14. Adjournment for the Meeting of November 15, 2022.

The meeting was adjourned by K. Donnelly at 2:53pm.

LOS ANGELES COUNTY COMMISSION ON HIV

2023 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

Committee Name: **PLANNING, PRIORITIES AND ALLOCATION COMMITTEE (PP&A)**	Co-Chairs: Kevin Donnelly & Alvaro Ballesteros
Committee Adoption Date:	Revision Dates:
Purpose of Work Plan: To focus and prioritize key activities for COH 2023	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Monitor the implementation of the CHP	The Committee will work with DHSP and various partners to implement and monitor progress toward meeting the goals and objectives of the CHP.	Ongoing 1/1/2023 – 12/31/2026	Agendize item at PP&A meetings.
2	Strengthen Core Planning Council Responsibilities	The Committee will continue to improve the Commission's prevention and care multi-year planning process and decision-making.	Ongoing	PP&A has increased the scope and frequency of data reviewed in the decision-making process to optimize services offered.
3	Develop Strategies for Maximizing Part A and MAI Funding	Monitor and assess COH directives for DHSP to effectively expend Part A and MAI funds to meet the needs of the underserved with specific focus on minority communities.	Ongoing	The Committee will continue to use data provided by DHSP and Ending the HIV Epidemic (EHE) Plan recommendations in multi-year planning efforts. *Program Directives for PY 32, 33, and 34 approved by the COH on 6/9/22. DHSP provided report on directives Nov. 2022*
4	Review, discuss and understand financial information from DHSP	Review and monitor fiscal reports on all HIV funds supporting LAC HIV Care and Prevention services.	Ongoing	The Committee has requested DHSP provide this information on a monthly basis.

LOS ANGELES COUNTY COMMISSION ON HIV

2023 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

5	Annual Progress Report (APR)	Review progress report prepared for Health Resources and Services Administration (HRSA) by DHSP	08/2023	
6	Review and re-evaluate, as needed, ranked service categories for PY 33-35 (FY 2023-24; 2024-2025; 2025-26)	Rank (HRSA) Ryan White services numerically and obtain Commission approval to provide service rankings to DHSP for program implementation.	TBD	This is part of the integrated prevention and care multi-year planning task required for the receipt Ryan White funding. The Committee leads the process for the Commission and dedicates several meetings to review data and deliberate on findings before ranking services. *PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY 32 allocations approved by the COH 7/14/22.*
7	Revise, as needed, funding allocations for FY 2023, 2024 and 2025 based on estimates and landscape analysis provided by DHSP.	Determine financial resource allocation percentages for HRSA ranked services and obtain Commission approval to provide to DHSP for program implementation.	TBD	*PY 33 and 34 service categories ranking approved by the COH 9/2021. Revised PY 32 allocations approved by the COH 7/14/22*
8	Incorporate Prevention Planning Workgroup strategies and priorities.	Develop integrated prevention and care planning strategies as related to HIV, STDs, HCV and SUD.	Ongoing	The committee established a Prevention Planning Workgroup (PPW) to prepare short- and long-term prevention activities for recommendation to DHSP; DHSP to provide prevention data
9	Discuss systems of care changes and impact on care and prevention planning.	Agendize the following topics for Committee discussion: 1. Medi-Cal expansion to low- income 50+ individuals regardless of documentation status.	Ongoing	Regular reports from DHSP. Discuss opportunities to utilize RWP funds to address changes.

2023 WORK PLAN – PLANNING, PRIORITIES AND ALLOCATIONS COMMITTEE

		2. CalAIM (California Advancing and Innovating Medi-Cal) 3. Decrease in purchasing power of grant funds due to inflation 4. Making status-neutral planning the norm for PP&A and COH		

ELIMINATING CONGENITAL SYPHILIS IN LOS ANGELES COUNTY: A CALL TO ACTION

Los Angeles County Department of Public Health
Division of HIV and STD Programs

This report offers detailed background information tied to the current congenital syphilis epidemic in Los Angeles County and provides a roadmap to enhance control efforts. The report draws from best practices and recommendations shared at the national, state and local levels. As an initial catalyst for shared action, this report focuses on three goals that require traditional and non-traditional partnerships. Achieving these goals is critical to building a strong congenital syphilis control foundation – a foundation that can support additional efforts over time.

NOTE: In this plan, we use the term "woman" to describe persons assigned female gender at birth. This is with the understanding that there are people who are assigned female at birth who may not identify as women. More inclusive wording would replace "pregnant women" with "pregnant persons" and "women of reproductive age" with "persons who could get pregnant." Unfortunately, many of the health and social services described in this plan remain oriented around cisgender and binary gender identities, and the terminology in this document reflects this.

January 2020

CONTENTS

Figures

EXECUTIVE SUMMARY

Congenital syphilis (CS) is a serious but preventable bacterial infection transmitted from mother to fetus. In the United States (U.S.) more newborn infants are affected by CS than by many other neonatal infections, including human immunodeficiency virus (HIV). To address this public health crisis and maximize CS prevention efforts, increased awareness of the scope of the problem is needed along with a renewed commitment to address the broader syphilis epidemic among policy makers, public health officials, public-sector and private-sector health care providers, and community-based stakeholders.

The current CS crisis is complex. Not only are syphilis rates in general in Los Angeles County (LAC) rising at levels not seen in over 30 years, but increases are most stark for women, with over a 400% increase in six years. Given this sudden rise, many women at elevated risk of syphilis are unaware of their risk and may not be screened for the infection by their health care provider. Unfortunately, in LAC, two thirds of the women giving birth to newborns with CS received no or late prenatal care. Almost half report active substance use during pregnancy, one-quarter had been arrested in the previous two years, and upwards of one-fifth had experienced housing instability or homelessness. It is likely that these factors may be contributing to inconsistent, late or no prenatal care, which in turn results in a delayed or missed diagnosis of syphilis in pregnancy.

To effectively prevent and eliminate CS, we need a reinvigorated effort to identify and prevent new syphilis infections. This also includes upstream efforts to reduce the risk and prevent the spread of infectious syphilis in the general population, particularly among men, including men who have sex with men and women. CS can be eliminated through early, effective screening of women for syphilis and stage-appropriate treatment and follow-up of women diagnosed with the infection and their sexual partners. LAC health care providers must implement robust syphilis screening and treatment for pregnant women and at-risk populations within health care settings. Suboptimal syphilis screening is multi-factorial, and at-risk women should be advised of the rising rates and offered expanded opportunities to test in non-clinical settings. Lastly, delayed or inconsistent prenatal care is a common contributor to CS, which speaks to the need for alternative models of medical care and case management to help some of our society's most vulnerable women.

INTRODUCTION

Syphilis is a sexually transmitted disease that has experienced a significant resurgence across the United States (U.S.), in California and in Los Angeles County (LAC) over the last decade. In 2018, there were nearly 8,000 reported cases of syphilis in LAC. Increasing U.S. congenital syphilis (CS) rates are driven by rising trends in western and southern states, with California, in particular, contributing one third of the U.S. CS cases.[i] In LAC, CS cases increased 800% between 2012 and 2018 (from 6 reported cases in 2012 to 54 in 2018), coinciding with a similar rise in annual syphilis cases among women of reproductive age, which increased 430% from 173 cases in 2012 to 924 cases in 2018.

CS, an infection transmitted from mother to child during pregnancy and/or delivery, is a preventable disease. Untreated syphilis infection in the womb can cause potentially severe consequences for a developing fetus. CS can lead to stillbirth, neonatal death, premature birth, low birth weight, and a range of complications. Fetal infection can occur during any trimester of pregnancy. Treating a pregnant woman infected with syphilis also treats her fetus.

To address the rising CS crisis, the Centers for Disease Control and Prevention (CDC) has called on health care providers to increase screening for syphilis among pregnant women and provide immediate treatment of women diagnosed with syphilis. In 2015, the California Department of Public Health (CDPH) recommended that local health departments improve their case management and contact tracing (also referred to as "Partner Services") for female syphilis cases and improve collaborations with organizations such as maternal and child health programs, family planning providers, correctional health, and drug treatment centers.[ii] Fortunately, in LAC, many of these elements for CS prevention are in place, including 1) universal first and third trimester prenatal syphilis screening recommendations, implemented in 2018; 2) public health staff to provide case management to pregnant women and their partners to ensure prompt screening and treatment; and 3) existing collaborations with women's health, substance use disorder (SUD), and correctional health care partners.

The overarching goal of the present initiative is the elimination of CS in LAC. Elimination of CS would reduce the numbers of miscarriages, stillbirths, preterm and low-birth-weight infants, and perinatal deaths, thus contributing to the achievement of the Department of Public Health (DPH) goals related to reducing infant mortality.

Clinical Overview of Syphilis and CS: Presentation, Natural History and Range of Outcomes

CS is a multi-system infection caused by the bacteria *Treponema pallidum* in a fetus or infant, passed via vertical transmission (mother to fetus) during pregnancy. Overall risk of infection of the fetus in utero is between 60 and 80%, and fetal infection is more likely when a mother is infected with syphilis during her pregnancy, when over a third of cases lead to fetal or neonatal mortality.[iii] However, fetal infection can occur at any stage of maternal disease, which means that even syphilis infections acquired by a woman before she becomes pregnant can lead to a CS diagnosis.

Syphilis in pregnancy is associated with multiple perinatal complications such as intrauterine growth restriction, preterm labor, placental abnormalities, and stillbirth. In infected neonates, manifestations of syphilis are classified as early congenital (i.e., birth through age two years) and late congenital (i.e., after age two years). Early CS commonly manifests in the first three months of life with symptoms such as skin lesions, neurologic problems, bony malformations, and facial disfiguration. Late CS manifests after two years of age and can present as ulcers, tooth and bony deformities, blindness, deafness, and intellectual disabilities.

The CDC requires that local health departments conduct data monitoring of all syphilis cases within their jurisdiction. The CDC defines a case of CS based if one or more of the following criteria are met:

For maternal case, mother has at least (one) of the following:

- New case of syphilis diagnosed <30 days prior to delivery or at delivery;
- Untreated (diagnosed with syphilis >30 days prior to delivery);
- Inadequately treated, e.g. incomplete treatment, inappropriate intervals between doses; or
- Reinfection during pregnancy (titer increase of ≥ 4-fold).

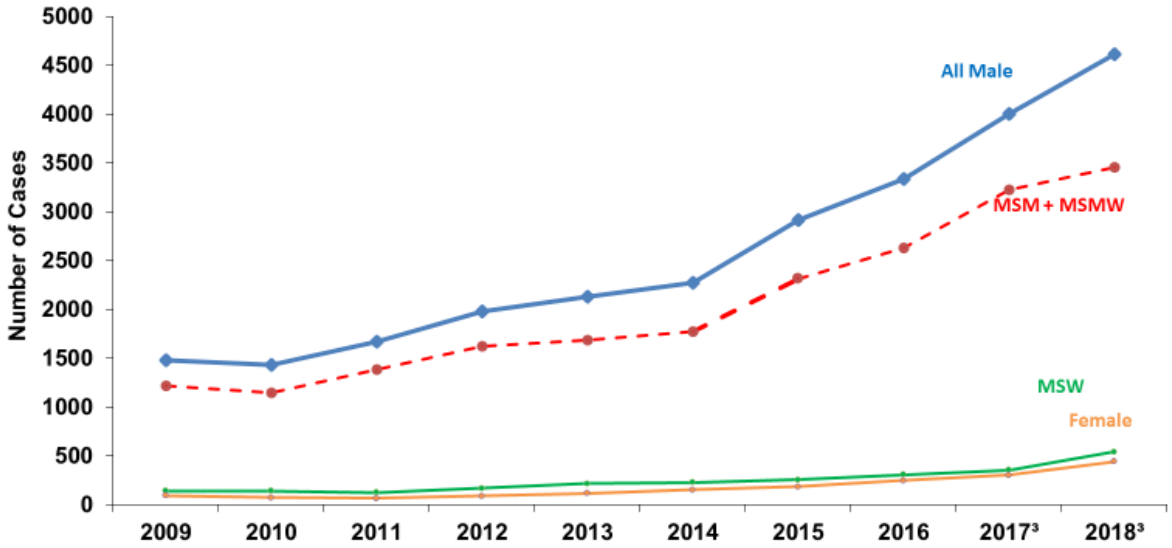
For neonatal case, neonate has at least (one) of the following

- Positive darkfield or PCR;
- Stillbirth (fetal death that occurs after 20 weeks gestation or weighing > 500g, and the mother had untreated or inadequately treated syphilis at delivery); or
- Reactive non-treponemal result, and has any one of the following: physical signs of CS, evidence of CS on long bone x-ray, reactive CSF-VDRL, or elevated CSF WBC count or protein (without other cause).

Overview of Epidemiology of Syphilis and CS in LAC, 2000-2019

A total of 7,858 cases of syphilis were reported in LAC in 2018. Two-thirds of cases were staged as early syphilis, which includes include primary, secondary, and early non-primary non-secondary syphilis, the infectious forms of syphilis (as opposed to late syphilis which is not an infectious stage). Since 2011, the number of reported early syphilis cases has risen by 195% from 1750 cases to 5171 cases in 2018. Most early cases of syphilis in 2018 were among males (89%), followed by females (9%), and individuals who identified as transgender (2%). Among males diagnosed with early syphilis in 2018, 82% of cases occurred among men who have sex with men (MSM), 4% among men who have sex with men and women (MSMW), and 14% among men who have sex with women (MSW).

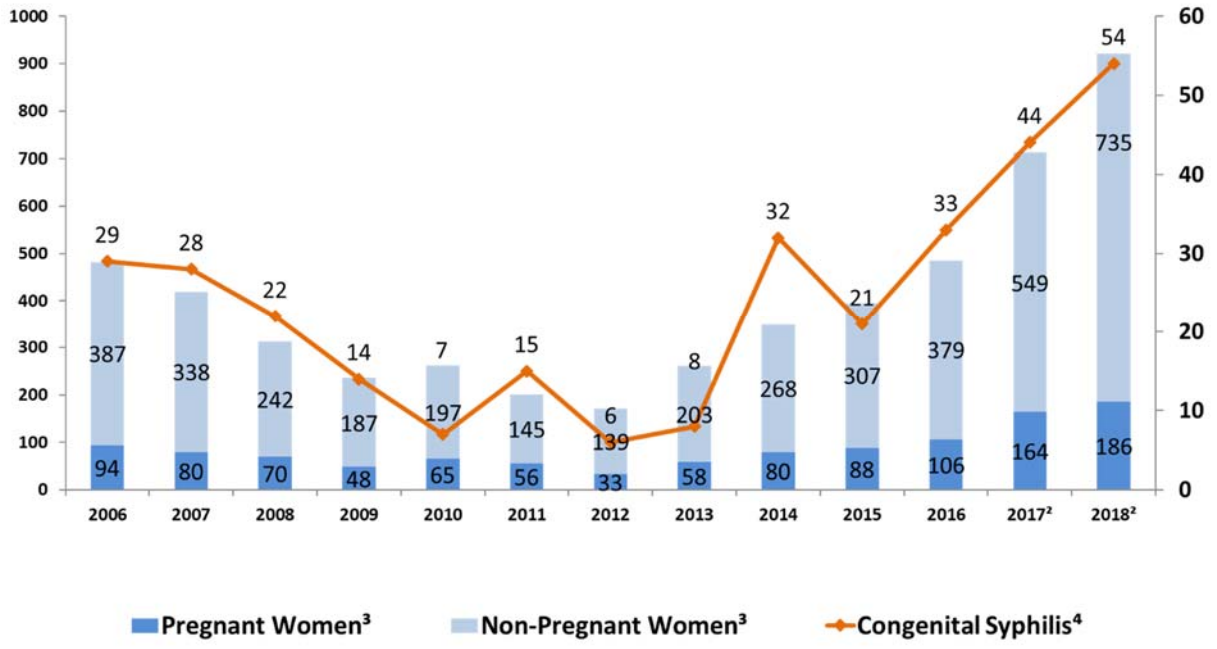
Figure 1. Early Syphilis, Number of Cases by Gender and Gender of Sex Partners, LAC, 2009-2018



Syphilis Trends in Pregnant Women and CS Cases

During the same period that LAC has experienced a rise in syphilis cases in women of reproductive age, it has also seen a significant increase in congenital syphilis cases, with an 800% increase between 2012 (6 cases) and 2018 (54 cases). Historically, cases of congenital syphilis have tracked closely to trends in syphilis cases among women of reproductive age and pregnant women, as depicted in Figure 2.

Figure 2. Number of Female Syphilis Cases (All Stages) and Congenital Syphilis Cases, LAC 2006-2018[1]



[1] Data are from STD Casewatch as of 06/16/2019 and excludes cases from Long Beach and Pasadena [2] 2017-2018 data are provisional due to reporting delay. [3] Syphilis among females of reproductive age (ages 15-44) including all cases staged as primary, secondary, early latent and late latent or unknown duration. [4] Congenital Syphilis includes syphilitic stillbirths.

After several years with no syphilitic stillbirths between 2007 to 2011, LAC has experienced one or more syphilitic stillbirth every year since 2012. In addition, in both 2017 and 2018, two neonates died within days of birth from complications that included syphilis. The stillbirths and neonatal deaths all occurred among women who became infected with syphilis during their pregnancy.

Unfortunately, the CS crisis is not isolated to LAC. In 2018, California experienced 329 cases of CS, representing a quarter of the nation's cases (1,306 CS cases). The 2018 U.S. rate of congenital syphilis was 33.1 cases per 100,000 live births, compared with 68.2 for California, and 53.6 for LAC. Within California, the jurisdictions with the highest cases are Fresno, Kern, San Bernardino, San Joaquin, and Los Angeles Counties; when adjusted for number of live births, Los Angeles has a lower rate than 16 other counties (ranked 17th of 58 counties).[iv]

Syphilis Trends in Women of Reproductive Age

In the U.S., California, and LAC, some communities experience disproportionately high rates of sexually transmitted infections. Men who have sex with men (MSM) face the largest burden of syphilis infection and certain racial/ethnic groups shoulder a disproportionate burden of sexually transmitted disease (STD), including syphilis, gonorrhea and chlamydia infections. The relationship between race/ethnicity and STDs

is multifactorial and complex. African-Americans have the highest rates of syphilis in LAC. While the rate of syphilis is higher among African-American women compared to Latinas, more cases occur among Latinas than any other group, as they make up a larger proportion of the LAC population.

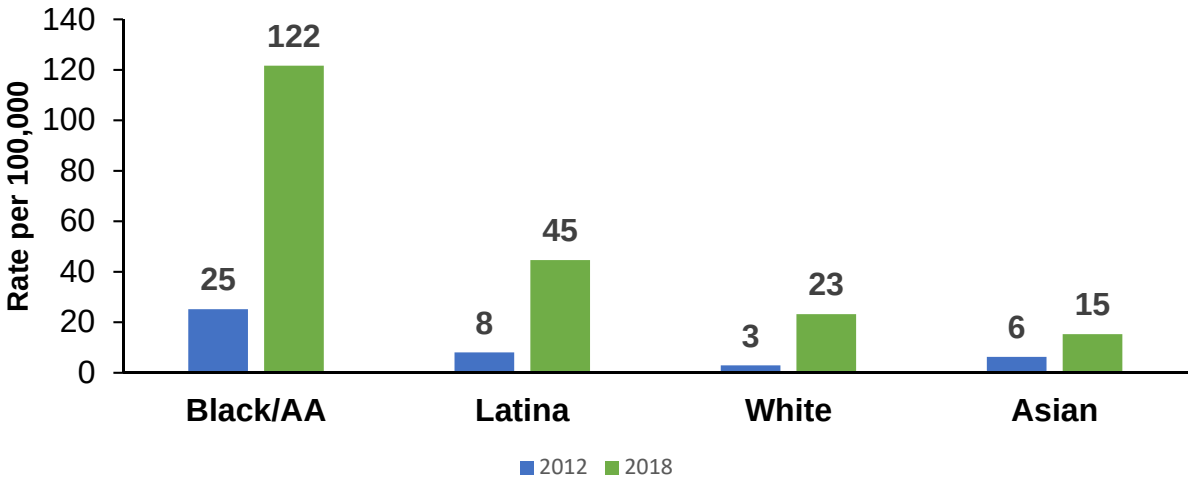
Figure 4 show syphilis case counts and rates, respectively, among women of reproductive age (15-44 years) in 2012, before the current CS crisis, and 2018, by race/ethnicity. In 2018, a total of 924 cases were reported in women in this age range. In LAC, the median age of a woman diagnosed with syphilis in 2018 was 34 years and the median age of a pregnant woman with syphilis was 27 years. In 2018, among pregnant women with syphilis, 61% were Latina, 20% were African American, 7% white, and 6% Asian.

Figure 3. Syphilis Cases among Reproductive Age Women, 15-44 years, by Race/Ethnicity, LAC, 2018[1]

Race/Ethnicity	Number of Cases (%), 2012	Number of Cases (%), 2018
Latina	86 (50)	485 (52)
Black/African American	42 (24)	201 (22)
White	14 (8)	111 (12)
Asian	18 (10)	44 (5)
Other/Missing/Unknown	13 (8)	83 (9)
TOTAL[2]	173	924

[1] 2018 data are provisional due to reporting delay. Syphilis includes all cases staged as primary, secondary, early latent and late latent or unknown duration. [2] Total includes other and missing race

Figure 4. Rate of Syphilis among Women Ages 15-44 by Race/Ethnicity, LAC, 2012 (n=160) and 2018 (N=640)[1]



[1]Total syphilis includes all cases staged as primary, secondary, early latent, late latent and late unknown duration; data for Native Hawaiians, Pacific Islanders, Native Americans, Alaska Natives, Multiple Race and Other Race are suppressed due to small numbers; 2017 data are provisional due to reporting delay and exclude cases in Long Beach and Pasadena.

In LAC, there are notable geographic variations associated with syphilis cases in women. Cases of syphilis in women are occurring throughout the County, with the greatest case counts in South Los Angeles, the San Gabriel Valley, and Metro/Downtown Los Angeles. The highest rates in 2018 occurred in the South Service Planning Area (SPA) 6, with 94 cases per 100,000 women, Antelope Valley SPA 1 with 59 per

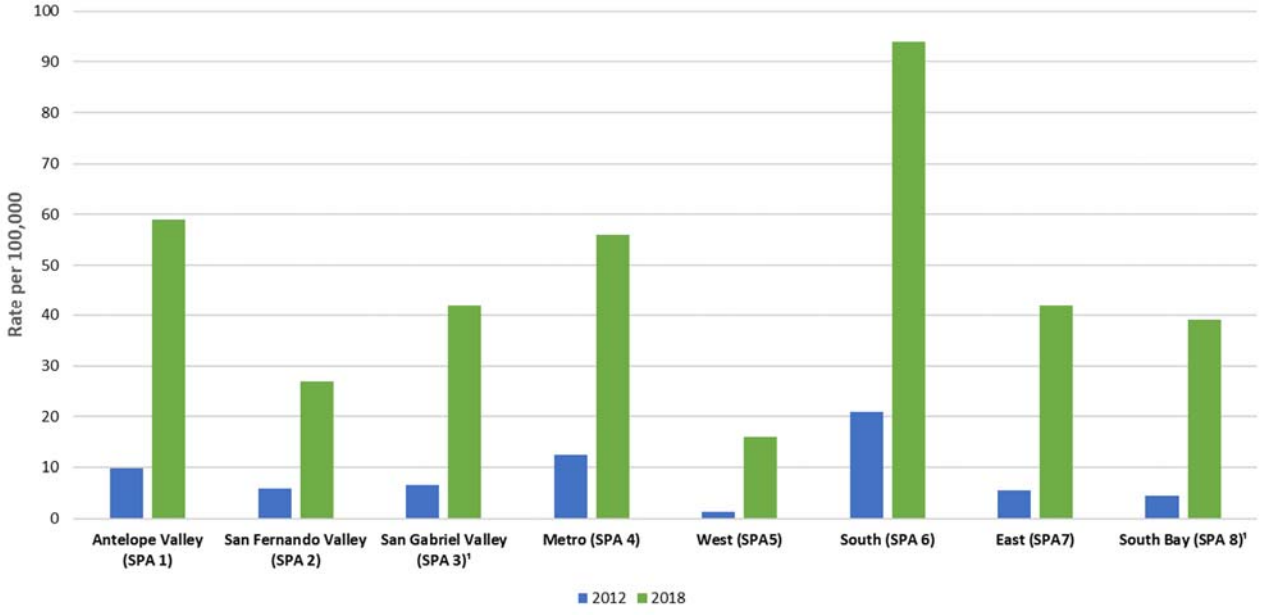
100,000 women, and Metro SPA 4, with 56 cases per 100,000 women, compared to the average LAC rate of 46 cases per 100,000 women ages 15-44 years.

Figure 5. Percentage Change in Female Syphilis Cases 2012-2018

Service Planning Area (SPA)	Female Syphilis Cases[1] 2012	Female Syphilis Cases[1] 2018	Percent Change 2012 to 2018
Antelope Valley (1)	8	50	+ 525%
San Fernando Valley (2)	27	123	+ 356%
San Gabriel (3)	22	142	+ 545%
Metro (4)	32	142	+ 344%
West (5)	2	24	+ 1100%
South (6)	50	229	+ 358%
East (7)	16	120	+ 650%
South Bay (8)	10	84	+ 740%
TOTAL[2]	173	924	+ 434%

[1] Includes female syphilis cases of reproductive age (15-44). [2] Includes cases with unknown SPA.

Figure 6. Rate of Syphilis among Women Ages 15-44 by Service Planning Area (SPA), LAC, 2012-18



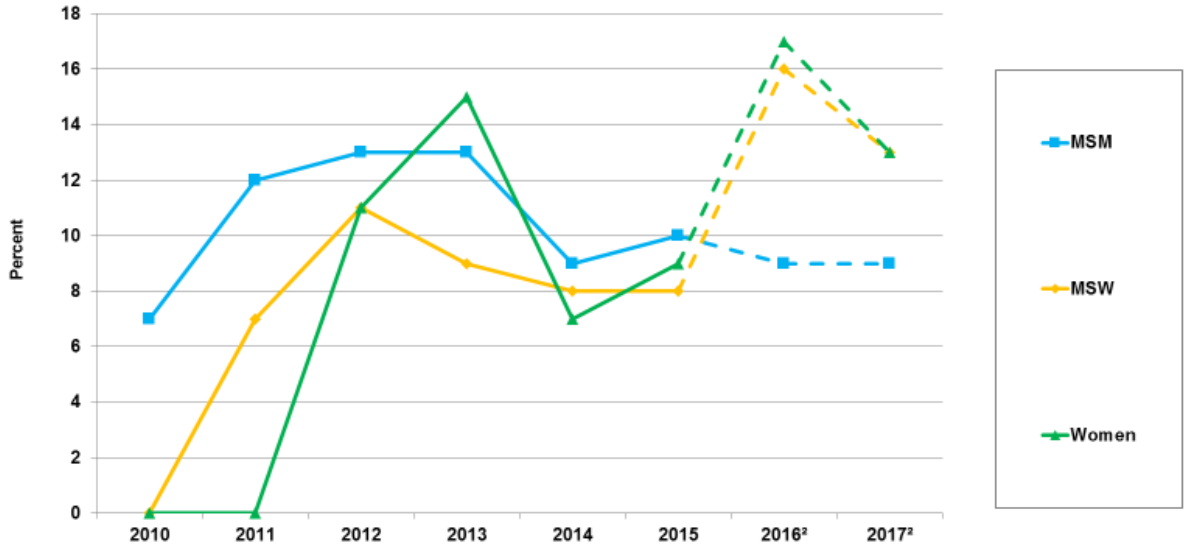
[1] SPA 3 cases do not include those in the City of Pasadena and SPA 8 do not include those in the City of Long Beach. Syphilis includes all cases staged as primary, secondary, early latent and late latent or unknown duration.[2] Total includes other and missing race.

Substance Use Disorders and Syphilis

While not directly a means of syphilis acquisition, substance use represents an important risk factor for syphilis. In a recently published Morbidity and Mortality Weekly Report, the CDC stated that a substantial percentage of the heterosexual syphilis transmission is occurring among persons who use substances (particularly methamphetamine), persons who inject drugs or have sex with persons who inject drugs, or

persons who use heroin.[v] The report highlighted that heterosexual syphilis and drug use are intersecting epidemics and that these overall trends were more acute on the west coast. In LAC, an increasing percentage of heterosexual persons with primary or secondary syphilis cases report methamphetamine use (Figure 7). During the past few years, up to two thirds of women who gave birth to babies with CS reported actively using substances (primarily methamphetamine) during pregnancy.

Figure 7. Percentage of Methamphetamine Use Among P&S Syphilis Cases by MSM, MSMW, and Women, LAC, 2010-2017[1]



[1]Primary & Secondary Syphilis cases with data on substance use in past 12 months. Excludes injection drug users. Data as of September 9, 2018.[2]2016-2017 data are provisional due to reporting delay. Source: Division of HIV and STD Programs

KEY FINDINGS FROM CS CASE REVIEWS

To better understand the missed opportunities and challenges associated with congenital syphilis cases in LAC, the DPH began conducting multidisciplinary morbidity and mortality (M&M) review boards in early 2018. These ongoing review boards provide an opportunity to closely examine each case of congenital syphilis and identify missed opportunities for CS prevention. While precise numbers vary slightly from year to year, there were some trends identified among women associated with congenital syphilis cases between 2016 and 2018, which are described below.

Clinical Findings:

- Approximately 60% of women received late (first prenatal visit in second or third trimester) (20%) or no prenatal care (40%);
- For those with early prenatal care, subsequent inconsistent prenatal care later contributed to low 3rd trimester screening;
- Almost 50% of the cases were identified by syphilis screening at delivery; of these, often women were discharged prior to the return of their syphilis test results;
- The mortality rate for CS was 9%, with two stillbirths and two neonatal deaths in both 2017 and 2018; and
- Two women in 2018 were diagnosed with both HIV and syphilis during pregnancy, with one infant being perinatally infected with HIV.

Demographics and Co-morbidities:

- Most cases occur primarily among Latina (60%) and African American (25%) women;
- Up to two-thirds of women reported active substance abuse during pregnancy, with methamphetamines alone being the most commonly report drug of choice (followed by polysubstance use of methamphetamine and heroin);
- Almost 30% of women had a history of arrest or incarceration;
- Between 10 and 20% of the women reported being homeless; and
- 30% or more of the infants with congenital syphilis were placed into the custody of the Department of Children and Family Services (DCFS) after birth.

Key contributors and opportunities for CS prevention

Three key factors appear to contribute to the growing CS crisis in LAC: the rising and **high prevalence of syphilis** in the general population, **suboptimal syphilis screening**, and **delayed or inconsistent prenatal care**.

Key Contributor: High prevalence of syphilis

In LAC, as syphilis cases continue to increase by up to 15% per year, there is a growing pool or reservoir of the infection locally. If the number of syphilis cases continues to increase at a high rate in LAC, it will be more likely that syphilis will be less concentrated and more generalized within the population. As the prevalence of syphilis infection in the overall population rise, so too will the rates among women of reproductive age. As seen in Figure **2**, the number of CS cases tracks closely with the number of syphilis cases in women of reproductive age.

GOAL 1: ROBUST SYPHILIS SCREENING AND TREATMENT FOR SYPHILIS IN AT-RISK POPULATIONS, INCLUDING WOMEN OF REPRODUCTIVE AGE AND PREGNANT WOMEN, WITHIN HEALTH CARE SETTINGS

Because syphilis infection can often be asymptomatic, screening is an important component of disease detection. When paired with timely treatment, this practice can reduce sexual transmission, prevent late-stage sequelae, and avert vertical transmission from mother to fetus for patients who become pregnant.[vi] Health care providers play a critical role in the control of syphilis given their access to patients and the fact that testing for and treatment of syphilis are two of the most effective ways to reduce future cases.

Key Contributor: Suboptimal syphilis screening

Despite rising syphilis rates in women, many women at risk may not be screened for the infection. Health care providers may not be fully aware of the extent to which syphilis is affecting their community and what local DPH clinical recommendations exist for congenital syphilis prevention. From the patient perspective, barriers to STD screening include cost, concerns about privacy, fear of judgement, and medical mistrust. [vii]

GOAL 2: INCREASE AWARENESS OF SYPHILIS AMONG WOMEN AT HIGHEST RISK WITH EXPANDED OPPORTUNITIES FOR TESTING IN NON-CLINICAL SETTINGS

To improve health outcomes in populations at risk for syphilis and CS, we must engage in activities that reduce barriers to information access, as well as screening and treatment. Culturally competent interventions should include appropriate messaging to those at risk, fostering community collaboration, and supporting the implementation of tailored intervention strategies for affected populations.

The need for new venues through which to identify and screen women for syphilis is high, and selection of setting should be guided by an understanding of how the women who are at highest risk of infection may be contacted. A recent California Department of Public Health analysis of women who birthed CS infants suggested the following as potential sites for future syphilis screening: programs for people with SUD, correctional facilities, and field outreach to homeless encampments.[viii]

Key Contributor: Delayed or inconsistent prenatal care

The most common picture painted by the DPH Morbidity & Mortality case reviews is that there are pregnant women in LAC who are at risk for syphilis who are not engaging in optimal prenatal care. A systematic review of studies examining women who do not seek prenatal care found that low valuation

of prenatal care was a common factor, second only to financial barriers.[ix] Fortunately, access to health care providers or health insurance was not noted as a significant barrier in LAC CS cases; this may be due to the fact that in California, all low-income pregnant women, regardless of their immigration status, are eligible for health care coverage through Medi-Cal for the duration of their pregnancy.

For many women, the daily stress, complications of life, and the powerful cravings and compulsions associated with substance use can result in prenatal care being a low priority.[x] Pregnant women with SUD may also fear the legal ramifications of their substance use, such as criminal prosecution or forcible removal of their children. In addition, perceptions of unfair treatment or disrespect are common among racial/ethnic minorities and have been associated with delayed care.[xi] Women in California and Louisiana involved in CS cases, interviewed by Jennifer Wagman and colleagues, shared significant mistrust of medical institutions, as summarized here[xii].

> *"Many pregnant women felt judged or as if providers were trying to rush them out, which created mistrust. Trepidations were most pronounced among active or recovered substance users, homeless women, undocumented immigrants, and women in violent relationships. Women commonly narrated fears of receiving a warrant or that child protection services would take their children away, causing some to evade prenatal care until birth."*

GOAL 3: ENHANCED CARE MODELS FOR VULNERABLE WOMEN

Appropriate and aggressive screening for syphilis is a critical intervention, but the health care system must evolve to better meet the needs of women challenged with multiple co-morbidities, such as SUD and homelessness. There is a need for disruptive innovation in health care and case management service models structured for pregnant woman in order to meet the needs of women experiencing such high levels of vulnerability, particularly women using methamphetamines.

Eliminating CS will require an intense focus on the three goals outlined above. Recommendations for specific partners to help achieve these goals are described and based on national best practices and lessons learned from other disease control efforts. However, to truly eliminate CS, we must address the upstream social, environmental and structural drivers that contribute to poor health outcomes in general, and syphilis infection. Absent these larger structural interventions to address the needs of and risks for women suffering from SUD, mental illness, and homelessness, congenital syphilis in LAC will be difficult to eliminate.

GOAL 1: ROBUST SCREENING AND TREATMENT FOR SYPHILIS IN AT-RISK POPULATIONS, INCLUDING WOMEN OF REPRODUCTIVE AGE AND PREGNANT WOMEN, WITHIN HEALTH CARE SETTINGS

Because syphilis infection can often be asymptomatic, screening is an important component of disease detection. When paired with timely treatment, this practice can reduce sexual transmission, prevent late-stage sequelae, and avert vertical transmission from mother to fetus for patients who become pregnant.[xiii] Health care providers play a critical role in the identification and control of syphilis given their access to patients and the fact that testing for and treatment of syphilis are two of the most effective ways to reduce future cases.

Primary Care and Family Planning Provider Recommendations

Primary care providers use their expertise on a range of conditions to a diverse array of patients and are therefore critical to any efforts to control congenital syphilis. Family planning clinics are ideal locations to implement aggressive syphilis screening due to their existing focus on delivering high quality sexual health care.

Aggressively screen all women of reproductive age for syphilis

Primary care and family planning providers should routinely ask sexual history questions to identify women who are at increased risk and may need more frequent testing. However, studies have shown that the frequency and consistency of sexual history taking among primary care providers is poor, with one study finding that during annual physical examinations only 58% of primary care physicians reported taking a sexual history.[xiv] As a result, DPH has moved away from risk-based syphilis screening recommendations to a universal screening recommendation that **all women ages 15 to 44 years be screened for syphilis at least once** and then more often based on risk.

The advantage of a more universal recommendation is that it is independent of providers taking a thorough sexual history, can be more readily normalized into clinical care, and more readily adopted and incorporated into order sets and clinical reminders in electronic health records.

Identify at-risk individuals for more aggressive syphilis screening

Based on analysis of syphilis patterns in LAC, the following groups of people may benefit from additional syphilis testing:

Women

- Women with a new sexual partner since her last syphilis test;
- Women whose sexual partner(s) may have other partners, especially male partners;
- Women with a substance use disorder, particularly if they inject drugs or use methamphetamines;
- Women who exchange sex for money, shelter, or other things of value to them;
- Women who have been involved in the criminal justice system;
- Women experiencing homelessness or housing instability; and
- Pregnant women who access prenatal care late or not at all.

Men

- Men who have sex with men;
- Men with a substance use disorder, particularly if they inject drugs or use methamphetamines;
- Men who exchange sex for money, shelter, or other things of value to them;
- Men with a diagnosis of HIV or risk factors for HIV acquisition; and
- Men who have been involved in the criminal justice system.

Address Upstream Factors

While prenatal care is universally covered for all pregnant women in California, obstacles to establishing and maintaining prenatal care may arise from a host of factors of which substance use as well as, unstable housing, incarceration, and poverty play roles. Women who may become pregnant in the next year who screen positive for substance use disorder (SUD) and/or mental health issues should be referred for appropriate care. Women who are at risk for unintended pregnancy who are either not using contraception or who are not satisfied with their current method should be offered or referred for the full spectrum of contraceptive options, including long acting reversible contraception. Health care providers should consider using One Degree or other community-based resources for health and wellness support for women who are pregnant or desiring pregnancy who are experiencing unstable housing, food insecurity, or other wellness needs.

Public Health Support for Primary Care and Family Planning Providers

Public Health Detailing

Many providers are not aware of the recent trends in syphilis in the County and therefore do not recognize the need for increased screening. In the recent past, syphilis rates in women were so low that many health care providers, including some family planning providers, did not test regularly for syphilis or they considered syphilis a "non-issue" for women in LAC.

To address this knowledge gap, in 2018, DPH launched a syphilis focused provider educational campaign to raise awareness of rising congenital syphilis and syphilis cases in women. An accompanying "Syphilis in Women Action Tool Kit" was developed with information on syphilis screening, staging and treatment as well as mandatory reporting guidelines, and general STD screening and treatment.[xv] This intervention was a success with a notable increase in provider self-reported use of syphilis screening; of the obstetricians included, self-reported use of third trimester screening increased from 23% at baseline to 71%.

While time and resource intensive, public health detailing has demonstrated efficacy in increasing provider knowledge and changing clinical practice. It is also a great way to reach health care providers in small or solo practice, who may not hear about new trends or clinical guideline changes as quickly as their counterparts working in larger groups or hospital-based practices. (For more information, see Appendix A).

STD Consultation Line

Syphilis diagnosis, staging, and treatment can be challenging for even the most experienced clinician. For this reason, DPH maintains an STD Consultation warmline for health care providers that operates Monday-Friday, 8a-5pm, at (213) 368-7441. Public health nurses with expertise in syphilis are available and can

query the LAC STD database to identify patients' prior syphilis lab results and treatment information to work with providers to ensure accurate staging and treatment for their patients.

Penicillin Delivery Program

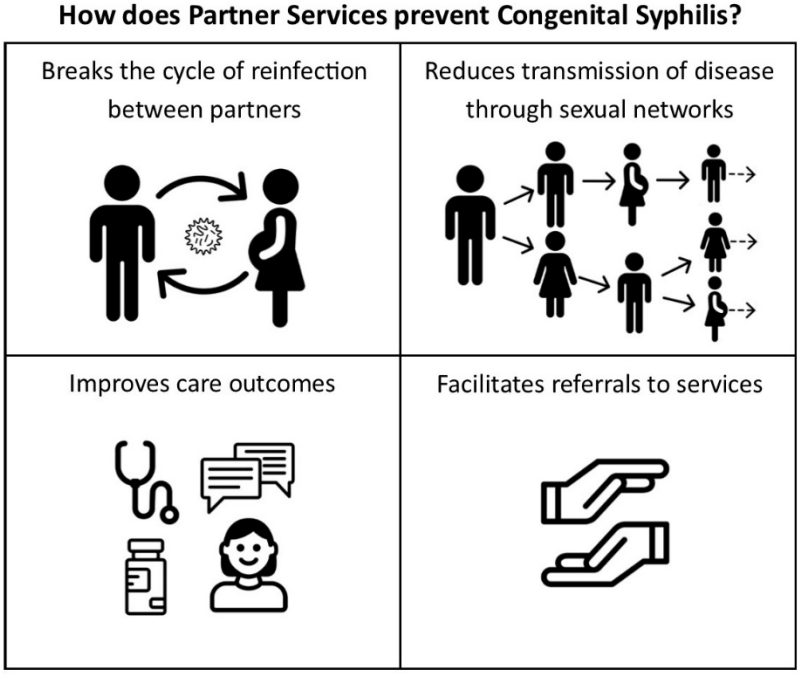
Unfortunately, many providers, particularly those working in small or solo practice, face challenges when attempting to provide treatment for patients with syphilis. The recommended treatment, penicillin, can be expensive and receiving reimbursement from health plans is challenging. In these cases, patients can be referred to one of the DPH's 11 STD clinics for treatment. Clinic locations and schedules can be found at http://publichealth.lacounty.gov/chs/Docs/ClinicSchedule.pdf.

Case Management and Partner Treatment

In LAC, all early (or infectious) cases and most late cases of syphilis, especially among women of reproductive age, are prioritized and assigned for case management. DPH staff work with the client and their provider to ensure that the client is treated for syphilis in a timely manner and referred for other services as needed. In addition, clients are asked to provide the names of their sexual partners with the idea that the DPH staff will confidentially notify them and ensure they are tested and treated for syphilis. This core public health activity, referred to as "partner services" is an evidence based public health practice that can interrupt the chain of disease transmission and is a critical component of an effective congenital syphilis prevention strategy.

Health care providers can increase the yield of "partner services" activities by letting their patients know at the time of syphilis diagnosis that they may be contacted by the health department and that any information they give to DPH staff will only be used confidentially to identify and treat people exposed to syphilis.

Figure 8. Partner Services and Congenital Syphilis



Other DPH educational resources

DPH regularly updates its website to include updated resources for providers and consumers. For providers, there is an on-demand webinar on Syphilis in Women and Congenital Syphilis available that provides free continuing medical education (CME) credits. In addition, DPH physicians with expertise in STDs are available to speak at staff meetings, in-person continuing medical education meetings, and "grand rounds" in hospitals and academic health centers.

Emergency Departments and Urgent Care Provider Recommendations

Emergency departments are a common location for patients to seek care for sexually transmitted diseases. In addition, some pregnant women who may not be in regular prenatal care can present at Emergency Departments (ED) or Urgent Care centers for pregnancy related or unrelated issues. As such, ED providers are important partners in identifying and treating cases in pregnant women and syphilis in women who do not receive health care services elsewhere.

Screening pregnant women for syphilis

It is a best practice for ED providers to confirm the syphilis status of all pregnant patients prior to discharge, either via documented test results from earlier in pregnancy, or a syphilis test in the ED if documentation is unavailable.[xvi] California Senate Bill (SB) 1152, approved in September 2018, requires that hospitals provide or refer any homeless patients they see for communicable disease testing in accordance with their local health department. In March 2019, LAC DPH's Health Officer issued a letter to local hospitals with specific screening requirements, which includes screening all homeless pregnant women for syphilis and linking them to prenatal care.[xvii]

Presumptive treatment for patients unlikely to receive follow-up care

Given the rapid turnover of patients in the ED, DPH recommends that women who test positive on one syphilis serologic test (which could include a STAT RPR and/or the point of care syphilis health check test with turnaround time of 8-15 minutes respectively) and are unlikely to receive follow-up care be treated empirically (with Benzathine penicillin G 2.4 million units IM x 1) while confirmatory syphilis serology results are pending. While syphilis diagnosis generally requires confirmatory testing, DPH believes that for these cases, the benefits of presumptive treatment far outweigh any negligible risks.

Address Upstream Factors

While prenatal care is universally covered for all pregnant women in California, obstacles to establishing and maintaining prenatal care may arise from a host of factors of which substance use as well as, unstable housing, incarceration, and poverty play roles. Women who may become pregnant in the next year who screen positive for substance use disorder (SUD) and/or mental health issues should be referred for appropriate care. Women who are at risk for unintended pregnancy who are either not using contraception or who are not satisfied with their current method should be offered or referred for the full spectrum of contraceptive options, including long acting reversible contraception. Health care providers should consider using One Degree or other community-based resources for health and wellness support for women who are pregnant or desiring pregnancy who are experiencing unstable housing, food insecurity, or other wellness needs.

Public Health Support for ED and Urgent Care Providers

STD Consultation Line

Syphilis diagnosis, staging, and treatment can be challenging for even the most experienced clinician. For this reason, DPH maintains an STD Consultation warmline for health care providers that operates Monday-Friday, 8a-5pm, at (213) 368-7441. Public health nurses with expertise in syphilis are available and can query the LAC STD database to identify patients' prior syphilis lab results and treatment information to work with providers to ensure accurate staging and treatment for their patients.

Technical Assistance

DPH provides technical assistance to EDs related to syphilis screening and treatment and to ensure their compliance to SB 1152. In cases where syphilis may have been detected earlier in a pregnant woman had she been screened in the ED, DPH will engage with the individual ED leadership to review their syphilis screening policies and protocols.

Obstetrician Recommendations

As the health care providers most likely to care for pregnant women, obstetricians and prenatal care providers have a unique role in identifying occult cases of syphilis among pregnant women.

Screen women during early third trimester and at delivery

In 2018, DPH began recommending that all pregnant women be screened for syphilis during the first trimester (or at their initial prenatal visit), and re-screened early in the third trimester (28-32 weeks) and at delivery. A detailed explanation of the rationale for these recommendations can be found in Appendix B. The California chapter of American College of Obstetrics and Gynecology (ACOG) is considering adoption of upcoming California Department of Public Health draft recommendations for universal third-trimester screening; this is important because many providers cite the ACOG guidelines as their trusted sources for the screening and treatment of pregnant women with syphilis.[xviii] This policy shift will help accelerate CS prevention efforts statewide.

Presumptive treatment in for patients unlikely to receive follow-up care

DPH recommends that pregnant or post-partum women who test positive on one syphilis serologic test and are unlikely to receive follow-up care be treated empirically (with Benzathine penicillin G 2.4 million units IM x 1) while confirmatory syphilis serology results are pending. While syphilis diagnosis generally requires confirmatory testing, DPH believes that for these cases, the benefits of presumptive treatment outweigh any negligible risks.

Address Upstream Factors

While prenatal care is universally covered for all pregnant women in California, obstacles to establishing and maintaining prenatal care may arise from a host of factors of which substance use as well as, unstable housing, incarceration, and poverty play roles. Women who may become pregnant in the next year who screen positive for substance use disorder (SUD) and/or mental health issues should be referred for appropriate care. Women who are at risk for unintended pregnancy who are either not using contraception or who are not satisfied with their current method should be offered or referred for the full spectrum of contraceptive options, including long acting reversible contraception. Health care providers should consider using One Degree or other community-based resources for health and wellness support for women who are pregnant or desiring pregnancy who are experiencing unstable housing, food insecurity, or other wellness needs.

Public Health Support for Obstetricians

STD Consultation Line

Syphilis diagnosis, staging, and treatment can be challenging for even the most experienced health care provider. For this reason, DPH maintains an STD Consultation warmline for health care providers that operates Monday-Friday, 8a-5pm, at (213) 368-7441. Public health nurses with expertise in syphilis are available and can query the LAC STD database to identify patients' prior syphilis lab results and treatment information to work with providers to ensure accurate staging and treatment for their patients.

Penicillin Delivery Program

Unfortunately, many providers, particularly those working in small or solo practice, face challenges when attempting to provide treatment for patients with syphilis. The recommended treatment, penicillin, can be expensive and receiving reimbursement from health plans is challenging. Patients can be referred to the DPH STD clinics for treatment (clinic locations and hours available here: http://publichealth.lacounty.gov/chs/Docs/ClinicSchedule.pdf), but it often makes more sense for the patient to receive treatment at her health care provider's office. On a case by case basis, DPH can supply penicillin to the provider at no cost for pregnant persons and their partners, with the goal of preventing congenital syphilis. Providers are encouraged to call the STD Consultation Line for more information.

Technical Assistance

The Comprehensive Perinatal Services Program (CPSP), a Title V program, provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum, to improve maternal and infant health outcomes. Given that half births in California occur to women whose primary medical insurance is Medi-Cal, CPSP providers are ideal for the new syphilis screening recommendations.[xix] DPH is working with the local Maternal Child Adolescent Health (MCAH) Program to educate CPSP programs on appropriate syphilis screening and treatment by these providers.

Staff Meetings and Grand Rounds

Recurring staff meetings, in-person continuing medical education meetings, and "grand rounds" in hospital and academic health centers present an opportunity for DPH staff to reach many providers at one time. In 2018, DPH conducted 24 presentations for 2170 health care providers in the top 21 CS birthing hospitals. DPH will continue to offer to present at Grand Rounds or other staff meetings for Obstetrics, Infectious Disease, Emergency Medicine, Pediatrics, and Internal Medicine departments at birthing hospitals**.**

In 2020, DPH will engage with all birthing hospitals that have been involved with congenital syphilis cases to survey their syphilis screening policies and protocols. DPH will subsequently provide technical assistance to each birthing hospital in LAC to encourage more rapid syphilis screening algorithms or use of rapid point-of-care syphilis testing for all pregnant women at delivery to improve timely detection and treatment of women and infants with syphilis prior to their discharge from the hospital.

Website/Webinars with CME

DPH regularly updates its website to include updated resources for providers and consumers. For providers, there is an on-demand webinar on Syphilis in Women and Congenital Syphilis available that provides free continuing medical education (CME) credits.

Birthing Hospital Recommendations

Birthing hospitals may be the only places where some pregnant patients receive medical care. Of the CS cases in Los Angeles County in 2018, over 40% were born to pregnant women who had received no prenatal care during that pregnancy. Given that LAC is designated as an area of high syphilis morbidity, it is crucial that birthing hospitals screen all pregnant women for syphilis upon delivery. Screening at delivery does not prevent CS, but it enables detection of cases and allows for prompt evaluation and treatment of the infant to prevent further sequelae. It also allows for the identification and treatment of women with syphilis to potentially prevent CS cases in future pregnancies.

Confirm syphilis status of all women and newborns prior to discharge

No newborn should leave the hospital without provider review of maternal serologic status during pregnancy, and preferably, review of maternal status at delivery. Timely syphilis serologic testing, either through rapid point-of-care syphilis testing or expedited syphilis laboratory testing, is a critical tool that should be pursued to reduce delays in discharge.

Presumptive treatment in for patients unlikely to receive follow-up care

DPH recommends that pregnant or post-partum women who test positive on one syphilis serologic test (which could include a STAT RPR and/or the point of care syphilis health check test with turnaround time of 8-15 minutes respectively) and are unlikely to receive follow-up care be treated empirically (with Benzathine penicillin G 2.4 million units IM x 1) while confirmatory syphilis serology results are pending. While syphilis diagnosis generally requires confirmatory testing, DPH believes that for these cases, the benefits of presumptive treatment far outweigh any negligible risks. For clinical questions regarding treatment of syphilis, please call the STD Consultation Line.

Report all cases of syphilis to DPH within one working day and preferably before discharge

Providers and Infection Control Personnel are asked to call the STD Consultation Line as soon as a possible syphilis case in a pregnant or post-partum woman or infant has been identified. DPH maintains an STD Consultation warmline for hospitals that operates Monday-Friday, 8a-5pm, at (213) 368-7441, public health nurses with expertise in syphilis are available and can query the LAC STD database to identify patients' prior syphilis lab results and treatment information. Discharge planning with DPH is optimal if the patient is still hospitalized, a DPH nurse can assist in real time by providing all necessary case management and treatment recommendations prior to hospital discharge.

Test any woman who has experienced a stillbirth for syphilis

Any woman who delivers a stillborn (fetal demise after 20 weeks gestation) should be evaluated for syphilis. In each of the past few years, LAC has experienced two cases of syphilitic stillbirths; it is possible that more cases were missed because the mother and infant were not tested for syphilis.

Screen for SUDs and Link women to SUD services, including Syringe Exchange Programs

Given the co-occurring conditions of SUD and syphilis infection in heterosexual men and women, identification, referral and linkage of pregnant and post-partum patients to SUD treatment and syringe exchange programs is critical. In 2020, DPH will explore models for supporting this work, which may include a roving SUD treatment counselor to serve as a resource for birthing hospitals in LAC.

Public Health Support for Birthing Hospitals

STD Consultation Line

Syphilis diagnosis, staging, and treatment can be challenging for even the most experienced health care provider. For this reason, DPH maintains an STD Consultation warmline for health care providers that operates Monday-Friday, 8a-5pm, at (213) 368-7441. Public health nurses with expertise in syphilis are available and can query the LAC STD database to identify patients' prior syphilis lab results and treatment information to work with providers to ensure accurate staging and treatment for their patients.

Technical Assistance

Of the over 140 hospitals in LAC, twenty have been identified as a hospital where infants diagnosed with congenital syphilis have been delivered in the past 4 years. DPH staff have had success in establishing strong relationships with these birthing facilities to implement recommendations for optimal clinical care of women and infants with syphilis. **Figure 9** lists hospitals in LAC that have experienced between one and fourteen cases since 2014.

Figure 9. Birthing Hospitals in LAC with Highest Cases of Congenital Syphilis Cases by Service Planning Area, 2013-2018

SPA 1 & 2 Antelope and San Fernando Valleys	Providence Tarzana Medical Center	Providence Holy Cross Hospital	Valley Presbyterian	Antelope Valley Medical Center
SPA 3 & 4 San Gabriel and Metro	Queen of the Valley Hospital Kaiser West Los Angeles Monterey Park Hospital	LAC/USC Medical Center Good Samaritan Hospital Huntington Hospital	Hollywood Presbyterian Hospital Pomona Valley Hospital Citrus Valley	White Memorial Medical Center San Gabriel Valley Medical Center Garfield Medical Center
SPA 5 & 6 West and South	St. Francis Medical Center	Harbor UCLA Medical Center		
SPA 7 & 8 East and South Bay	Centinela Hospital Medical Center	St. Mary Medical Center		

Staff Meetings and Grand Rounds

Recurring staff meetings, in-person continuing medical education meetings, and "grand rounds" in hospital and academic health centers present an opportunity for DPH staff to reach many providers at one time. In 2018, DPH conducted 24 presentations for 2170 health care providers in the top 21 CS birthing hospitals. DPH will continue to reach out to Obstetrics, Infectious Disease, Emergency Medicine, Pediatrics, and Internal Medicine departments at birthing hospitals to offer to present at Grand Rounds or other staff meetings**.** In 2020, DPH will engage with all birthing hospitals that have been involved with congenital syphilis cases to survey their syphilis screening policies and protocols. DPH will subsequently

provide technical assistance to each birthing hospital in LAC to encourage more rapid syphilis screening algorithms or use of rapid point-of-care syphilis testing for all pregnant women at delivery to improve timely detection and treatment of women and infants with syphilis prior to their discharge from the hospital.

GOAL 2: INCREASED AWARENESS OF SYPHILIS AMONG WOMEN AT HIGHEST RISK WITH EXPANDED OPPORTUNITIES FOR TESTING IN NON-CLINICAL SETTINGS

To improve health outcomes in populations at risk for syphilis and CS, we must engage in activities that reduce barriers to information access, as well as screening and treatment. The need for new venues through which to identify and screen women for syphilis is high, and selection of setting should be guided by an understanding of how the women who are at highest risk of infection may be contacted. A recent California Department of Public Health analysis of women who birthed CS infants suggested the following as potential sites for future syphilis screening: programs for people with SUD, correctional facilities, and field outreach to homeless encampments.[xx]

SUD Treatment and Prevention Provider Recommendations

In the U.S., among women and men who have sex with women with a diagnosis of primary and secondary syphilis, reported use of methamphetamine, injection drugs and heroin more than doubled between 2013-2017.[xxi] LAC has seen a notable increase in reported methamphetamine drug use among heterosexual men and women diagnosed with syphilis in LAC (Figure 9). In 2018 in LAC, 57% of women involved in CS cases had evidence of some type of substance use, with methamphetamine being the most common. Given the co-occurring conditions of SUD and syphilis infection in heterosexual men and women, SUD prevention and treatment providers are critical partners to address recent increases in heterosexual syphilis and reduce congenital syphilis cases.

Syringe Exchange Programs (SEPs) offer people who inject drugs (PWID) new, clean syringes, allow for safe disposal of dirty, used syringes, and provide education to promote safer ways of using drugs. DPH funds 6 SEP providers who currently operate 12 sites across LAC offering a range of harm reduction services beyond clean syringe exchange. These include overdose education and naloxone as well as condoms. SEPs have the potential to connect clients to important health services such as HIV and STD screening and treatment, substance abuse counseling and therapy, drug detoxification and treatment services, and various other medical and health services.

Incorporate key STD prevention best practices into SUD Service Provision

- Distribute or make available condoms at the point of service.
- Making routine STD testing available to all patients, either through referral or onsite testing, when feasible.
- Institute “one-key question” to improve the quality of care provision to women in SUD treatment who are of reproductive age through early and recurrent identification of their reproductive health goals.
- Ensuring that all women of reproductive age (15-44 years) are offered syphilis screening, either onsite when feasible, or by referral.
- Ensure referral to prenatal care for pregnant women within 7 days of the date that pregnancy status was documented.

Public Health Support for SUD Prevention and Treatment Providers

DPH can work with SUD providers to ensure that all existing and new staff members are offered basic syphilis education that includes, prevention (including the basics of syphilis transmission and the role of condom use), screening for syphilis (screening guidelines), and potential locations to refer clients for STD

screening and treatment. DPH also supports a robust condom distribution program which can include SUD providers. DPH is also able to provide local data to agencies for them to better display the distribution and concentration of syphilis in their service area.

Correctional Facility Recommendations

The Los Angeles County jail system is one of the largest in the world and has an average daily inmate population of 17,000; 2,000 are women housed at the Century Regional Detention Center (CRDF). Eighty-three percent of the women booked into CRDF are of childbearing age (44 years and younger).[xxii]

In LAC, a significant number of pregnant women with syphilis have a history of arrest, often around the time when they likely acquired syphilis. Between 2013 and 2015, of 239 pregnant women with syphilis, 34% had a history of arrest, and 25% of women with early syphilis had been arrested in the previous year.[xxiii] In 2017, forty-six percent of the LAC's CS cases were born to mothers with a history of arrest or incarceration in the LAC jail system.

Implement LAC syphilis screening recommendations

Given the data above, expanded syphilis screening of more women by LAC Correctional Health Services could have a tremendous impact with regards to syphilis case identification and potential congenital syphilis prevention. Pregnant women are already screened for syphilis routinely and repeatedly while in custody, but women of reproductive age do not routinely or universally get screened. Jail medical services are often juggling many competing demands; considering this, one relatively low-cost intervention would be to incorporate syphilis testing into commonly used order sets within the electronic health record (EHR). Another approach would be bundled testing, meaning that a syphilis test order is added on when any woman gets an order for a blood draw for any reason.

Presumptive treatment in for patients unlikely to receive follow-up care

DPH recommends that all incarcerated women who test positive on one syphilis serologic test and are unlikely to receive follow-up care be empirically (with Benzathine penicillin G 2.4 million units IM x 1) while confirmatory syphilis serology results are pending. While syphilis diagnosis generally requires confirmatory testing, we believe that for these cases, the benefits of presumptive treatment outweigh any negligible risks. For clinical questions regarding treatment of syphilis, please call the STD Consultation Line.

Address Upstream Factors

While prenatal care is universally covered for all pregnant women in California, obstacles to establishing and maintaining prenatal care may arise from a host of factors of which substance use as well as, unstable housing, incarceration, and poverty play roles. Women who may become pregnant in the next year who screen positive for substance use disorder (SUD) and/or mental health issues should be referred for appropriate care. Women who are at risk for unintended pregnancy who are either not using contraception or who are not satisfied with their current method should be offered or referred for the full spectrum of contraceptive options, including long acting reversible contraception. Health care providers should consider using One Degree or other community-based resources for health and wellness support for women who are pregnant or desiring pregnancy who are experiencing unstable housing, food insecurity, or other wellness needs.

Public Health Support for Correctional Health Providers

DPH will continue to work with correctional health partners to implement rapid syphilis testing more universally throughout the housing pods in CRDF and explore offering testing in the jail's Inmate Reception

Center. Given the strong association among pregnant women with syphilis and the correctional system, in 2018, DPH partnered with the LAC Correctional Health Services to initiate a syphilis screening pilot using a newly FDA approved rapid syphilis test to offer point-of-care screening to women of child-bearing age incarcerated at CRDF. Between December 2018 and September 2019, DPH staff conducted approximately 1049 rapid syphilis tests with incarcerated women, and nineteen individuals were identified as having an active syphilis infection requiring treatment. The overall positivity of 1.8% indicates that this is a population at high risk for syphilis. The pilot proved that it was feasible to offer rapid syphilis testing in the CRDF pods and the women diagnosed with syphilis represent 19 potential cases of congenital syphilis averted. The testing process was well-received by the inmates and almost no women refused the opportunity to test.

Homeless Service Provider Recommendations

Homelessness is considered a risk factor for syphilis in Los Angeles County. In 2017, 27% women involved in CS cases reported homelessness. However, due to inconsistent data collection on housing status, the number who experience homelessness and housing instability is possibly higher.

Expand opportunities to pair syphilis testing with homeless service provision

Field outreach, testing, and care services can be an effective intervention to effectively locate and serve this population. Persons experiencing unstable housing can be particularly hard to reach via traditional testing and treatment methods that rely on utilization of the brick-and-mortar health care system. Persons experiencing homelessness not only have competing needs, but they may experience higher rates of medical mistrust and may be less willing to seek services in a traditional clinic setting.[xxiv-xxv] Homeless women may also experience a higher vulnerability to STDs that may relate to comorbid mental illness, SUD, or the need to engage in transactional or survival sex.[xxvi-xxvii] In addition, day-to-day concerns specific to individuals experiencing homelessness may affect their engagement in care; some homeless clients have reported reluctance to leave their encampments for fear of losing their 'spot' or having their belongings stolen.[xxviii] These considerations highlight the importance of incorporating syphilis testing into existing health care of social services provided by organizations with expertise and cultural competence in serving people experiencing homelessness.

Address Upstream Factors

While prenatal care is universally covered for all pregnant women in California, obstacles to establishing and maintaining prenatal care may arise from a host of factors of which substance use as well as, unstable housing, incarceration, and poverty play roles. Women who may become pregnant in the next year who screen positive for substance use disorder (SUD) and/or mental health issues should be referred for appropriate care. Women who are at risk for unintended pregnancy who are either not using contraception or who are not satisfied with their current method should be offered or referred for the full spectrum of contraceptive options, including long acting reversible contraception. Health care providers should consider using One Degree or other community-based resources for health and wellness support for women who are pregnant or desiring pregnancy who are experiencing unstable housing, food insecurity, or other wellness needs.

Public Health Support for Homeless Service Providers

A few initial pilot DPH field outreach and testing efforts to homeless women of reproductive age have been successful in locating, testing, and in some instances, even treating individuals in the field. Given the varied and sometimes siloed outreach activities taking place for homeless individuals in LAC, DPH has and will continue to partner with existing and established homeless or housing organizations, such as Los Angeles Homeless Service Authority (LAHSA), LA Family Housing, and Housing for Health, to identify and locate pregnant women and women of reproductive age at risk for syphilis. Field staff from these organizations often have existing relationships with clients that can be critical to establishing trust and encouraging client engagement with DPH staff.

Going forward, DPH will work with county partners to enhance coordination of field outreach and testing efforts to highly impacted populations, specifically women of reproductive age and pregnant women experiencing homelessness. This will include offering core public health services, such as STD and HIV

testing, vaccine administration, health education information, harm reduction tools (e.g., condoms, syringe exchange, medication assisted treatment for opioid use), and family planning and prenatal care services. These individuals will then be linked to care or will directly be offered services in the field. Syphilis testing will be incorporated into clinical outreach to homeless individuals for tuberculosis screening required for admission to shelters in the Metro and South regions of LA. DPH Clinic Services will also add syphilis screening for pregnant women in the Skid Row area at the SPA 4 satellite clinic which currently also offers TB evaluation. In addition, DPH will explore collaborating with community clinics or Federally Qualified Health Centers (FQHCs) that have existing homeless health services and offer rapid syphilis test kits to those organizations to screen their clients.

GOAL 3: ENHANCED CARE MODELS FOR WOMEN EXPERIENCEING INCREASED VULNERABILITY

Appropriate and aggressive screening for syphilis is a critical intervention, but the health care system must evolve to better meet the needs of women challenged with multiple co-morbidities, such as SUD and homelessness. Analysis of LAC CS cases have demonstrated an ongoing need for improving uptake of early prenatal care and removal of barriers to prenatal care if syphilis screening recommendations are to have their greatest impact. Prior poor experiences with the health care system or other institutions, in part informed by well-documented implicit biases and stigma of both women with SUD and women of color, result in delays in seeking or avoidance of health care services. [x-xii]

Prenatal Care Provider Recommendations:

Explore alternative models of prenatal care to meet the needs of patients. Organizations across the County should work together to explore and implement models of prenatal and women's health programs which are patient-centered and accommodate the unique needs of marginalized women. Despite the growing homeless population and increased resources for programs that prioritize pregnant women and families, the health care and social service systems remain fragmented and uncoordinated. The following are examples of alternative models that may better serve vulnerable women.

- *"MAMA's Neighborhood" program.* One promising model in LAC is that developed by the Department of Health Services. Their "MAMA's Neighborhood" program is a health care and parent support program that is particularly focused on assisting pregnant women experiencing medical challenges, behavioral health conditions, or complex, stressful life circumstances (e.g., homelessness, incarceration). In MAMA's Neighborhood, the frequency of home, community, and clinic-based support is customized to parents' needs.
- *"Roving OB Team."* For homeless pregnant women who have experienced severe trauma or for other reasons will not engage in traditional health or social services, another possible approach may include a "roving OB team," such as that developed recently by Zuckerberg San Francisco General Hospital's Obstetrics department.[xxix] Stated in October 2018, "Project Lily" has served 27 pregnant patients experiencing housing insecurity, active SUD, and/or mental illness. A team of an obstetrician, prenatal mental health provider, and case worker together offer patient-centered street-based prenatal care, with the goal of building trust and ultimately bringing the patient into a clinic for an ultrasound and more traditional medical care. While likely costly, such programs are a potentially effective way to offer essential health care services to women who would otherwise not receive care and are at high risk for poor health outcomes.

Enhance prenatal case management home visitation programs to meet the needs of more vulnerable patients. In LAC, there are many programs the focus on improving health outcomes for babies and mothers. These include many home visitation programs such as the Nurse Family Partnership and those conducted by First 5 LA and associates. While these well-studied interventions are successful in certain populations, it is less clear whether they are well-suited to the needs of women with active SUD, mental illness, or experiencing homelessness. These programs not only rely on relatively prescribed protocols, but they are also based on the assumption that a woman is stably housed. In order to meet the different needs of women experiencing vulnerability, modified and flexible case management programs are important.

Public Health Support to Prenatal Care Providers

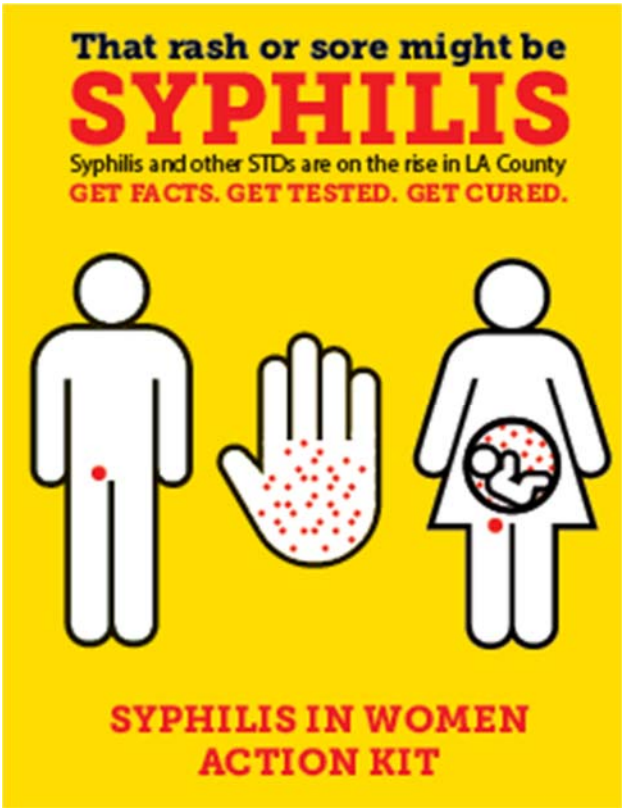
The DPH directly provides prenatal home visitation programs as well as coordinates with other county agencies, such as First 5 LA, who provide specialized programs for pregnant women and new mothers. In its coordinating role, DPH can bring relevant issues of public health importance to the attention of members of the collaborative. DPH will continue to partner with these programs to ensure that syphilis screening recommendations have been incorporated into nursing protocols and trainings.

CONCLUSIONS

The elimination of congenital syphilis as a public health problem in Los Angeles County is possible. The building blocks for CS prevention in LAC are here but dramatic enhancements are necessary. Given the complex intersection of syphilis with many other social determinants of health, efforts to reduce CS will require more than interventions focused on maternal care and should include reaching women in broad and diverse non-clinical settings. In addition, a reduction in the prevalence of syphilis in reproductive age women is a key upstream component, so simultaneous control of infectious syphilis in the general population, particularly among men is also necessary. However, absent larger structural interventions to 1) improve uptake of early prenatal care and removal of barriers to prenatal care and 2) to identify, prevent and address the needs of women suffering from SUD, mental illness, and homelessness, the congenital syphilis epidemic in LAC is likely to continue or worsen.

APPENDIX A: PUBLIC HEALTH DETAILING KEY FINDINGS

Public Health Detailing

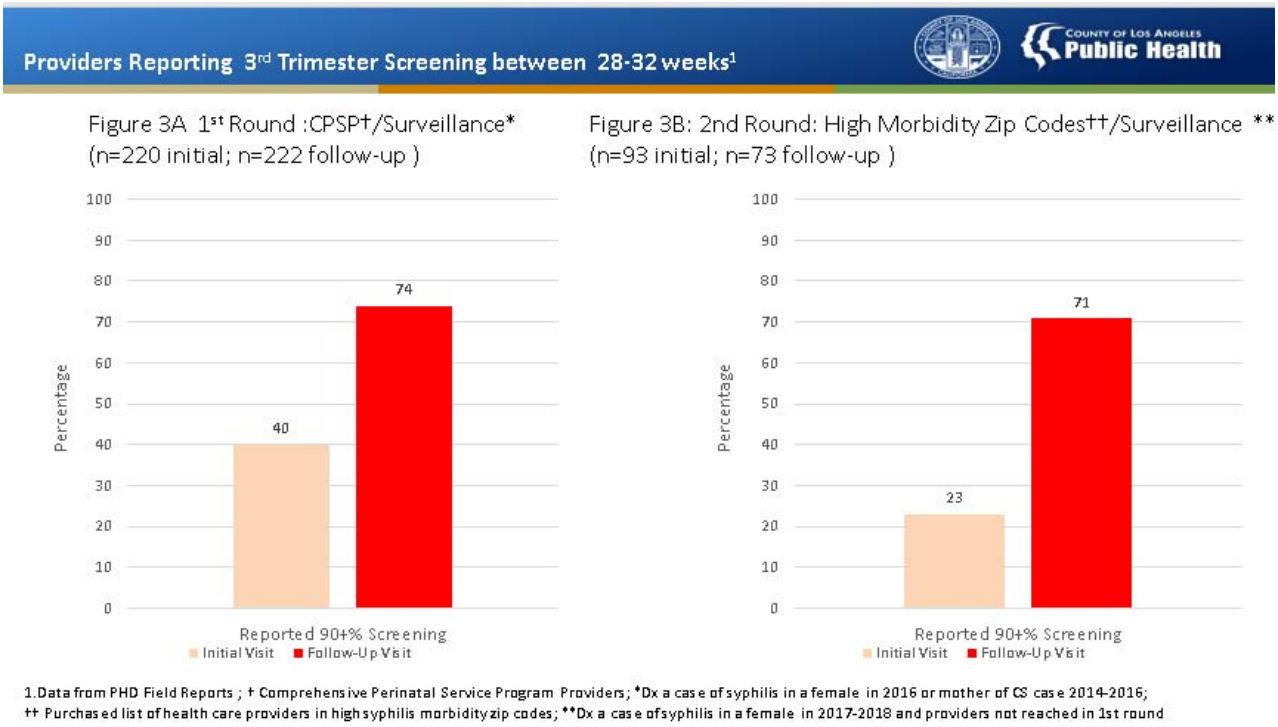


Public Health Detailing (PHD) is a promising intervention used by local health departments to effectively communicate with health care providers about new or best practices. Like academic detailing, public health detailing builds on some of the techniques used by medical industry representatives (such as pharmaceutical representatives) to gain access to health care providers for a brief encounter and tutorial, and to advance key public health messages. New York City has a long history of PHD for a range of clinical campaigns, including colon cancer screening, tobacco cessation, and HIV pre-exposure prophylaxis (PrEP).[xxx] In 2017, LAC launched its first PHD campaign, which was focused on PrEP for HIV prevention. In 2018, DPH built on the success of the first effort by creating a first of its kind syphilis focused campaign to raise awareness of rising congenital syphilis and syphilis cases in women. An accompanying "Syphilis in Women Action Kit" was developed with information on syphilis screening, staging and treatment as well as mandatory reporting guidelines, and general STD screening and treatment.[xxxi]

The first round of PHD, conducted between May and July 2018, focused on two groups of health care providers: 1) Medi-Cal Comprehensive Perinatal Services Program providers, and 2) health care providers identified through LAC's STD database based on their diagnosis of at least one case of syphilis in a woman in the past year. Four trained and experienced representatives of the LAC DPH completed visits with health care providers 795 times within a six-week period (432 were initial visits and 363 were follow-up visits within 4-6 weeks of the initial visit). There was a notable increase in provider self-reported knowledge of recent LAC syphilis trends and screening guidelines; most significantly, self-reported use of syphilis screening for their patient population also increased at the follow-up visit. Of the obstetricians who completed follow-up in this phase, the self-reported use of third trimester screening increased from 23% at baseline to 71% after receiving detailing.

In the second phase of PHD, which was conducted between September and December of 2018, the detailing representatives reached out to primary care and urgent care providers in high syphilis morbidity areas of LAC. They completed 934 total provider visits, including 588 initial and 348 follow-up visits. Findings from the second phase were like the first phase, except that these providers reported lower baseline knowledge of trends and guidelines. Of the OB providers who completed follow-up in this phase, the self-reported use of third trimester screening increased from 23% at baseline to 71% after receiving detailing.

Figure 10. Providers Reporting 3rd Trimester Screening between 28-32 weeks



1.Data from PHD Field Reports ; † Comprehensive Perinatal Service Program Providers; *Dx a case of syphilis in a female in 2016 or mother of CS case 2014-2016; †† Purchased list of health care providers in high syphilis morbidity zip codes; **Dx a case of syphilis in a female in 2017-2018 and providers not reached in 1st round

While time and resource intensive, this intervention has demonstrated efficacy in increasing provider knowledge and changing clinical practice. It is also a great way to reach health care providers in small or solo practice, who may not hear about new trends or clinical guideline changes as quickly as their counterparts working in larger groups or hospital-based practices. If funding allows for additional PHD campaigns, DPH will target providers caring for women of child-bearing age in vulnerable populations. This includes providers who care for people with substance use disorders, the criminal justice-involved and homeless individuals.

APPENDIX B: RATIONALE FOR INCREASED SYPHILIS SCREENING IN PREGNANT WOMEN AND WOMEN OF REPRODUCTIVE AGE

Rationale for Increased Syphilis Screening in Pregnant Women

The value of mandated syphilis screening has been well documented, and most states require screening at least once during pregnancy. California law mandates that all pregnant women be screened for syphilis at their first prenatal visit which should be in the first trimester, although as this plan reports, that is not typically the case with women most at risk for syphilis. In 2018, in response to the CS epidemic, LAC DPH began recommending that, in addition to the first trimester screening, all pregnant women be re-screened for syphilis early in the third trimester (28-32 weeks estimated gestational age) and again at delivery. One key benefit of a transition from a risk-based assessment (as recommended by the USPSTF) to a universal recommendation of both third trimester screening and screening at delivery is that the latter approach can be more easily normalized into clinical care and can more readily be adopted and incorporated into order sets and clinical reminders in electronic health records.

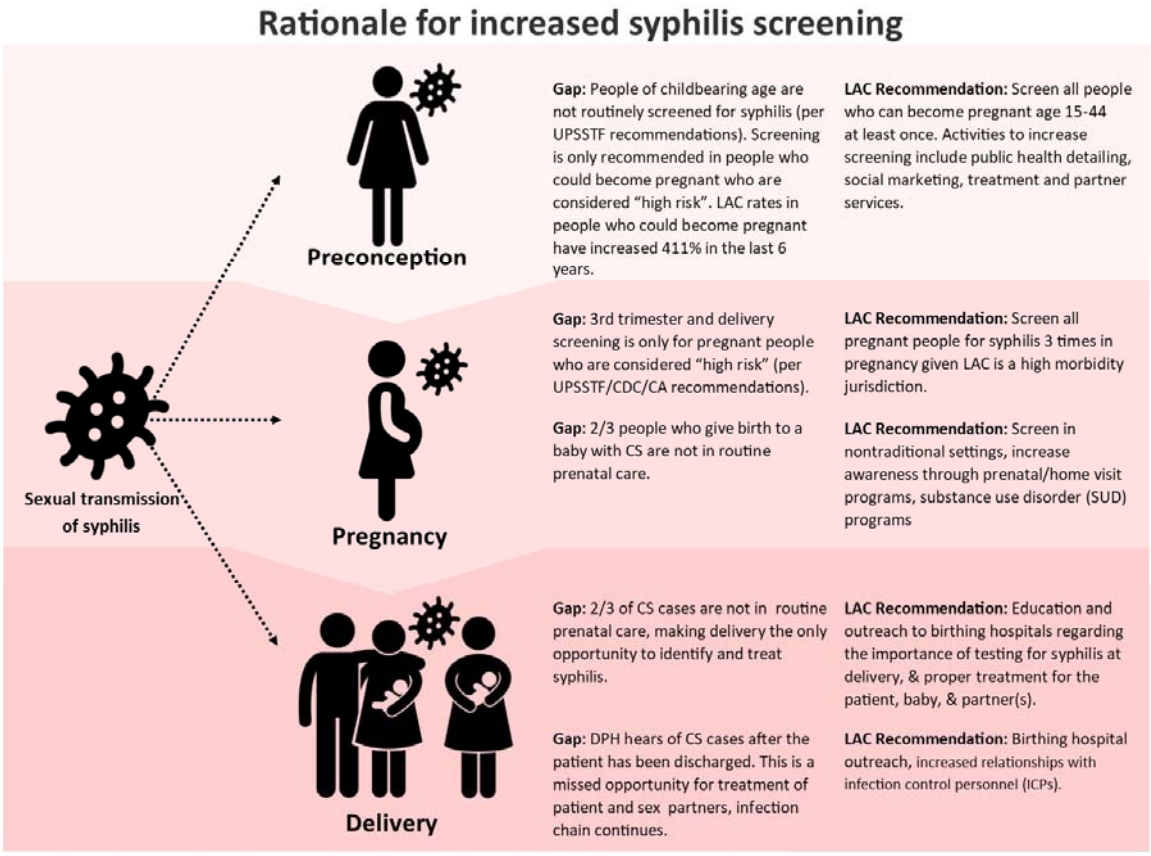
Maximizing the benefits of the recommendation for expanded pregnancy rescreening and screening women of reproductive age will require strengthening and expanding provider and patient education efforts and implementing system-wide changes already underway throughout much of California.[xxxii] Other states with third trimester and/or delivery rescreening recommendations and requirements have found mixed results. For example, benefits of third trimester rescreening rest on the premise that all pregnant patients receive comprehensive and timely prenatal care, including initial screening during first trimester. Analysis of LAC CS cases have demonstrated an ongoing need for improving uptake of early prenatal care and removal of barriers to prenatal care if these screening recommendations are to have their greatest impact.

Rationale for Increased Syphilis Screening Among Women of Reproductive Age

For non-pregnant adults, the USPSTF has had a longstanding Grade A recommendation that persons at increased risk of syphilis be screened for syphilis; this includes persons with new sexual partners, HIV positive persons, men who have sex with men, and persons residing in a high morbidity area. In 2018, considering the significant increases in syphilis among women 15 to 44 years old, LAC DPH began recommending that all health care providers screen for syphilis among ***all*** non-pregnant women at least once in their lifetime, and more often based on risk.

Expanded screening to non-pregnant women of reproductive age could identify syphilis cases that would be otherwise undetected. When paired with timely treatment, this practice could reduce sexual transmission, potential late-stage sequelae, and vertical transmission from mother to fetus for women who become pregnant.[xxxiii] Over the period 2016 through 2017, over 50% of the newborns diagnosed with CS were born from pregnancies that involved limited or no prenatal care. Identification and treatment of syphilis prior to pregnancy, along with a discussion about pregnancy intention and a referral to family planning for people who do not want to become pregnant, can prevent future cases of CS. Finally, establishing the syphilis status of women prior to pregnancy may help distinguish between early-stage versus late-latent and unknown duration stages of infection, should syphilis be detected in a future pregnancy.

Figure 11. Rationale for Increased Syphilis Screening in Los Angeles County



ACRONYMS

ACOG	The American College of Obstetricians and Gynecologists
CDC	Centers for Disease Control and Prevention
CME	Continuing Medical Education
CPSP	Comprehensive Perinatal Services Program
CRDF	Century Regional Detention Facility
CS	Congenital Syphilis
DHSP	Division of HIV & STD Programs
DPH	Department of Public Health
ED	Emergency Department
EHR	Electronic Health Record
HIV	Human Immunodeficiency Virus
LAC	Los Angeles County
M&M	Morbidity and Mortality
MAMA's	Maternity Assessment Management Access and Service Synergy
MCAH	Maternal, Child and Adolescent Health
MSM	Men who Have Sex with Men
MSW	Men Who have Sex with Women
OB	Obstetrician
PrEP	Pre-Exposure Prophylaxis
SEP	Syringe Exchange Program
SPA	Service Planning Area
STD	Sexually Transmitted Disease
USPSTF	United States Preventive Services Task Force

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COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS
RYAN WHITE PART A, MAI YR 32 AND PART B YR 32 EXPENDITURES BY RWP SERVICE CATEGORIES
Expenditures reported by January 9, 2023

1	2	3	4	5	6	7	8	9	10	11	12
SERVICE CATEGORY	YEAR TO DATE EXPENDITURES PART A	YEAR TO DATE EXPENDITURES MAI	TOTAL YEAR TO DATE EXPENDITURES PART A AND MAI (Total Columns 2+3)	FULL YEAR ESTIMATED EXPENDITURES PART A	FULL YEAR ESTIMATED EXPENDITURES MAI	FULL YEAR ESTIMATED EXPENDITURES PART A + MAI (Total Columns 5+6)	PART A + MAI EXPENDITURES %	YEAR TO DATE EXPENDITURES PART B	FULL YEAR ESTIMATED EXPENDITURES PART B	TOTAL YEAR TO DATE EXPENDITURES FOR RWP SERVICES (Total Columns 4+9)	COH YR 32 ALLOCATIONS %
OUTPATIENT/ AMBULATORY MEDICAL CARE (AOM)	$ 4,349,781	$ -	$ 4,349,781	$ 5,736,482	$ -	$ 5,736,482	14.17%	$ -	$ -	$ 4,349,781	23.70%
MEDICAL CASE MGMT (Medical Care Coordination)	$ 6,968,094	$ -	$ 6,968,094	$ 9,360,785	$ -	$ 9,360,785	23.12%	$ -	$ -	$ 6,968,094	21.87%
ORAL HEALTH CARE	$ 4,491,802	$ -	$ 4,491,802	$ 7,215,445	$ -	$ 7,215,445	17.82%	$ -	$ -	$ 4,491,802	16.36%
MENTAL HEALTH	$ 173,624	$ -	$ 173,624	$ 223,071	$ -	$ 223,071	0.55%	$ -	$ -	$ 173,624	3.78%
EARLY INTERVENTION SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ -	$ -	$ -	0.00%
HOME AND COMMUNITY BASED HEALTH SERVICES	$ 1,995,396	$ -	$ 1,995,396	$ 2,740,909	$ -	$ 2,740,909	6.77%	$ -	$ -	$ 1,995,396	6.30%
CHILD CARE SERVICES	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ -	$ -	$ -	0.88%
NON-MEDICAL CASE MANAGEMENT-Benefits Specialty Services	$ 1,089,058	$ -	$ 1,089,058	$ 1,489,867	$ -	$ 1,489,867	3.68%	$ -	$ -	$ 1,089,058	2.27%
NON-MEDICAL CASE MANAGEMENT-Transitional Case Management	$ -	$ 391,251	$ 391,251	$ -	$ 563,157	$ 563,157	1.39%	$ -	$ -	$ 391,251	0.99%
HOUSING-RCFCI, TRCF	$ 393,621	$ -	$ 393,621	$ 759,637	$ -	$ 759,637	1.88%	$ 3,040,650	$ 4,192,560	$ 3,434,271	0.91%
HOUSING-Temporary and Permanent Supportive with Case Management	$ -	$ 1,576,854	$ 1,576,854	$ -	$ 3,311,394	$ 3,311,394	8.18%	$ -	$ -	$ 1,576,854	7.38%
SUBSTANCE ABUSE TREATMENT - RESIDENTIAL	$ -	$ -	$ -	$ -	$ -	$ -	0.00%	$ 459,150	$ 750,000	$ 459,150	--
MEDICAL TRANSPORTATION	$ 417,845	$ -	$ 417,845	$ 523,365	$ -	$ 523,365	1.29%	$ -	$ -	$ 417,845	2.01%
LANGUAGE SERVICES	$ 3,122	$ -	$ 3,122	$ 4,163	$ -	$ 4,163	0.01%	$ -	$ -	$ 3,122	0.60%
FOOD BANK/HOME DELIVERED MEALS - NUTRITION SUPPORT	$ 2,283,880	$ -	$ 2,283,880	$ 3,933,543	$ -	$ 3,933,543	9.72%	$ -	$ -	$ 2,283,880	8.31%

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HIV AND STD PROGRAMS

RYAN WHITE PART A, MAI YR 32 AND PART B YR 32 EXPENDITURES BY RWP SERVICE CATEGORIES

Expenditures reported by January 9, 2023

EMERGENCY FINANCIAL ASSISTANCE	$ 1,199,395	$ -	$ 1,199,395	$ 1,713,065	$ -	$ 1,713,065	4.23%	$ -	$ -	$ 1,199,395	3.70%
REFERRAL/OUTREACH (LINKAGE AND REENGAGEMENT PROGRAM)	$ 1,097,911	$ -	$ 1,097,911	$ 2,326,147	$ -	$ 2,326,147	5.75%	$ -	$ -	$ 1,097,911	--
LEGAL	$ 440,512	$ -	$ 440,512	$ 587,349	$ -	$ 587,349	1.45%	$ -	$ -	$ 440,512	0.93%
SUB-TOTAL DIRECT SERVICES	$ 24,904,041	$ 1,968,105	$ 26,872,146	$ 36,613,828	$ 3,874,551	$ 40,488,379	100.00%	$ 3,499,800	$ 4,942,560	$ 30,371,946	100.00%
YR 32 ADMINISTRATION (INCLUDING PLANNING COUNCIL)	$ 3,654,259	$ 258,851	$ 3,913,110	$ 4,214,223	$ 378,020	$ 4,592,243		$ 281,868	$ 504,249	$ 4,194,978	
YR 32 CLINICAL QUALITY MANAGEMENT (HRSA Part A Legislative Requirement)	$ 621,620	$ -	$ 621,620	$ 973,910	$ -	$ 973,910		$ -	$ -	$ 621,620	
TOTAL EXPENDITURES	$ 29,179,920	$ 2,226,956	$ 31,406,876	$ 41,801,961	$ 4,252,571	$ 46,054,532		$ 3,781,668	$ 5,446,809	$ 35,188,544	
TOTAL GRANT AWARD				**$ 42,142,230**	**$ 3,780,205**	**$ 45,922,435**			**$ 5,446,809**		
VARIANCE				(340,269)	472,366				0		
MAI Carryover from YR 31 to YR 32	$	1,747,329									
Estimated MAI Carryover from YR32 to YR 33	**$**	**1,615,232**									

Opportunities for Enhanced Planning: New Unmet Need Focus and Approach

Wendy Garland, MPH
Chief Epidemiologist
Program Monitoring & Evaluation
Division of HIV and STD Programs

What is Unmet Need?

- Defined by HRSA HIV/AIDS Bureau as:

  " the need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary [HIV] health care."
- Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
- New and expanded methodology released 2021 for implementation in 2022

1."HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

Evolving Definition of Unmet Need

2005

- Focus on people aware of their HIV/AIDS diagnosis but getting regular HIV medical care
- People living with diagnosed HIV and AIDS with no evidence of care (at least one viral load [VL] or CD4 test or ART prescription) in past 12 months

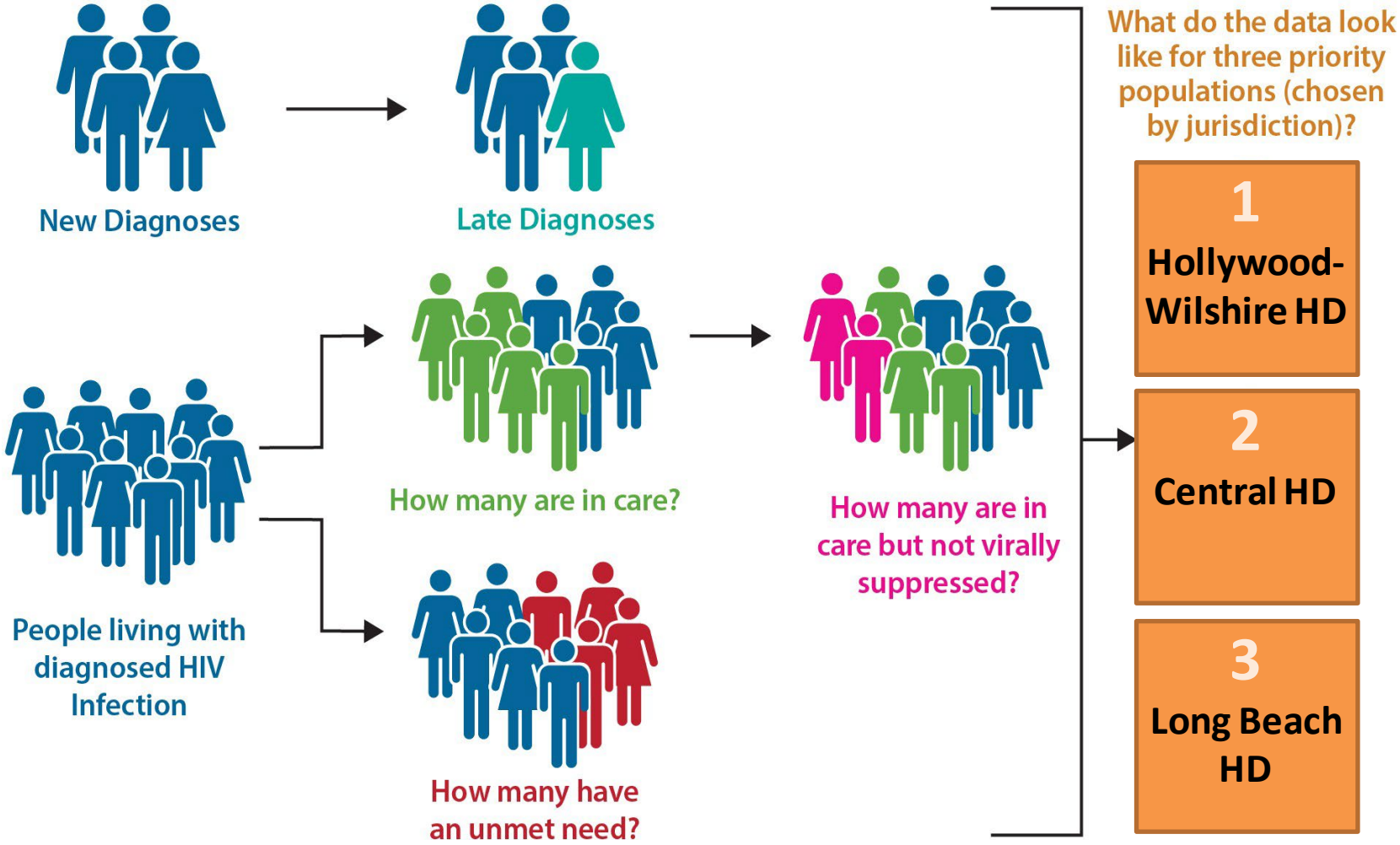
2017

- Care markers updated to align with HIV Care Continuum Definitions
- People living with diagnosed HIV and AIDS with no evidence of care (2 or more **medical visits** or VL or CD4 tests at least 90 days apart) in past 12 months

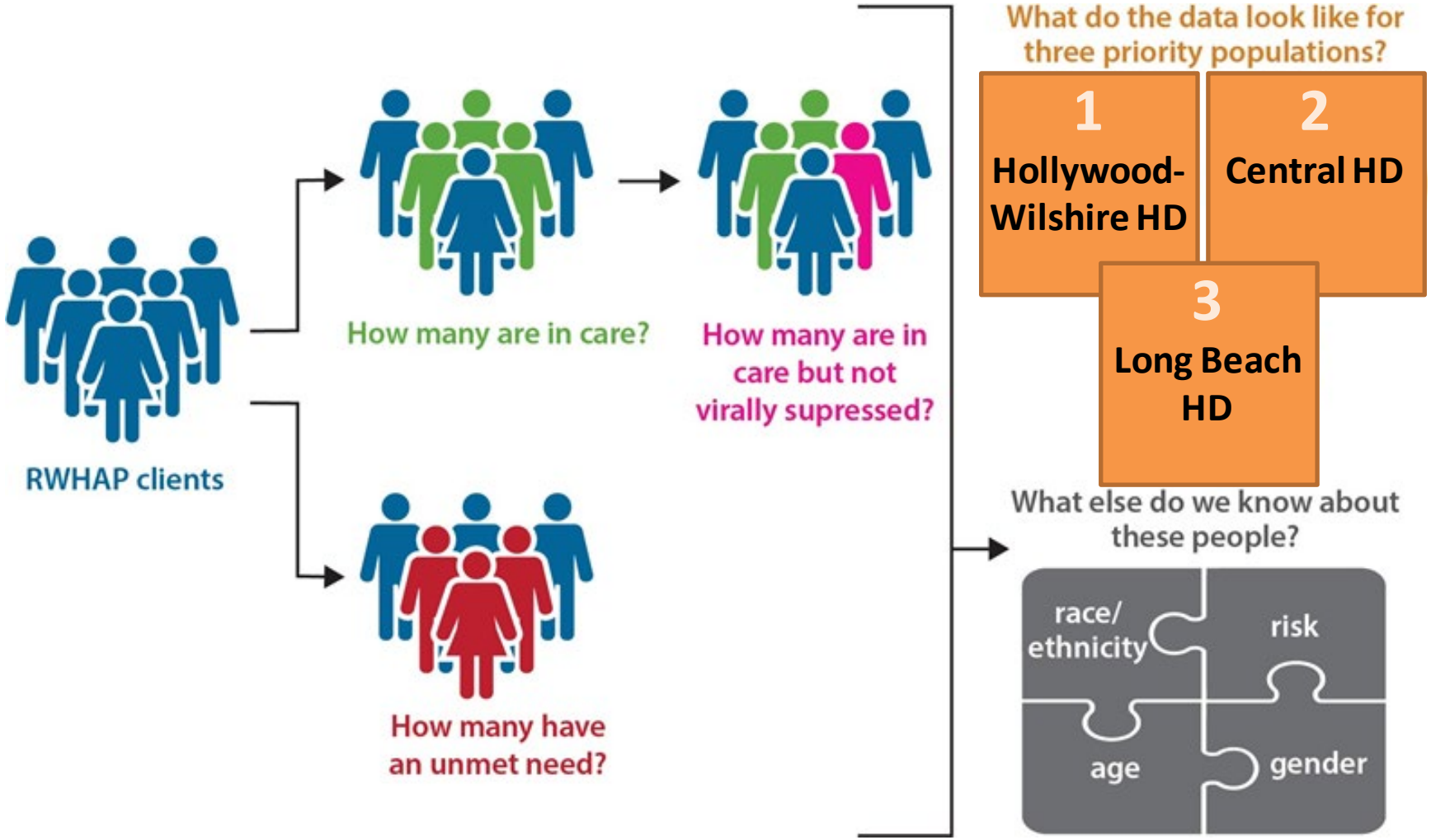
2021

- Revised care markers and expanded populations
- People living with **diagnosed HIV** with no evidence of care (at least one **VL or CD4 test**) in the past 12 months
- Adds two new indicators:
  - Persons diagnosed with HIV in the past 12 months with **LATE DIAGNOSIS (first CD4**
  - Persons living with diagnosed HIV **IN MEDICAL CARE** (at least one VL or CD4 test) who were **NOT VIRALLY SUPPRESSED** in the past 12 months

LAC Populations for Estimates of Unmet Need



RWP Populations for Estimates of Unmet Need



How will the Unmet Need Estimates support COH activities?

Priority Setting and Resource Allocation

Identification of Service Gaps

Design/Refine Service Models

Planning for Special Initiatives

Next Steps for Unmet Need Estimates

- Internal review by DHSP
  - PLWDH
  - RWP
- Summary report and presentation to COH expected early 2023

References and Resources

- Webinar video and slides: https://targethiv.org/library/updated-framework-estimating-unmet-need-hiv-primary-medical-care
- Methodology for Estimating Unmet Need: Instruction Manual https://targethiv.org/library/methodology-estimating-unmet-need-instruction-manual
- Enhanced Unmet Need Estimates and Analyses: Using Data for Local Planning https://targethiv.org/library/enhanced-unmet-need-estimates-and-analyses-using-data-local-planning

Additional HRSA Guidance on Unmet Need

- Unmet Need Reporting Fact Sheet: https://targethiv.org/library/required-and-enhanced-estimates-rwhap-unmet-need-reporting-fact-sheet

- Using Unmet Need Estimates and Analysis for HIV Primary Care to Inform Planning: https://targethiv.org/library/using-unmet-need-estimates-and-analysis-hiv-primary-medical-care-inform-planning

LOS ANGELES COUNTY
COMMISSION ON HIV

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December 6, 2023

To: Planning, Priorities and Allocations Committee
From: Aging Caucus Co-Chairs
Re: Augmentation of Existing Ryan White Services to Meet the Needs of Older Adults with HIV

The Ryan White Program Year 31 Care Utilization Data Summary Report provided by the Division of HIV and STD Programs (DHSP) to the Planning, Priorities and Allocations (PP&A) Committee on September 27, 2022, showed that from Year 27 to Year 31, the proportion of Ryan White Program (RWP) clients aged 60 years and older has continued to increase, from 13.2% in Program Year (PY) 27 to 17.6% in PY 31. Furthermore, DHSP estimates that by 2027 (PY 37) more than 50% of the RWP will be aged 50 years and older. By PY 40, the Los Angeles County Ryan White HIV care system will have more than 53% of people aged 50 and older.

The Aging Caucus believes that the time to act is now and that there are actions the County may take within its existing administrative framework to augment services. We recommend that the PP&A Committee collaborate with DHSP to enhance the payment structure for services rendered to older adults living with HIV as they may require more frequent, longer, and more intensive and individualized medical visits and routine care to maintain their overall health as they progress in the age continuum.

We recommend augmentation of existing contracts to fund:

- nutritional visits for older adults with HIV under the ambulatory/outpatient and Medical Care Coordination (MCC)programs
- a gerontologist to review medical records and assess needs for mental health, polypharmacy, social support, mobility, cognitive functioning, and other markers of overall health and quality of life
- additional HIV and aging assessments and provide training for non-gerontologist MCC staff to conduct assessments
- programs that provide remedial therapy or exercise to mitigate frailty, promote physical activity, and enhance social support networks