LOS ANGELES COUNTY
COMMISSION ON HIV

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PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE MEETING

Tuesday, March 19, 2024
1:00pm - 3:00pm (PST)

Vermont Corridor
510 S. Vermont Ave. Terrace Conference Room TK05
****Valet Parking: 523 Shatto Place, LA 90020****

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Password: PLANNING **Access Code:** 2539 821 0472

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together.

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LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

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

PLANNING, PRIORITIES, & ALLOCATIONS COMMITTEE

TUESDAY, MARCH 19, 2024 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room, Los Angeles, CA 90020

Validated Parking: 523 Shatto Place, Los Angeles 90020

MEMBERS OF THE PUBLIC:
To Register + Join by Computer:
https://tinyurl.com/nhkzetrv
To Join by Telephone: 1-213-306-3065
Password: PLANNING Access Code: 2539 821 0472

Planning, Priorities, and Allocations Committee Members:			
Kevin Donnelly, Co-Chair	Felipe Gonzalez Co-Chair	Al Ballesteros, MBA	Lilieth Conolly
Michael Green, PhD	Ish Herrera	William King, MD, JD	Miguel Martinez, MPH, MSW
Derek Murray, MPH, MPA	Dechélle Richardson (Alternate)	Daryl Russell	Harold Glenn San Agustin, MD
LaShonda Spencer, MD	Lambert Talley (Alternate)	Jonathan Weedman	
QUORUM: 8			

AGENDA POSTED: March 14, 2024

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 mailto:hivcomm@lachiv.org -or- submit your Public Comment electronically here. All Public Comments will be made part of the official record.

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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, Los Angeles, CA 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. **Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.*

I. ADMINISTRATIVE MATTERS

1.	Call to Order & Meeting Guidelines/Reminders		1:00 PM – 1:03 PM
2.	Roll Call & Conflict of Interest Statements		1:03 PM – 1:05 PM
3.	Approval of Agenda	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Meeting Minutes	**MOTION #2**	1:07 PM – 1:10 PM

II. PUBLIC COMMENT

1:10 PM – 1:15 PM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

III. COMMITTEE NEW BUSINESS ITEMS

6. 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

7. Executive Director/Staff Report 1:15 PM – 1:20 PM
    a. 2023 Annual Report

b. General Orientation and Commission on HIV Overview March 26, 2024

8. Co-Chair Report 1:20 PM – 1:30 PM
   a. Prevention Standards Approval from Standards and Best Practices Committee
   b. Approval of Status Neutral Priority Setting and Resource Allocation (PSRA) Framework
   c. Convening with Consumer Caucus

9. Division of HIV and STD Programs (DHSP) Report 1:30 PM – 1:50 PM
   a. CDC Notice of Funding: High-Impact HIV Prevention and Surveillance Programs for Health Departments
   b. Programmatic and Fiscal Updates

V. DISCUSSION ITEMS 1:50 PM—2:50 PM

10. Prevention Focused Planning: Overview of Available Prevention Data and Review of Key Highlights of Comprehensive HIV Plan Situational Analysis Section
    a. What data is needed to inform PP&A prevention planning?
    b. What does the data show?
       i. What are we doing right?
       ii. What do we need to improve?

VI. NEXT STEPS 2:50 PM – 2:55 PM

11. Task/Assignments Recap
12. Agenda Development for the Next Meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

13. Opportunity for members of the public and the committee to make announcements.

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the meeting of March 19, 2024.

PROPOSED MOTIONS	
MOTION #1	Approve the Agenda Order as presented or revised.
MOTION #2	Approve the Planning, Priorities and Allocations Committee minutes, as presented or revised.

HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

(Updated 6.12.23)

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Public comment is limited to 2 minutes per person. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY
COMMISSION ON HIV

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 3/7/24

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts. ***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
ALVAREZ	**Miguel**	No Affiliation	No Ryan White or prevention contracts
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
CAMPBELL	**Danielle**	T.H.E. Clinic, Inc.	Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			Transportation Services
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
CUEVAS	**Sandra**	Pacific AIDS Education and Training - Los Angeles	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DONNELLY	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
FERGUSON	**Kerry**	ViiV Healthcare	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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**	Invisible Men	No Ryan White or prevention contracts
GERSH	**Lauren**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
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
HALFMAN	**Karl**	California Department of Public Health, Office of AIDS	Part B Grantee
HARDY	**David**	LAC-USC Rand Schrader Clinic	No Ryan White or prevention contracts
HERRERA	**Ismael "Ish"**	Unaffiliated consumer	No Ryan White or prevention contracts
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
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)
			Transportation Services
			Promoting Healthcare Engagement Among Vulnerable Populations
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MURRAY	**Derek**	City of West Hollywood	No Ryan White or prevention contracts
NASH	**Paul**	University of Southern California	Biomedical HIV Prevention
NELSON	**Katja**	APLA Health & Wellness	Case Management, Home-Based
			Benefits Specialty
			Nutrition Support
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Sexual Health Express Clinics (SHEx-C)
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Oral Healthcare Services
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention Services in Long Beach
			Transportation Services
			Residential Care Facility - Chronically Ill
			Data to Care Services
OSORIO	**Ronnie**	Center For Health Justice (CHJ)	Transitional Case Management - Jails
			Promoting Healthcare Engagement Among Vulnerable Populations

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
PATEL	**Byron**	Los Angeles LGBT Center	Ambulatory Outpatient Medical (AOM)
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
			STD Screening, Diagnosis and Treatment
			Health Education/Risk Reduction
			Biomedical HIV Prevention
			Medical Care Coordination (MCC)
			Promoting Healthcare Engagement Among Vulnerable Populations
			Transportation Services
PERÉZ	**Mario**	Los Angeles County, Department of Public Health, Division of HIV and STD Programs	Ryan White/CDC Grantee
RICHARDSON	**Dechelle**	AMAAD Institute	Community Engagement/EHE
ROBINSON	**Erica**	Health Matters Clinic	No Ryan White or prevention contracts
ROBINSON	**Mallery**	No Affiliation	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts
RUSSEL	**Daryl**	Unaffiliated consumer	No Ryan White or prevention contracts
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	No Ryan White or prevention contracts
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
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
SPENCER	**LaShonda**	Oasis Clinic (Charles R. Drew University/Drew CARES)	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
STALTER	**Kevin**	Unaffiliated consumer	No Ryan White or prevention contracts
TALLEY	**Lambert**	Grace Center for Health & Healing (No Affiliation)	No Ryan White or prevention contracts
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention
YBARRA	**Russell**	Capitol Drugs	No Ryan White or prevention contracts

LOS ANGELES COUNTY
COMMISSION ON HIV

DRAFT

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PLANNING, PRIORITIES, AND ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES
February 20, 2024

COMMITTEE MEMBERS P = Present | P* = Present as member of the public; does not meet AB 2449 requirements | A = Absent | EA = Excused Absence			
Kevin Donnelly, Co-Chair	P	Miguel Martinez, MPH, MSW	P
Al Ballesteros, MBA, Co-Chair	A	Derek Murray	EA
Lilieth Conolly	P	Dechelle Richardson	A
Felipe Gonzalez	P	Harold Glenn San Agustin, MD	P
Joseph Green	P	LaShonda Spencer, MD	P
Michael Green, PhD, MHSA	P	Lambert Talley	P
Ismael "Ishh" Herrera	EA	Jonathan Weedman	A
William King, MD, JD	EA		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Dawn McClendon, Lizette Martinez			
DHSP STAFF			
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.

I. ADMINISTRATIVE MATTERS

1. CALL TO ORDER AND MEETING GUIDELINES/REMINDERS

Kevin Donnelly and Felipe Gonzalez, Planning, Priorities and Allocations (PP&A) co-chairs, called the meeting to order at approximately 1:03pm. K. Donnelly reviewed the hybrid meeting guidelines with the group; see meeting packet for more details.

2. ROLL CALL & CONFLICT OF INTEREST STATEMENTS

K. Donnelly asked committee members to introduce themselves and reminded them to state their conflicts.

ROLL CALL (PRESENT): L. Connolly, J. Green, M. Green, M. Martinez, H. San Agustin, L. Spencer, L. Talley, K. Donnelly, F. Gonzalez

3. Approval of Agenda

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

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

II. PUBLIC COMMENT

5. **Opportunity for members of the public to address the Committee on items of interest that is within the jurisdiction of the Committee.**
   - *Russell Ybarra, unaffiliated consumer, requested that the Committee can discuss the potential to increase funding for housing for people living with HIV. He noted the importance of helping people who are not yet displaced but are struggling to pay their rent and utilities to avoid becoming homeless. He also noted increasing rent prices make it very challenging for individuals on fixed incomes, particularly seniors, to pay their rent and are getting pushed into homelessness.*
   - *J. Green commented that any member of the public is always welcome to attend and make comments or ask questions at COH meetings.*

III. COMMITTEE NEW BUSINESS

6. **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

7. **Execute Director/Staff Report**
   a. **2023 Annual Report**
      - C. Barrit, Commission on HIV (COH) Executive Director, reminded the Committee that the 2023 COH Annual Report is due to the Board of Supervisors (BOS) by the end of the month. She noted that the Executive Committee would be doing a final review of the document in their next meeting on February 22 and will forward to the BOS for final submittal. Commission staff will announce when it is sent to the BOS and will post the final version on the COH website.

   b. **PP&A Committee Role and Priority Setting & Resource Allocation (PSRA) Overview**
      - C. Barrit provided a refresher on the role of the PP&A Committee and a brief overview of the priority setting and allocation process. See meeting packet for more details.
      - D. Russell asked if agencies could overlap funds and services from the various Ryan White Program (RWP) Parts (e.g. Part A and Part C). C. Barrit clarified that all program parts follow the same service categories and that qualified agencies can apply for funding from DHSP

(Part A recipient) through a competitive solicitation process even if they are already receiving funding directly from the Health Resources and Services Administration (HRSA) because they are separate grants. K. Donnelly added that there is additional HIV related funding that the COH does not oversee - Ending the HIV Epidemic from HRSA and the Centers for Disease Control and Prevention (CDC) that agencies may compete for as well.

- Dr. San Agustin commented that accessing information to file a grievance is currently confusing and not easily accessible for members of the public. He recommended creating a card or document with a QR code that people can scan to link them directly to the grievance process. He added that this may also be helpful for recruitment efforts.
- M. Martinez asked if conflicts that members must disclose refer to funds that are received from DHSP. C. Barrit confirmed it conflict disclosure is for funds received from DHSP.
- D. Russell requested a copy of HRSA acronyms.

8. Co-Chair Report

a. New Member Introduction

- K. Donnelly welcomed new member Darrel Russell to the committee.

b. Commissioner Duty Statement

- K. Donnelly noted that commissioners should be aware of their role and duties as a member of the COH; see meeting packet for more details. He also reminded the group to continue to participate in meetings and attend COH trainings. Meeting information and trainings can be found on the COH website.

c. Integrating Caucus' Recommendations into PP&A Work & Follow-Up and Accountability

- K. Donnelly commented that the PP&A Committee will be looking to the various caucuses for feedback and recommendations to help inform the priority setting and resource allocation process. Commission staff will summarize recommendations and present them to the committee as they prepare for deliberations and create directives.

9. Division of HIV and STD Programs (DHSP) Report

a. Program Year (PY) 33 Expenditure Report

- DHSP staff, Victor Scott, provided a review of the Ryan White Program Year 33 Expenditures. The total RWP Part A award is approximately $42.9 million, Part B award is approximately $5.4 million, Minority AIDS Initiative (MAI) award of $3.6 million and an MAI carryover from RWP Year 32 of $685,000. See meeting packet for more details. The current estimated carryover into PY 34 is approximately $467,000.
- K. Nelson asked how the administrative cap to RWP funds works. V. Scott noted that no more than 10% of the RWP award are used toward administrative costs. For example, salaries for staff, planning council, travel to the annual Ryan White Program Conference, etc.

- Dr. San Agustin asked if an itemized budget could be provided to the Committee. He commented that Medical Case Management (MCC) expenditures exceed Ambulatory Outpatient Medical Care (AOM). V. Scott stated an itemized budget could not be provided as it would disclose specific providers/agencies. He also noted that current MCC expenditures are in line with expenditures from previous years but expenditures within AOM have decreased due to Medi-Cal expansion and the Department of Health Services (DHS) no longer utilizing RWP funds.
- J. Green asked if DHSP has ever been penalized for not spending the full award amount. V. Scott commented that there is a 5% penalty if there is more than a certain percentage of unobligated balance under formula funds. Part A funding is separated into two pots, formula award and supplemental award. The supplemental award cannot be carried over to the following program year. The formula award can be penalized the 5% if over a certain amount but DHSP has never incurred a penalty. Unspent formula funds are typically shifted towards the Minority AIDS Initiative (MAI) balance where carryover funds can be used without penalty.
- K. Donnelly asked what services were covered under the Outreach/Engagement service category noting that there is currently no funding allocated towards the Outreach/ Engagement service category. V. Scott responded that the Outreach/Engagement service category is for the Linkage and Re-engagement Program (LRP) services. He noted the program was previously under Early Intervention Services but, after further review, the program was a better fit under the Outreach/Engagement service category. DHSP will be requesting a reallocation at a future PP&A Committee meeting.
- C. Barrit asked what services are currently being funded under the Early Intervention Services category. V. Scott noted that funds in the Early Intervention Services category are to fund bundled HIV and STD testing in emergency departments.
- K. Donnelly asked if the new transitional case management program that is currently being developed by DHSP going to funded via the Transitional Case Management-Jails service category. V. Scott confirmed the new program will be funded via the Transitional Case Management-Jails service category. C. Barrit asked if the new program was specific to a certain population (e.g. youth). V. Scott could not confirm but noted he would follow up with DHSP staff to provide an answer.
- Bamby Salcedo asked if the funding under the Transitional Case Management-Jails service category was going to be reallocated or if incarcerated individuals will no longer be supported. V. Scott noted that the program will continue and that it is currently in transition. DHSP is currently developing the new program for Transitional Case Management and a Request for Proposal (RFP) will be released once finalized. C. Barrit also explained that part of the recent Medi-Cal expansion was to address the health needs of incarcerated individuals. Because the RWP is the payor of last resort, RWP funds cannot pay for services that another payor source is paying for. She noted transitional case management services have not gone away but rather have been transferred to another payor source. She added that the PP&A Committee must continually pause to assess

whether they are maximizing RWP funds, what are other payor sources and if there are gaps in what is covered and how to use RWP funds to supplement the gaps.

- C. Barrit noted that additional services that align with RWP service categories were included in the meeting packet and include funding allocations. See meeting packet for more details.
- Additional questions submitted to Commission staff include the following:
  - Without naming names of agencies, how many MCC teams are fully funded and how many are partially funded, and in aggregate, what percentage of the overall expenditure is spent on staff salaries? What are some examples of non-salary expenditures, and what percentage of the total expenditures this accounts for in aggregate?
  - AOM expenditures year to date (YTD) account for approximately 13% of the total expenditures YTD. The committee approved 25.5%. This is a difference of more than 10%; does this difference need to be mentioned or approved?

b. 2024 Solicitation Priorities

- Dr. Green announced that DHSP solicitation schedule for the 2024 year. See meeting packet for details.

V. DISCUSSION

10. Review Draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework

- C. Barrit provided an overview of the Draft Status Neutral Priority Setting and Resource Allocations (PSRA) Framework and Process document (Policy 09.5203); see meeting packet for more details.
- C. Barrit noted that the document was sent to HRSA program officers for review to ensure compliance with federal regulations.
- The PP&A Committee will convene a combined meeting with the Consumer Caucus to ensure consumers provide input on the PSRA process and increase knowledge/skills around using data and understanding the RWP and CDC funded programs.
- L. Connelly requested a copy of the attachments that are referenced in the document. Commission staff will send a Word version of the document and attachments for Committee members to review and provide feedback. She applauded the effort to include consumers in the process and build knowledge/understanding.
- M. Martinez expressed concern over the logistics of convening the meeting with the Consumer Caucus before the end of the first quarter. He also requested that future expenditure reports include percentages allocated in their reports to help committee members grasp the concept of allocating percentages to services categories in preparation of the PSRA process. F. Gonzalez added that percentages are used to allocate funding instead of dollars because the Committee often times does not know the total award amount until after completing the PSRA process.

- A. Burton asked if the meeting with the Consumer Caucus will be during a regular PP&A meeting, during a regular Consumer Caucus meeting or a separate meeting altogether. C. Barrit noted that Commission staff will work with PP&A and Consumer Caucus co-chairs to determine a meeting time and accommodations may need to be made to ensure participation from all parties but noted previous convenings occurred during a PP&A Committee meeting.
- Dr. San Agustin asked if the Committee received an expenditure report halfway through the program year and if adjustments are made at this mid-year point to align with approved allocations or align with actual expenditures. K. Donnelly commented that the Committee received recent expenditure reports in October and December and did go through a reallocation process in June 2023 to align with actual expenditures. He noted reallocations are common. M. Martinez also noted that DHSP can reallocate up to 10% without requesting a reallocation from the planning council (Commission on HIV).
- A. Burton requested that future expenditure reports contain allocation percentages and priority rankings.
- D. Russell recommended letting the Consumer Caucus determine the best time to meet as many have various levels of capacity to engage and understand the process. B. Salcedo agreed and reiterated the need to make the convening consumer oriented.

VI. NEXT STEPS

11. Task/Assignments Recap

a. Commission staff with send the draft Status Neutral Priority Setting and Resource Allocation (PSRA) Framework, with corresponding attachments, to committee members for further review.
b. Commission staff will follow up on any outstanding questions that were not answered during the meeting.
c. Commission staff will work with PP&A and Consumer Caucus co-chairs to plan the joint meeting.

12. Agenda Development for the Next Meeting

a. Review and discuss prevention services and data.
b. Approve Status Neutral Priority Setting and Resource Allocation (PSRA) Framework

VII. ANNOUNCEMENTS

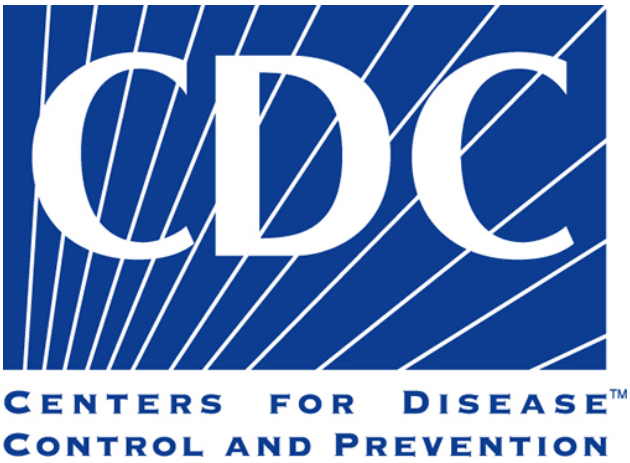
13. Opportunity for Members of the Public and the Committee to Make Announcements

- *R. Ybarra announced that Capitol Drugs will be hosting their annual health fair on March 23rd from 12pm-4pm at 8578 Santa Monica Blvd. West Hollywood, CA 90069. Flu shots and MPox vaccinations will be provided as well as free health screenings. The event typically attracts around 500 people. Anyone interested in being a vendor at the event can contact Russell Ybarra.*
- *Dr. Spender reminded the group that the E4: Educate Engage Empower Elevate LA County HIV Care and Prevention Community Advisory Board (CAB) conference is on February 26th from 9:30am to 3:30pm at the Magic Johnson Recreation Center.*
- *B. Salcedo announced the 15th anniversary of the TransLatin@ Coalition. The coalition will be hosting an event on Nov. 16th and invited all to attend. More details to follow.*

VIII. ADJOURNMENT

14. Adjournment for the Meeting of February 20, 2024.

The meeting was adjourned by K. Donnelly at 2:56pm.



Centers for Disease Control and Prevention

NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STD AND TB PREVENTION

High-Impact HIV Prevention and Surveillance Programs for Health Departments

CDC-RFA-PS-24-0047

04/29/2024

2. CDC Project Description

a. Approach

Bold indicates period of performance outcome.

<table>
<tr><th>Strategies and Activities</th><th>Short-term Outcomes</th><th>Intermediate Outcomes</th><th>Long-term Outcomes</th></tr>
<tr><td colspan="3">Strategy 1. Diagnose – Ensure all people with HIV receive a diagnosis as early as possible</td><td rowspan="4">Reduced new HIV infections
Improved health outcomes for PWH, including sustained viral suppression
Reduced HIV-related health disparities</td></tr>
<tr><td>1A. Implement HIV testing in health care settings, including routine opt-out HIV screening

1B. Implement HIV testing in non-health care community settings, including HIV-self testing

1C. Support integrated screening of HIV in conjunction with STIs, TB, viral hepatitis, and mpox</td><td>Increased routine opt-out HIV screenings in health care settings
Increased availability of and accessibility to HIV testing in health care and non-health care settings, including HIV self-testing
Increased identification of people with new HIV diagnoses and people with HIV who are not in care or not virally suppressed
Increased integrated screening of HIV with other STIs, TB, viral hepatitis, and mpox</td><td>Increased knowledge of HIV status
Reduced late HIV diagnoses</td></tr>
<tr><td colspan="3">Strategy 2. Treat – Implement a comprehensive approach to treat people with diagnosed HIV infection rapidly and reach viral suppression</td></tr>
</table>

2A. Link to HIV medical care within 30 days all people who test positive for HIV, provide HIV partner services, and refer to or provide prevention and essential support services to support improved quality of life 2B. Support people with diagnosed HIV infection to receive rapid and effective treatment	• **Increased rapid linkage to HIV medical care** • **Increased receipt of HIV partner services** • **Increased engagement in HIV prevention, medical care, and treatment services for PWH who are not in care or not virally suppressed** • **Increased early initiation of ART** • **Increased receipt of essential support services to improve quality of life**	• **Increased receipt of HIV medical care** • Increased retention in HIV medical care • **Increased HIV viral suppression**	
Strategy 3. Prevent – Reduce new HIV transmission by increasing PrEP and PEP services and supporting HIV prevention, including, condom distribution, perinatal transmission prevention and harm reduction services			
3A. Support and promote awareness and access to PrEP/PEP services 3B. Conduct condom distribution	• **Increased linkage to PrEP services** • **Increased linkage to PEP services** • Increased availability of condoms	• **Increased PrEP prescriptions and use** • **Increased PEP prescriptions and use** • **Increased use of SSPs**	

3C. Support harm reduction services, including syringe services programs (SSPs) 3D. Support and promote social marketing campaigns and other communication efforts 3E. Conduct perinatal, maternal, and infant health prevention and surveillance activities	• **Increased availability of harm reduction services, including SSPs** • **Increased awareness of PrEP/PEP and other prevention approaches** • **Improved completeness, timeliness, and accuracy of perinatal HIV surveillance data** • **Improved provision and coordination of perinatal HIV services**	• Increased knowledge of evidence based SSPs • **Reduced perinatally acquired HIV infection**	
Strategy 4. Respond – Identify and quickly respond to HIV clusters and outbreaks to address gaps and inequities in services for communities who need them			
4A. Develop and maintain a cluster detection and response (CDR) leadership and coordination group 4B. Communicate and	• Improved plans and policies to respond to HIV clusters and outbreaks • Increased health department and community engagement for CDR • **Improved early identification and investigation of**	• **Improved response to HIV clusters and outbreaks at individual, network, and system levels**	

collaborate about CDR 4C. Detect and prioritize clusters 4D. Respond to prioritized clusters and outbreaks to identify and address gaps and inequities in services	**HIV clusters and outbreaks** • **Improved completeness and timeliness of data about clusters and response to clusters**		
Strategy 5. Conduct HIV Surveillance activities			
5A. Conduct data collection and reporting 5B. Maintain data systems and conduct data management activities 5C. Conduct data analysis, dissemination, and evaluation 5D. Support data for action and special considerations	• **Improved completeness, timeliness, and accuracy of HIV surveillance data for public health action** • **Improved monitoring of trends in HIV infection** • **Improved data security, confidentiality, and protections for data sharing**	• **Improved use of HIV surveillance data to identify populations affected by relevant syndemics** • **Improved electronic data exchange capacity** • **Improved visualization of HIV surveillance data for public health action**	

Strategy 6. Support community engagement and HIV planning			
6A. Conduct strategic community engagement 6B. Establish and maintain an HIV planning group 6C. Conduct and facilitate the HIV planning process and the development of integrated HIV prevention and care plan	• **Increased collaborations and engagement with local partners, people with HIV, and communities** • **Increased coordination, availability, and access to comprehensive HIV prevention, treatment, and support services**	• **Sustained community partnerships to inform strategic planning and implementation**	

i. Purpose

The purpose of this NOFO is to implement a comprehensive, person-centered HIV prevention and surveillance program to prevent new HIV infections and improve the health of people with HIV. Additionally, the NOFO aligns with DHP's strategic focus areas to bolster community engagement, health equity, and focus on whole-person approaches to HIV prevention. Applicants will have the opportunity to build their proposed HIV prevention and surveillance program by identifying and implementing activities within the jurisdiction, based on need and resources, to reach the stated goal(s) for each strategy.

ii. Outcomes

The programs supported by this NOFO are expected to demonstrate measurable progress toward addressing the short-term and intermediate outcomes that appear in bold in the NOFO logic model. Indicators that quantify these outcomes are described in the section entitled CDC Evaluation and Performance Measurement Strategy. Please note that EHE-specific program

CDC-RFA-PS-24-0047 High-Impact HIV Prevention and Surveillance Programs for Health Departments

Estimated Funding Ranges for Core HIV Surveillance and Prevention, and Ending the HIV Epidemic Activities

The table below lists anticipated funding ranges for CDC-RFA-PS-24-0047 budget period 1 and subsequent budget periods for core HIV surveillance and prevention activities and for Ending the HIV Epidemic (EHE) activities for eligible jurisdictions. Funding is apportioned to each eligible state, territory, or directly funded city based on the number of people living with diagnosed HIV in that jurisdiction as of 2021, the most recent year for which complete data are available. All amounts presented in the table are estimates based on current resources and are subject to change depending on the annual availability of funds.

Anticipated award levels to support integrated core HIV surveillance and prevention programs are based on the proportionate share of each eligible jurisdiction to the number of people living with diagnosed HIV infection in 2021. Awards to eligible jurisdictions were calculated for both core HIV surveillance and prevention activities by multiplying their prevalence proportion by the total amount available to core program activities. CDC adjusted the allocation to ensure an established floor of $1,220,000 to each jurisdiction.

Anticipated award levels to support EHE activities in eligible jurisdictions is based on a data driven formula developed to better align funding with the ending the HIV epidemic initiative. This formula ensures that resources are distributed in a reliable manner, and that the federal investment in HIV prevention programs is based on need. Funding levels were determined by a formula reflecting a base funding amount, HIV disease prevalence (2021), and number of counties within the health department jurisdiction (if applicable).

Applicants must allocate funding for each of the three core initiatives: Prevention, Surveillance, and EHE (if applicable).

Funding availability in subsequent fiscal years will be determined by satisfactory recipient performance, and a decision that continued funding is in the best interest of the Federal Government.

Table 1: PS24-0047 Estimated Funding Ranges for Core HIV Surveillance and Prevention and Ending the HIV Epidemic Activities, for Budget Period 1 (10 months)

States and Cities	Core HIV Surveillance and Prevention Funding				Ending the HIV Epidemic (EHE) Funding[1]		Total Funding[2]	
	Surveillance Budget period 1 (10 months)		Prevention Budget period 1 (10 months)		Budget period 1 (10 months)		Budget period 1 (10 months)	
	Range		Range		Range		Range	
	Min	Max	Min	Max	Min	Max	Min	Max
Alabama	$629,003	$695,213	$3,174,424	$3,508,574	$1,863,553	$2,059,716	$5,666,979	$6,263,504
Alaska	$169,505	$187,347	$817,675	$903,746			$987,179	$1,091,093
Arizona	$756,255	$835,861	$4,007,823	$4,429,699	$1,792,930	$1,981,660	$6,557,009	$7,247,220
Arkansas	$353,244	$390,427	$1,368,434	$1,512,480	$1,708,791	$1,888,664	$3,430,469	$3,791,570
California	$2,627,233	$2,903,784	$16,261,157	$17,972,858	$6,773,021	$7,485,970	$25,661,412	$28,362,613
Los Angeles	$1,836,731	$2,030,071	$11,084,029	$12,250,769	$2,378,571	$2,628,947	$15,299,331	$16,909,787
San Francisco	$574,315	$634,770	$2,980,019	$3,293,705	$1,792,261	$1,980,920	$5,346,596	$5,909,395
Colorado	$595,614	$658,310	$2,955,756	$3,266,888			$3,551,370	$3,925,198
Connecticut	$501,247	$554,010	$2,345,507	$2,592,402			$2,846,754	$3,146,412
Delaware	$262,229	$289,832	$817,675	$903,746			$1,079,903	$1,193,577
District of Columbia	$653,769	$722,586	$3,487,263	$3,854,343	$1,793,947	$1,982,784	$5,934,979	$6,559,714
Florida	$4,078,773	$4,508,118	$25,767,525	$28,479,896	$7,794,674	$8,615,165	$37,640,972	$41,603,179
Georgia	$2,138,571	$2,363,683	$13,060,827	$14,435,651	$4,780,680	$5,283,910	$19,980,078	$22,083,244
Hawaii	$224,281	$247,890	$817,675	$903,746			$1,041,956	$1,151,635
Idaho	$188,378	$208,207	$817,675	$903,746			$1,006,053	$1,111,953
Illinois	$577,148	$637,900	$2,998,102	$3,313,692			$3,575,250	$3,951,592
Chicago	$1,008,280	$1,114,415	$5,658,374	$6,253,993	$1,898,220	$2,098,032	$8,564,874	$9,466,440
Indiana	$559,845	$618,776	$2,721,500	$3,007,973	$1,786,701	$1,974,774	$5,068,045	$5,601,524
Iowa	$246,976	$272,974	$817,675	$903,746			$1,064,651	$1,176,719
Kansas	$261,693	$289,239	$817,675	$903,746			$1,079,367	$1,192,985
Kentucky	$417,540	$461,492	$1,789,524	$1,977,895	$1,744,876	$1,928,547	$3,951,940	$4,367,934

Louisiana	$867,685	$959,021	$4,737,596	$5,236,290	$2,780,342	$3,073,010	$8,385,623	$9,268,320
Maine	$201,318	$222,509	$817,675	$903,746			$1,018,992	$1,126,255
Maryland	$1,267,278	$1,400,676	$5,102,702	$5,639,828	$2,782,885	$3,075,820	$9,152,865	$10,116,324
Baltimore[3]	$0	$0	$3,007,487	$3,324,065	$1,791,117	$1,979,656	$4,798,604	$5,303,721
Massachusetts	$853,002	$942,792	$4,641,434	$5,130,007	$1,787,262	$1,975,395	$7,281,699	$8,048,194
Michigan	$726,185	$802,626	$3,810,890	$4,212,036	$1,788,586	$1,976,858	$6,325,661	$6,991,520
Minnesota	$454,382	$502,212	$2,030,806	$2,244,575			$2,485,188	$2,746,787
Mississippi	$475,401	$525,443	$2,168,462	$2,396,721	$1,777,348	$1,964,438	$4,421,211	$4,886,601
Missouri	$584,384	$645,898	$2,882,208	$3,185,598	$1,838,512	$2,032,039	$5,305,103	$5,863,535
Montana	$168,566	$186,310	$817,675	$903,746			$986,241	$1,090,055
Nebraska	$224,348	$247,964	$817,675	$903,746			$1,042,023	$1,151,709
Nevada	$527,160	$582,651	$2,507,442	$2,771,383	$1,790,649	$1,979,138	$4,825,251	$5,333,172
New Hampshire	$190,188	$210,208	$817,675	$903,746			$1,007,863	$1,113,954
New Jersey	$1,389,683	$1,535,965	$8,185,448	$9,047,074	$2,784,404	$3,077,499	$12,359,534	$13,660,538
New Mexico	$279,192	$308,580	$883,455	$976,451			$1,162,647	$1,285,031
New York	$1,290,389	$1,426,219	$6,963,806	$7,696,838			$8,254,194	$9,123,057
New York City	$3,596,395	$3,974,963	$23,017,750	$25,440,672	$5,662,570	$6,258,630	$32,276,716	$35,674,265
North Carolina	$1,296,677	$1,433,170	$7,547,134	$8,341,569	$1,787,785	$1,975,973	$10,631,596	$11,750,712
North Dakota	$162,565	$179,678	$817,675	$903,746			$980,240	$1,083,423
Ohio	$953,001	$1,053,317	$5,296,342	$5,853,852	$3,774,322	$4,171,620	$10,023,666	$11,078,788
Oklahoma	$377,782	$417,549	$1,529,142	$1,690,104	$1,722,563	$1,903,885	$3,629,487	$4,011,538
Oregon	$395,616	$437,260	$1,645,941	$1,819,198			$2,041,557	$2,256,458
Pennsylvania	$819,312	$905,555	$4,420,790	$4,886,136			$5,240,102	$5,791,692
Philadelphia	$706,943	$781,358	$3,794,905	$4,194,369	$1,796,595	$1,985,711	$6,298,444	$6,961,438
Rhode Island	$235,344	$260,117	$817,675	$903,746			$1,053,018	$1,163,862
South Carolina	$752,199	$831,378	$3,981,258	$4,400,338	$1,932,693	$2,136,134	$6,666,150	$7,367,850
South Dakota	$168,633	$186,384	$817,675	$903,746			$986,308	$1,090,129
Tennessee	$773,754	$855,202	$4,122,426	$4,556,366	$1,788,017	$1,976,229	$6,684,197	$7,387,797
Texas	$2,589,822	$2,862,435	$16,016,143	$17,702,053	$4,785,428	$5,289,158	$23,391,394	$25,853,646
Houston	$1,078,377	$1,191,890	$6,117,446	$6,761,388	$1,868,809	$2,065,526	$9,064,632	$10,018,804
Utah	$260,318	$287,720	$817,675	$903,746			$1,077,993	$1,191,466
Vermont	$168,767	$186,532	$817,675	$903,746			$986,442	$1,090,278
Virginia	$963,695	$1,065,136	$5,366,377	$5,931,259			$6,330,072	$6,996,396
Washington	$634,199	$700,956	$3,208,454	$3,546,186	$1,788,541	$1,976,809	$5,631,194	$6,223,951
West Virginia	$217,945	$240,887	$817,675	$903,746			$1,035,620	$1,144,632
Wisconsin	$374,162	$413,547	$1,505,431	$1,663,897			$1,879,593	$2,077,445
Wyoming	$156,934	$173,453	$817,675	$903,746			$974,608	$1,077,198
US Territories								
Puerto Rico	$720,100	$795,900	$3,910,729	$4,322,385	$1,785,583	$1,973,539	$6,416,411	$7,091,823
U.S. Virgin Islands	$163,202	$180,382	$817,675	$903,746			$980,877	$1,084,127

Note: The funding model for core surveillance, prevention, and EHE capped losses at 10% compared to previous funding.

[1]EHE Health Department Eligible Jurisdictions

[2]These amounts are estimates based on current resources and are subject to the availability of funds. Awards for FY 2024 – FY 2029 will be based on FY 2024 available funds.

[3]Jurisdiction not separately funded for surveillance.

Table 2: PS24-0047 Estimated Funding Ranges for Core HIV Surveillance and Prevention and Ending the HIV Epidemic Activities, for Budget Period 2 onwards (12 months)

States and Cities	Core HIV Surveillance and Prevention Funding				Ending the HIV Epidemic (EHE) Funding[1]		Total Funding[2]	
	Surveillance Budget period 2 onwards (12 months)		Prevention Budget period 2 onwards (12 months)		Budget period 2 onwards (12 months)		Budget period 2 onwards (12 months)	
	Range		Range		Range		Range	
	Min	Max	Min	Max	Min	Max	Min	Max
Alabama	$757,834	$837,606	$3,824,607	$4,227,198	$2,245,244	$2,481,586	$6,827,686	$7,546,390
Alaska	$204,223	$225,720	$985,150	$1,088,850			$1,189,373	$1,314,570
Arizona	$911,151	$1,007,062	$4,828,702	$5,336,987	$2,160,157	$2,387,542	$7,900,010	$8,731,590
Arkansas	$425,595	$470,394	$1,648,716	$1,822,265	$2,058,784	$2,275,499	$4,133,095	$4,568,157
California	$3,165,341	$3,498,535	$19,591,756	$21,654,046	$8,160,266	$9,019,241	$30,917,363	$34,171,823
Los Angeles	$2,212,929	$2,445,868	$13,354,252	$14,759,963	$2,865,748	$3,167,406	$18,432,929	$20,373,237
San Francisco	$691,946	$764,783	$3,590,385	$3,968,320	$2,159,351	$2,386,651	$6,441,682	$7,119,753
Colorado	$717,607	$793,145	$3,561,152	$3,936,010			$4,278,759	$4,729,154
Connecticut	$603,912	$667,482	$2,825,912	$3,123,376			$3,429,824	$3,790,858
Delaware	$315,938	$349,195	$985,150	$1,088,850			$1,301,088	$1,438,045
District of Columbia	$787,673	$870,586	$4,201,522	$4,643,787	$2,161,382	$2,388,896	$7,150,577	$7,903,269
Florida	$4,914,185	$5,431,467	$31,045,211	$34,313,127	$9,391,173	$10,379,717	$45,350,568	$50,124,312
Georgia	$2,576,591	$2,847,811	$15,735,936	$17,392,350	$5,759,856	$6,366,156	$24,072,383	$26,606,318
Hawaii	$270,218	$298,662	$985,150	$1,088,850			$1,255,368	$1,387,512
Idaho	$226,962	$250,852	$985,150	$1,088,850			$1,212,112	$1,339,702
Illinois	$695,359	$768,554	$3,612,171	$3,992,400			$4,307,530	$4,760,954
Chicago	$1,214,795	$1,342,669	$6,817,318	$7,534,931	$2,287,012	$2,527,750	$10,319,125	$11,405,349
Indiana	$674,512	$745,513	$3,278,915	$3,624,064	$2,152,651	$2,379,246	$6,106,079	$6,748,824
Iowa	$297,561	$328,884	$985,150	$1,088,850			$1,282,711	$1,417,734
Kansas	$315,292	$348,481	$985,150	$1,088,850			$1,300,442	$1,437,331
Kentucky	$503,061	$556,014	$2,156,053	$2,383,006	$2,102,260	$2,323,551	$4,761,374	$5,262,571
Louisiana	$1,045,404	$1,155,447	$5,707,947	$6,308,783	$3,349,810	$3,702,421	$10,103,161	$11,166,651
Maine	$242,552	$268,083	$985,150	$1,088,850			$1,227,702	$1,356,933
Maryland	$1,526,841	$1,687,561	$6,147,834	$6,794,974	$3,352,874	$3,705,808	$11,027,548	$12,188,343
Baltimore[3]	$0	$0	$3,623,479	$4,004,897	$2,157,973	$2,385,128	$5,781,451	$6,390,025
Massachusetts	$1,027,714	$1,135,894	$5,592,090	$6,180,731	$2,153,328	$2,379,994	$8,773,131	$9,696,619
Michigan	$874,922	$967,019	$4,591,433	$5,074,742	$2,154,923	$2,381,757	$7,621,278	$8,423,518
Minnesota	$547,448	$605,074	$2,446,754	$2,704,307			$2,994,202	$3,309,382
Mississippi	$572,772	$633,064	$2,612,604	$2,887,615	$2,141,383	$2,366,792	$5,326,760	$5,887,472
Missouri	$704,077	$778,190	$3,472,539	$3,838,070	$2,215,074	$2,448,240	$6,391,690	$7,064,500
Montana	$203,092	$224,470	$985,150	$1,088,850			$1,188,242	$1,313,320
Nebraska	$270,299	$298,751	$985,150	$1,088,850			$1,255,449	$1,387,601
Nevada	$635,133	$701,989	$3,021,014	$3,339,015	$2,157,408	$2,384,504	$5,813,555	$6,425,508
New Hampshire	$229,143	$253,263	$985,150	$1,088,850			$1,214,293	$1,342,113
New Jersey	$1,674,317	$1,850,560	$9,861,986	$10,900,089	$3,354,703	$3,707,830	$14,891,005	$16,458,480
New Mexico	$336,375	$371,783	$1,064,404	$1,176,447			$1,400,779	$1,548,230
New York	$1,554,685	$1,718,336	$8,390,127	$9,273,298			$9,944,812	$10,991,634

New York City	$4,333,007	$4,789,113	$27,732,229	$30,651,411	$6,822,373	$7,540,518	$38,887,609	$42,981,042
North Carolina	$1,562,262	$1,726,711	$9,092,932	$10,050,083	$2,153,958	$2,380,690	$12,809,152	$14,157,484
North Dakota	$195,862	$216,479	$985,150	$1,088,850			$1,181,012	$1,305,329
Ohio	$1,148,194	$1,269,057	$6,381,135	$7,052,833	$4,547,376	$5,026,048	$12,076,705	$13,347,938
Oklahoma	$455,159	$503,071	$1,842,340	$2,036,270	$2,075,377	$2,293,838	$4,372,876	$4,833,179
Oregon	$476,646	$526,820	$1,983,061	$2,191,804			$2,459,707	$2,718,624
Pennsylvania	$987,123	$1,091,030	$5,326,253	$5,886,911			$6,313,376	$6,977,942
Philadelphia	$851,739	$941,396	$4,572,175	$5,053,457	$2,164,573	$2,392,423	$7,588,487	$8,387,275
Rhode Island	$283,547	$313,394	$985,150	$1,088,850			$1,268,697	$1,402,244
South Carolina	$906,264	$1,001,660	$4,796,696	$5,301,612	$2,328,546	$2,573,656	$8,031,506	$8,876,928
South Dakota	$203,172	$224,559	$985,150	$1,088,850			$1,188,322	$1,313,409
Tennessee	$932,234	$1,030,364	$4,966,779	$5,489,598	$2,154,237	$2,380,999	$8,053,250	$8,900,960
Texas	$3,120,267	$3,448,717	$19,296,558	$21,327,775	$5,765,576	$6,372,479	$28,182,402	$31,148,971
Houston	$1,299,249	$1,436,012	$7,370,417	$8,146,251	$2,251,578	$2,488,586	$10,921,244	$12,070,848
Utah	$313,636	$346,651	$985,150	$1,088,850			$1,298,786	$1,435,501
Vermont	$203,334	$224,738	$985,150	$1,088,850			$1,188,484	$1,313,588
Virginia	$1,161,078	$1,283,297	$6,465,515	$7,146,095			$7,626,593	$8,429,392
Washington	$764,095	$844,526	$3,865,607	$4,272,513	$2,154,869	$2,381,697	$6,784,571	$7,498,736
West Virginia	$262,585	$290,225	$985,150	$1,088,850			$1,247,735	$1,379,075
Wisconsin	$450,797	$498,250	$1,813,772	$2,004,696			$2,264,570	$2,502,945
Wyoming	$189,077	$208,979	$985,150	$1,088,850			$1,174,227	$1,297,829
US Territories								
Puerto Rico	$867,590	$958,915	$4,711,722	$5,207,692	$2,151,304	$2,377,758	$7,730,616	$8,544,365
U.S. Virgin Islands	$196,629	$217,327	$985,150	$1,088,850			$1,181,779	$1,306,177

Note: Reductions in funding are capped at 10%, therefore, no jurisdiction will have funding losses greater than 10% when compared to previous funding.

[1]EHE Health Department Eligible Jurisdictions

[2]These amounts are estimates based on current resources and are subject to the availability of funds. Awards for FY 2024 – FY 2029 will be based on FY 2024 available funds.

[3]Jurisdiction not separately funded for surveillance.

Table 3: PS24-0047 Estimated Funding Ranges for Ending the HIV Epidemic (EHE) Initiative, for Budget Periods 1 (10 months)

Recipient with Corresponding Eligible Phase I Jurisdictions	Ending the HIV Epidemic (EHE) Funding	
	Budget Period 1 (10 months)	
	Range	
	Min	Max
Alabama Department of Health	$1,863,553	$2,059,716
Arizona Department of Health • Maricopa County	$1,792,930	$1,981,660
Arkansas Department of Health	$1,708,791	$1,888,664
California (CA) **CA Department of Public Health** • Alameda County • Orange County • Riverside County • Sacramento County • San Bernardino County • San Diego County	$6,773,021	$7,485,970
Los Angeles County Department of Public Health • Los Angeles County	$2,378,571	$2,628,947
San Francisco Department of Public Health • San Francisco County	$1,792,261	$1,980,920
Florida Department of Health • Broward County • Duval County • Hillsborough County • Miami-Dade County • Orange County • Palm Beach County • Pinellas County	$7,794,674	$8,615,165
Georgia Department of Public Health • Cobb County • DeKalb County • Fulton County • Gwinnett County	$4,780,680	$5,283,910
Illinois **Chicago Department of Health** • Cook County	$1,898,220	$2,098,032
Indiana State Department of Health • Marion County	$1,786,701	$1,974,774
Kentucky State Cabinet for Health	$1,744,876	$1,928,547

Louisiana Department of Health • East Baton Rouge Parish • Orleans Parish	$2,780,342	$3,073,010
Maryland (MD) **Baltimore City Health Department** **MD Department of Health** • Montgomery County • Prince George's County	 $1,791,117 $2,782,885	 $1,979,656 $3,075,820
Massachusetts Department of Public Health • Suffolk County	$1,787,262	$1,975,395
Michigan Dept. of Health and Human Services • Wayne County	$1,788,586	$1,976,858
Mississippi State Department of Health	$1,777,348	$1,964,438
Missouri Department of Health	$1,838,512	$2,032,039
Nevada Department of Health Southern Nevada Health District • Clark County	$1,790,649	$1,979,138
New Jersey Department of Health • Essex County • Hudson County	$2,784,404	$3,077,499
New York **New York City Dept. of Health & Mental Hygiene** • Bronx County • Kings County • NY County • Queens County	 $5,662,570	 $6,258,630
North Carolina Department of Health • Mecklenburg County	$1,787,785	$1,975,973
Ohio Department of Health • Cuyahoga County • Franklin County • Hamilton County	$3,774,322	$4,171,620
Oklahoma State Department of Health	$1,722,563	$1,903,885
Pennsylvania **Philadelphia Department of Health** • Philadelphia County	 $1,796,595	 $1,985,711
South Carolina Department of Health and Environmental Control	$1,932,693	$2,136,134

Tennessee Department of Health • Shelby County	$1,788,017	$1,976,229
Texas **Houston Dept of Health and Human Services** • Harris County **Texas Department of State Health Services** • Bexar County • Dallas County • Tarrant County • Travis County	$1,868,809 $4,785,428	$2,065,526 $5,289,158
Washington State Department of Health • King County	$1,788,541	$1,976,809
Washington, D.C. **District of Columbia Department of Health**	$1,793,947	$1,982,784
Puerto Rico Department of Health • San Juan Municipio	$1,785,583	$1,973,539

Table 4: PS24-0047 Estimated Funding Ranges for Ending the HIV Epidemic (EHE) Initiative, for Budget Period 2 onwards (12 months)

Recipient with Corresponding Eligible Phase I Jurisdictions	Ending the HIV Epidemic (EHE) Funding	
	Subsequent Budget Periods (12 months)	
	Range	
	Min	Max
Alabama Department of Health	$2,245,244	$2,481,586
Arizona Department of Health • Maricopa County	$2,160,157	$2,387,542
Arkansas Department of Health	$2,058,784	$2,275,499
California (CA) **CA Department of Public Health** • Alameda County • Orange County • Riverside County • Sacramento County • San Bernardino County • San Diego County	$8,160,266	$9,019,241
Los Angeles County Department of Public Health • Los Angeles County	$2,865,748	$3,167,406
San Francisco Department of Public Health • San Francisco County	$2,159,351	$2,386,651
Florida Department of Health • Broward County • Duval County • Hillsborough County • Miami-Dade County • Orange County • Palm Beach County • Pinellas County	$9,391,173	$10,379,717
Georgia Department of Public Health • Cobb County • DeKalb County • Fulton County • Gwinnett County	$5,759,856	$6,366,156
Illinois **Chicago Department of Health** • Cook County	$2,287,012	$2,527,750
Indiana State Department of Health • Marion County	$2,152,651	$2,379,246
Kentucky State Cabinet for Health	$2,102,260	$2,323,551

Louisiana Department of Health • East Baton Rouge Parish • Orleans Parish	$3,349,810	$3,702,421
Maryland (MD) **Baltimore City Health Department** **MD Department of Health** • Montgomery County • Prince George's County	 $2,157,973 $3,352,874	 $2,385,128 $3,705,808
Massachusetts Department of Public Health • Suffolk County	$2,153,328	$2,379,994
Michigan Dept. of Health and Human Services • Wayne County	$2,154,923	$2,381,757
Mississippi State Department of Health	$2,141,383	$2,366,792
Missouri Department of Health	$2,215,074	$2,448,240
Nevada Department of Health Southern Nevada Health District • Clark County	$2,157,408	$2,384,504
New Jersey Department of Health • Essex County • Hudson County	$3,354,703	$3,707,830
New York **New York City Dept. of Health & Mental Hygiene** • Bronx County • Kings County • NY County • Queens County	 $6,822,373	 $7,540,518
North Carolina Department of Health • Mecklenburg County	$2,153,958	$2,380,690
Ohio Department of Health • Cuyahoga County • Franklin County • Hamilton County	$4,547,376	$5,026,048
Oklahoma State Department of Health	$2,075,377	$2,293,838
Pennsylvania **Philadelphia Department of Health** • Philadelphia County	 $2,164,573	 $2,392,423
South Carolina Department of Health and Environmental Control	$2,328,546	$2,573,656

Tennessee Department of Health • Shelby County	$2,154,237	$2,380,999
Texas **Houston Dept of Health and Human Services** • Harris County **Texas Department of State Health Services** • Bexar County • Dallas County • Tarrant County • Travis County	$2,251,578 $5,765,576	$2,488,586 $6,372,479
Washington State Department of Health • King County	$2,154,869	$2,381,697
Washington, D.C. **District of Columbia Department of Health**	$2,161,382	$2,388,896
Puerto Rico Department of Health • San Juan Municipio	$2,151,304	$2,377,758

DHSP Funding Table (updated 2.8.23)

Funding Source	Amount	Description
HRSA Ryan White Program Part A (March 1-February 28/29) Year 1 of 3-year award	**$42,142,230**	Grant must fund at least one or more core or support service for people living with HIV/AIDS per policy clarification notice 16-02. The Ryan White Program is the payor of last resort. AOM, Oral Health, Early Intervention Services, Emergency Financial Assistance Services, Home and Community Based Health Services, Mental Health Services, Medical Case Management (MCC), Non-medical Case Management (Benefits Specialty), Food Bank and Home Delivered Meals, Housing Services (RCFCI, TRCF), Legal Services, Linguistic Services, Medical Transportation, Substance Abuse Residential Services
HRSA Ryan White Program Part B April 1- March 31 (year 4 of 5-year cycle)	**$5,446,809**	Grant must fund at least one or more core or support service for people living with HIV/AIDS per policy clarification notice 16-02. The Ryan White Program is the payor of last resort. Housing Services (RCFCI and TRCF. Mental health portion of these contracts is covered under Part A. Substance Use Residential services for one agency is also supported with RWP Part B)
HRSA Ryan White Program Minority AIDS Initiative (March 1-February 28/29) Year 1 of 3-year award	**$3,780,205**	Grant must fund at least one or more core or support service for HIV-positive racial or ethnic or sexual minorities. The Ryan White Program is the payor of last resort. Outreach (LRP), Housing (Permanent Supportive Housing), and Non-medical Case Management (Transitional Case Management) is supported with RWP MAI.
HRSA Ending the HIV Epidemic March 1-February 28/29 (Year 3 of a 5-year cycle)	**$6,168,850**	Grant supports 1) Data system infrastructure development and systems linkages; 2) Surveillance improvements and building organizational capacity, 3) Emerging practices, evidence-informed and evidence-based interventions for diagnosis and rapid linkage to care; 4) Reengagement in care and viral suppression; and 5) Community engagement, information dissemination specifically calling attention to the activities for PLWH who are not virally suppressed.
CDC Ending the HIV Epidemic August 1-July 31 (Year 3 of a 5-year cycle)	**$3,360,658**	Grant supports HIV prevention strategies, including 1) HIV self-testing; 2) Community engagement; 3) Increased access to syringe services; 4) Increased screening for PrEP; 5) HIV prevention media campaigns; and 6) Improved surveillance data for real-time HIV cluster detection and response.
CDC Integrated HIV Surveillance and Prevention (January 1-December 31)-1-year extension of a 5-year cycle	**$17,950,095**	Grant supports 11 HIV surveillance and prevention strategies including active and passive surveillance; outbreak investigation; data management, analysis and reporting; comprehensive individual-level and community-level HIV-related prevention services; and data-driven planning.
State Block Grant – HIV Surveillance (July 1-June 30)	**$1,972,378**	Grant supports active and passive HIV surveillance, data management, analysis and reporting.
CDC National HIV Behavioral Survey & TG supplement (January 1-December 31) - year 2 of a 5-year cycle)	**$1,362,085**	Grant supports Los Angeles County's participation in this four-cycle national survey (MSM, IDU, Heterosexuals, and TG). Survey findings are used for the Los Angeles County HIV/AIDS Strategy, program development, and resource allocation.
CDC Medical Monitoring Project (June 1-May 31) - year 3 of a 5-year cycle	**$728,648**	Grant supports Los Angeles County's participation in the national surveillance project designed to learn more about the experiences and needs of PLWH (in and out of care).
CDC Strengthening STD Prevention and Control for Health Departments (January 1-December 31) - year 4 of a 5-year cycle	**$3,356,049**	Grant must be used to support 5 strategy areas: STD surveillance, disease investigation and intervention, screening and treatment, promotion and policy, and data management and utilization. No more than 10% of grant funds can support contracts.
CDC STD Prevention and Control for Health Departments – Disease Investigation Specialist (DIS) Workforce Development Infrastructure (January 1-December 31) – year 2 of a 5-year cycle	**$6,598,516**	Grant supports expanding, training, and sustaining local DIS workforce to support increased capacity to conduct disease investigation, linkage to prevention and treatment, case management and oversight, and outbreak response for COVID-19 and other infectious diseases.
CDC Gonococcal Isolates Surveillance Project (August 1-July 31)	**$15,000**	ELC Grant supports participation in the national sentinel surveillance system to monitor trends in antimicrobial susceptibilities of Neisseria gonorrhea strains in the US among selected STD clinics and covers salary, fringe benefits and supplies
State STD General Funds Allocation July 1-June 30 (year 4 of 5-year cycle)	**$547,050**	Grant funds support CT/GC Patient Delivered Partner Therapy (PDPT) Distribution Project, condom distribution, training for PHNs and PHIs and DHSP staff.
State STD Management and Collaboration Project (July 1-June 30) - year 4 of 5-year cycle	**$1,952,013**	Grant funds support Category 1 and Category 2 STD contracts, Audacy for condom distribution, and rapid Syphilis test kits
State Syphilis and Congenital Syphilis Outbreak Strategy (SOS) (July 1 – June 30)	**$3,957,227**	Funds support innovative and impactful syphilis and congenital syphilis prevention and control activities, with a focus on disproportionately impacted populations as determined by local or regional syphilis and congenital syphilis epidemiology.
SAPC Non-Drug Medi-Cal (July 1-June 30)	**$3,249,000**	Grant supports HIV risk reduction interventions that contain a substance abuse component.
Total	**$102,586,813**	

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

December 2022

County of Los Angeles Public Health

Los Angeles County Commission on HIV

County of Los Angeles California

Section IV: Situational Analysis

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

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

LA County DPH supports a cross-section of organizations to conduct HIV testing in a variety of settings, including non-clinical venues that serve priority populations, community-based HIV/STD clinics, social and sexual network testing programs, and commercial sex venues. Overall, DPH supports 42 HIV testing providers with annual goals to provide over 80,000 HIV tests and with the goal of diagnosing more than 800 individuals with HIV each year. In addition, LAC DPH staff directly provides HIV testing in the county jails and STD Clinics. These public-sector supported HIV testing and diagnosis efforts are an important complement to private sector HIV testing efforts supported by commercial health plans.

Routine HIV Testing: Expanding routine HIV testing within emergency departments, hospitals in highly HIV impacted geographic areas, FQHCs, and other clinical settings is crucial to meet HIV testing goals. While targeted testing often provides the highest positivity rate, implementing routine testing in health care settings is an important component to not only move towards destigmatizing HIV, but also allowing individuals who do not recognize their HIV risk to be tested for HIV. Given the co-occurrence of HIV and other STDs and substance use, it is essential that we continue to promote HIV testing as a part of routine STD screenings and at substance use disorder treatment facilities and SSPs. Routine testing in a subset of clinical settings can have an acceptable yield while leveraging multiple revenue streams, including public and private health plans, to cover testing costs. Despite these opportunities and benefits, launching new routine HIV testing programs in healthcare settings in LAC has been difficult. To catalyze routine HIV testing, a variety of policy changes are needed

including changes that require low barrier reimbursement for HIV screening and strong annual screening mandates. In addition, we must address several non-financial routine HIV testing barriers, including broad scale training and technical assistance of routine HIV testing staff, broad scale adaptation of electronic medical records to incorporate HIV testing prompts and export critical HIV testing data, the development of protocols to ensure the immediate linkage of newly-diagnosed HIV- positive persons to care, and incentives to recruit and maintain a county-wide cadre of health care settings based routine HIV testing "champions."

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

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

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

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

Rescreening individuals with elevated HIV risk: Both national and local data indicate that many people at higher risk for HIV infection are not screened according to clinical guidelines (e.g. CDC recommendation of at least once per year). Among CDC's NHBS participants, 15% of transwomen, 16% of MSM and 45% of PWID had not had a test in the past 12 months; and a lower proportion of

persons with ongoing HIV risk received an HIV test every three or six months as recommended by the CDC.

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

Self-Test Kits: Alternative HIV testing approaches are necessary to ensure that HIV diagnoses continue among individuals who may be HIV-positive but who may be less inclined to seek in-person services. The U.S. Food and Drug Administration (FDA) has approved HIV self-test kits, that while less sensitive than other rapid tests, provide an important low barrier option for individuals to confirm their HIV status. In response to this alternate testing strategy, LA County DHSP joined the multi-jurisdictional Take Me Home initiative. Take Me Home is a timely and innovative HIV self-test kit ordering program that centralizes advertising, data collection, and test kit distribution to clients, relieving health departments from coordinating and hiring staff during the COVID crisis. As a strategy to promote linkage to care efforts, DHSP has also made available HIV self-test kits to community-based partners who also offer video or phone assistance and support by trained test counselors and who prioritize providing linkage to care services to persons testing HIV-positive. TakeMeHome is working to expand its reach and diversify its users by implementing active social media strategies and partnering with local credible messengers to increase the recognition of and trust in the program. Providing the opportunity for no-cost self-test kits is a strategy to increase access to HIV testing services with minimal staff support. Since January 2021, Public Health has distributed over 15,000 kits to contracted HIV prevention agencies, other community partners, and through community events. DPH plans to expand self-test kit distribution through programs that serve people who inject drugs, transitional aged youth, and people experiencing homelessness. LA County is also pursuing distribution options through non-traditional partners such as barbershops, religious institutions, mutual aid groups, as well as through large scale community events.

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

The County welcomes traditional and non-traditional partners to further explore HIV testing opportunities that allows for the highest impact in increased testing access points, reduced barriers for clients, and integration of routine “syndemic” testing that includes viral hepatitis and STDs. DHSP will continue to expand or support the existing HIV testing portfolio especially for populations where HIV rates are rising and is committed to partnering with agencies such as homeless service providers conducting street outreach to further increase HIV testing opportunities, given their expertise of the communities and clients they serve.

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

Linkage to care: Since 2011, DHSP has incentivized timely linkage to HIV medical care for its network of community-based HIV testing providers. HIV testing providers assume primary responsibility for linking a newly diagnosed person to HIV care by setting up appointments and following up with the client until the first appointment is completed. While this incentive structure initially produced significant improvements in initial linkage to care, more recently performance has generally plateaued. Only 76% of persons who were newly diagnosed in 2020 were linked to HIV care within one month and only 54% were linked to HIV care within one week. This is likely due to a combination of factors, such as denial or competing life demands, and structural barriers, such as lengthy financial screening requirements and administrative paperwork. The current system must evolve to make rapid initiation of antiretroviral therapy (ART) the easiest choice for both the provider and the patient. DHSP, together with HIV prevention and medical providers, must restructure its approach to linkage to care, must treat new HIV diagnoses with more urgency, and must ensure that providers receive technical assistance to make same day linkage referrals a standard practice. In addition, DHSP will utilize its position as funder to provide technical assistance to clinics to reduce unnecessary administrative barriers for patients and improve the client experience. An exciting LTC project recently launched by DHSP is the Rapid and Ready program focusing on same-day linkage to care which has received 52 referrals to date, of which, 50% have been linked to care.

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

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

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

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

Addressing the Meth Epidemic: In LA County, the SAPC Program leads and facilitates the delivery of prevention, treatment, and recovery support services intended to reduce the impact of substance use, abuse, and addiction county-wide. The LAC DPH Division of HIV and STD Programs collaborates with SAPC to connect clients to HIV and STD-related services. Given the consistent increase in methamphetamine use over time and its well- established intersection with HIV, syphilis, and poor HIV-related health outcomes, it is imperative that LA County facilitates greater integration and synergy of HIV and substance use disorder services. Stronger partnerships among HIV service providers and SUD providers must include strategies that address meth use and its role with sexual HIV risk behavior, must promote adherence to PrEP or ART, and must prioritize the expansion of contingency management services coupled with these biomedical HIV prevention tools. More broadly across the substance using spectrum, programs that promote harm reduction, mitigate the sharing of injection equipment and promote syringe services programs must be prioritized, including geographic areas with high rates of HIV transmission but devoid of SSPs. The LA- based Act Now Against Meth Coalition, a long-standing community mobilization and awareness effort launched to address the alarming increase in meth use among gay and bisexual men has recently developed the Los Angeles County Platform Addressing the Meth Epidemic. The platform includes a list of recommendations for meth prevention, treatment, and policy, some of which we have folded into our goals and objectives. Separately, SAPC has launched a Countywide Meth Task Force to inform meth prevention and treatment strategies and address both the upstream drivers of meth use and abuse. DHSP actively participates in both the Prevention and Treatment Committees of the Meth

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

Task Force.

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

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

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

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

The current safety net in LAC to address the needs of PLWH with multiple health and/or life circumstances (e.g., substance use disorder, homeless, mentally ill, other co-morbidities, and chronic health conditions) persons living with HIV is fraught and complex. Navigating the healthcare system and identifying accessible and quality mental health and SUD services, particularly for low-income persons, can be difficult; at the same time, mental health services specifically designed for PLWH remain underutilized in parts of LAC. To ensure that we improve the health outcomes of PLWH who have not achieved viral suppression, disruptive programming that provides supportive services with an emphasis on education, emotional support, trauma informed care and stigma reduction; and improves the lives of people experiencing financial hardship, homelessness, mental illness, and SUD are greatly needed. New and unconventional programming, such as conditional financial incentives,

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

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

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

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

also known as contingency management, must be expanded, as well as advances in antiretroviral therapy such as long acting injectables, particularly for individuals facing the most complex life circumstances. For communities most impacted by HIV, the importance of addressing barriers to care and ensuring PLWH are informed and able to easily access various programs and resources will be important.

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

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

Mistrust of new pharmacologic interventions and medical providers in communities of color are understandable and justifiable given the history of mistreatment of Black Americans, Native Americans, and other people of color, as unwilling subjects of medical research and continued racial biases in access to and the delivery of health care services. Unsurprisingly, the uptake of PrEP among Black and Latinx MSM and transgender persons has consistently been lower compared to their White counterparts. In addition, many individuals incorrectly believe that PrEP will be too expensive and therefore inaccessible. While federal, state, and local programs that support PrEP at low to no-cost remain in place; community-based organizations, medical providers, and public health departments all have a role to play to help address misinformation and mistrust as a step towards deconstructing institutional racism and improving healthcare access patterns. The Commission's *Black/African American (AA) Community Task Force*[56] recommended increasing culturally sensitive PrEP advertising designed with input from the very communities it is attempting to reach, including Black/African American cisgender women, transgender individuals and MSM. In addition, voices of influential individuals through social media and marketing may help destigmatize both HIV and PrEP use and could potentially activate some individuals to take action.

For PrEP to reach the individuals who would most benefit from this prevention tool, health care partners across all sectors and disciplines must not only understand its clinical use, but, more importantly, be mindful and comfortable in their approach to discussing sexual behaviors with patients, ideally in an open non-judgmental manner. The network of LAC PrEP Centers of Excellence (COEs) was launched in 2016 with the goal of creating culturally competent access points where patients can also receive assistance navigating PrEP-related cost and health insurance coverage issues. Since the FDA approval of PrEP, the number of medical providers in LAC who report being a PrEP provider has steadily increased.[12] Recently, 39 Federally Qualified Health Centers (FQHCs) in LAC were funded directly through the federal Ending the HIV Epidemic initiative to expand their PrEP and HIV prevention efforts. Additionally, recent California legislation and policy changes have further expanded PrEP access points to include pharmacies[57] and telemedicine providers.

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

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

An outstanding concern regarding PrEP uptake is its duration of use among individuals with continued risk. Discontinuation of PrEP is likely due to multiple factors, including pill fatigue, administrative barriers, and competing life demands. To ensure consistent, sustained access for clients at highest risk for HIV and other STDs in sexual health and prevention services and PrEP services, providers must develop more systematic and innovative ways of staying engaged with their clients. PrEP providers can reduce barriers to care for follow up appointments by offering telemedicine visits and allowing patients to come in only when laboratory work is needed. Expansion of technology to allow for accurate and sensitive home or self-collected HIV and STD tests will be a significant step toward further minimizing the frequency and length of time for medical visits and ensuring PrEP adherence. Many clients, especially younger individuals, prefer digital forms of communication and care, yet many community health centers still lack secure technology platforms to facilitate easier communication with patients.

DHSP and stakeholders must continue to promote all PrEP access points to further increase uptake. Studies have demonstrated that the "2-1-1" PrEP regimen[58] (where an individual takes two pills 2 to 24 hours before sex, one pill 24 hours after the initial dose, and one final pill 24 hours later), as well as long-acting injectable PrEP options, are important alternatives to oral daily PrEP. These alternate regimens have the added benefit of being attractive for individuals with pill fatigue or those struggling with adherence issues. Lastly, providers must be aware of clients who have or continue to utilize PEP, the use of antiretroviral drugs for people who are HIV- negative after a single high-risk exposure to stop HIV acquisition. Clients utilizing PEP should be connected to PrEP service providers to further prevent HIV transmission and acquisition. Although providers must acknowledge that for some clients, repeated use of PEP overtime may be the most beneficial form of biomedical prevention.

Syringe Services Programs: Historical data in LAC have shown injection drug use (IDU) to be a consistent, but less common risk factor for HIV transmission, accounting for less than 5% of HIV cases annually. However, recent increases in opioid and methamphetamine use via both injection drug use and non-injection drug use is concerning. Additionally, the rise of conditions that contribute to drug use, such as economic inequality, homelessness and untreated mental illness are pervasive in LAC, increasing our susceptibility to an IDU outbreak. Fortunately, syringe services programs (SSPs) are legal under California law, but programs in LAC experience fragmented or insufficient support from County and City of Los Angeles partners. In addition, LAC DPH funded SSPs continue to be small in scale, including only nine agencies funded at modest levels through the DPH SAPC program. Of the nine currently funded EOP agencies, only two currently provide HIV, STD, and hepatitis C (HCV) testing. Unfortunately, there is limited data and an absence of an in-depth analysis to confirm the impact of the LAC DPH-supported SSP programs, including data tied to linking clients to testing, other HIV prevention and care resources as well as Hepatitis and substance use disorder services. LAC has recently increased our investment in this area and we plan to continue to enhance the SSP service portfolio to ensure clients are linked to HIV prevention and treatment services and allow for more robust data collection. Despite recent legislative setbacks, we will also continue to support the creation of supervised drug consumption sites and services. Supervised Consumption Sites (SCS) are designated sites where people can use pre-obtained drugs under the safety and support of trained personnel. SCS have been implemented across over 200 sites in countries around the world and have been proven to save lives.[59]

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

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

d. Respond Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People who Need Them: The use of client-level data reported to the public health department to identify and target PLWH for contact tracing and linkage to services has a long precedent that continues today. The use of this client data for expanded HIV prevention and outreach efforts, however, is relatively recent. For decades, national guidelines and state laws restricted access and use of client-level HIV surveillance data to traditional surveillance functions, such as generating aggregated reports to describe population-based trends among PLWDH. While these limits on the use of surveillance data in the early days of the HIV epidemic as a way to protect the privacy of PLWH were understandable, these laws severely limited the ability of public health staff to use available information to further advance outbreak investigation efforts. Fortunately, we find ourselves in a different era where data driven HIV public health strategies, such as data-to-care, the use of geospatial analysis, and molecular cluster analysis are available (and required) and can be leveraged to ensure that the HIV public health response is more targeted and timely, and has the greatest impact. These activities require real-time access to client-level surveillance data and will be carried out regularly to not only identify individuals who need enhanced services, but to also detect and rapidly respond to early clusters or outbreaks of HIV in the community.

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

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

While the Partner Services program in LAC has been mostly successful in interviewing newly diagnosed clients, there is opportunity to further expand the program's capacity to ensure all newly diagnosed clients and their partners are being interviewed in a timely and more efficient manner. In LAC, improved data system integration, easier data access, and increased staffing will improve the ability of LAC DHSP to reach all newly diagnosed persons with HIV. The latest estimate suggests that 73% of newly diagnosed persons with HIV in LAC receive an offer of Partner Services around the time of their diagnosis, but only 46% of those newly diagnosed are interviewed and only 10% name contacts. There is an opportunity to build staff capacity within the Partner Services program as well as expand partnerships with providers at high volume HIV/STD clinical testing sites to 1) establish more on-site counseling and education for persons testing positive within clinics, 2) promote rapid linkage to care and treatment efforts, and 3) reinforce community driven service sites that support and empower clients to prioritize their wellness and connect identified partners with critical HIV testing and/or PrEP. In addition, Partner Services will need to adapt to new technologies in order to respond to the use of web- based platforms, mobile apps, and other internet-based modalities that facilitate identifying and connecting with partners to testing, prevention, or care.

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

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

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

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

HIV Molecular Cluster Detection: In 2018, LAC adopted the use of the CDC's HIV TRACE program to identify priority molecular clusters (defined as a group of 5 or more persons whose HIV genotype is identified as being highly similar and a transmission cluster requiring additional review and intervention.) Because HIV has a high mutation frequency, individuals whose HIV genotypes are highly similar are likely connected through recent sexual or social networks where there is ongoing HIV transmission. In addition, there is a high likelihood that persons who may be part of new cluster are unaware of their HIV status or know their status but are not virally suppressed. LAC staff perform molecular cluster analysis of available surveillance and programmatic data to determine if the individuals are in care, virally suppressed, and if they need contact and engagement from linkage to care, re-engagement or partner services/notification teams. Given the novel nature of molecular cluster detection, in late 2019 LAC DPH launched an effort to engage community stakeholders regarding its use and assess potential unintended consequences. LAC DHSP provided an overview of molecular surveillance to the Commission on HIV to provide background information, address community concerns, address misperceptions related to the use of data, and review the potential legal ramifications and privacy issues. Planned activities for further community dialogue were put on hold due to the deployment of staff to the local COVID-19 response, however they have recently resumed. As a part of continued community engagement and awareness on molecular cluster detection and the monitoring of cluster outbreaks, DHSP will develop a communication strategy for community members and organizations in 2022 and beyond.

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

As we continue to move forward with EHE and develop new or strengthen existing partnerships with community stakeholders and service providers, LAC DHSP will continue to adopt common language and improve understanding of the Respond Pillar. This will be important to advance strategies designed to support the adoption of this new technology, more efficiently serve clients in need, and prevent outbreaks. Successful EHE efforts are strongly dependent on the extensive partnerships between LAC's HIV medical homes, Medical Care Coordination teams, vast network of HIV support services providers, leaders from the most impacted communities, and a broad-based coalition of non-traditional service partners. An integrated data management system for case management and surveillance data is foundational to future programmatic enhancements. LAC DPH's Informational Technology branch has begun to add HIV and STDs to its new surveillance data system for all communicable diseases; the new system will offer large-scale improvements to overall data management, facilitate data linkages across diseases, and improve timely access to surveillance data for staff working with clients. We are hopeful that the social acceptance of contact tracing for COVID-19, and the societal shift in understanding its importance in disease investigation will translate into improved HIV case- finding efforts under the Respond Pillar.

Priority Populations: Based on epidemiologic and needs assessment data, the priority populations for the Integrated Plan are: Black/African American MSM, Latinx MSM, women of color, people who inject drugs, transgender persons, youth under 30 years of age and PLWH aged 50 and older. These populations are inclusive of the priority populations in the EHE with the addition of the 50 and older population group. Although these populations will be prioritized, the County's HIV portfolio will continue to support *all* populations affected by HIV and will not diminish efforts to prevent, diagnose, and treat HIV for populations who remain a critical concern, including people experiencing unstable housing or homelessness, among others.

Capacity Building & HIV Workforce: For many years, there has been a resounding call from frontline HIV service providers and others to provide the HIV workforce with the tools, resources, and support to maintain their health and wellbeing while continuing to diligently serve people affected by and living with HIV. The jurisdiction is committed to exploring additional opportunities to support frontline workers by addressing staff burnout, identifying and addressing training needs, and supporting continued professional development and advancement, all of which will improve the quality of services and strengthen the local HIV response. LAC DHSP will continue to work with the AETCs and the California Prevention Training Center to identify trainings to support the HIV workforce, with a particular focus on client-centered and trauma-informed approaches to HIV care. Given recent events and persistent social injustices, including COVID-19, a housing crisis, and worsening economic, racial and social injustice, the emotional and physical capacity of individuals, organizations, and the HIV workforce continues to be strained and tested. We recognize the need to support programs and services that 1) address intersectional issues that go beyond HIV prevention, care and treatment needs, 2) support PLWH with meeting basic human needs and 3) better support the HIV workforce. We will continue to encourage organizations to diversify the HIV workforce by hiring diverse employees to promote cultural competency, mirror the populations most impacted by the HIV epidemic, and combat systemic racism as we operationalize all Pillars.

Prevention Focused Planning:

Overview of Available Prevention Data and Review of Key Highlights of Comprehensive HIV Plan Situational Analysis Section

Planning, Priorities, and Allocations Committee

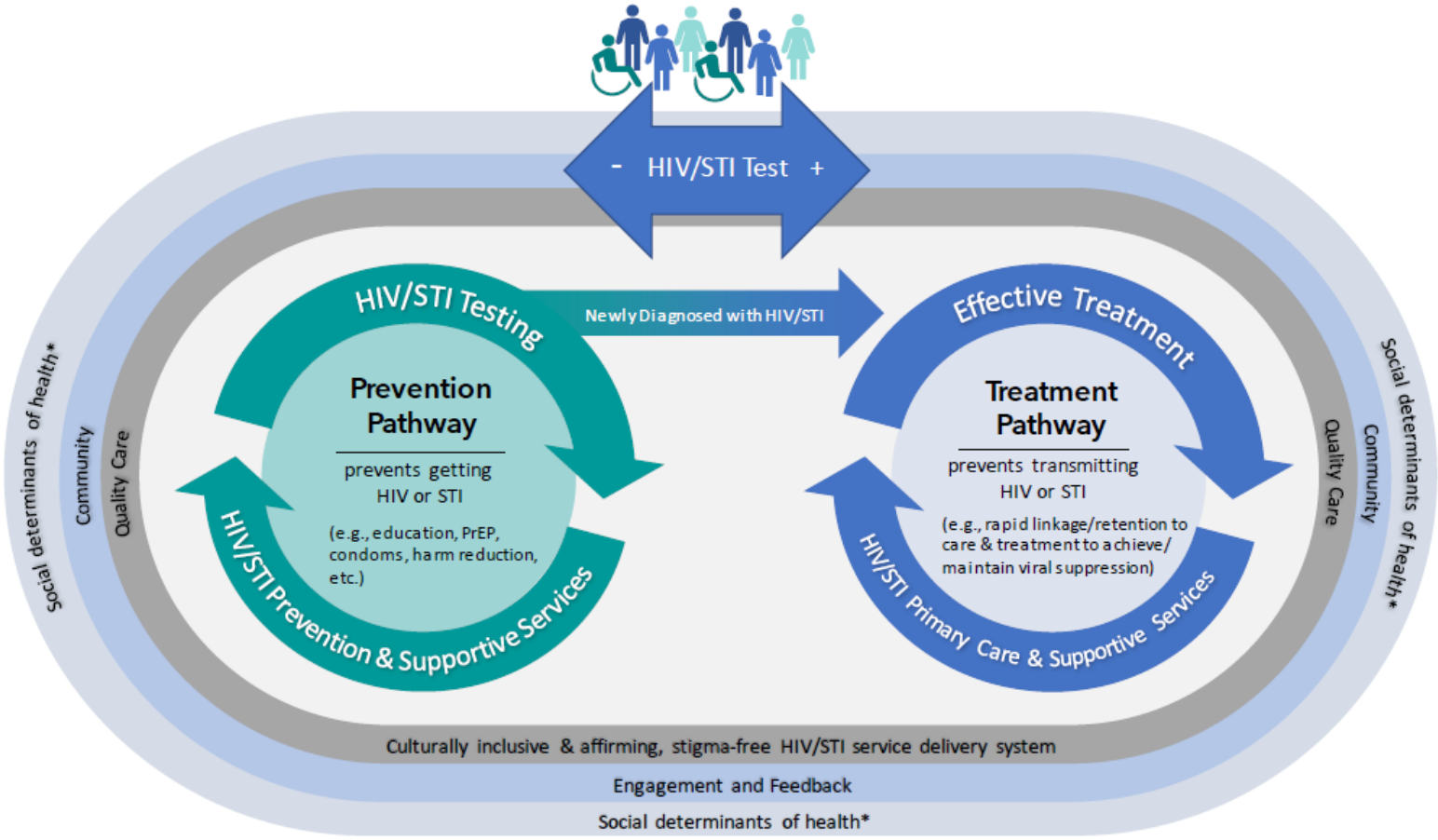
March 19, 2022

LOS ANGELES COUNTY
COMMISSION ON HIV

Objective:

- Review prevention data sources
- Determine if additional data is needed to inform prevention planning
    - What other data is needed? How will PP&A use the additional data?
- Review current strategies – Comprehensive HIV Plan Situational Analysis
- What are we doing well?
- What improvements are needed?

Status Neutral HIV and STI Service Delivery System



LOS ANGELES COUNTY COMMISSION ON HIV

Revised 10/18/23

* Social determinants of health include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

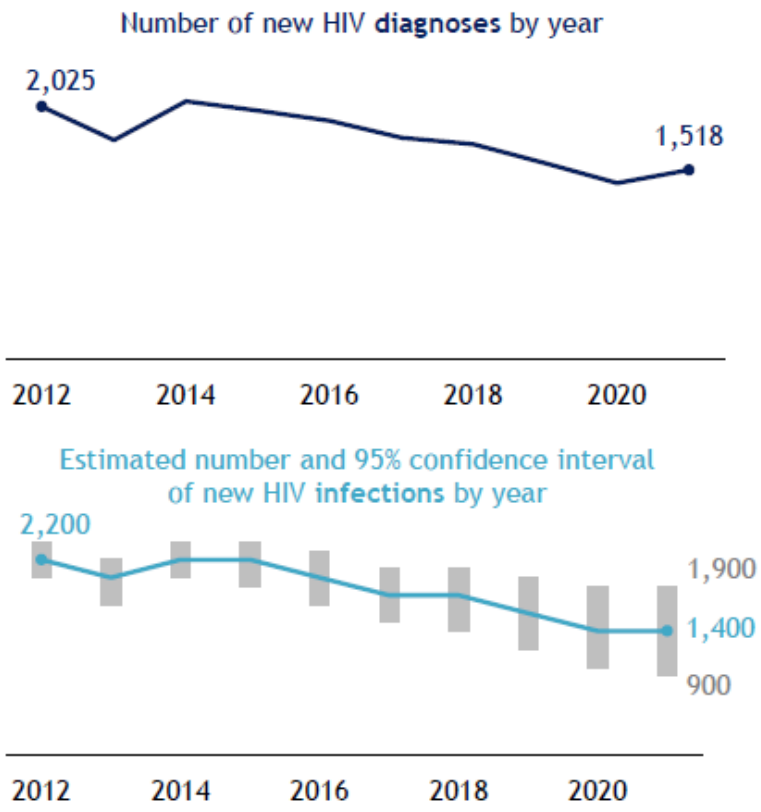
See Healthy People 2030 for more details on the social determinants of health.

S:\Committee - Planning, Priorities & Allocations\Prevention Planning Workgroup\LAC Status Neutral Framework

HIV/STD Prevention Data Sources

- HIV Surveillance Report 2022
- 2021 STD Snapshot – STD Surveillance Report currently under review
- PLWH & Experiencing Homelessness 2022
- Biomedical Prevention Services, Year 6
- Comprehensive HIV Plan Situational Analysis – p. 71-81
- National HIV Behavioral Surveillance Reports
- CDC National Center for HIV, Viral Hepatitis, STD, and TB Prevention Atlas Plus
- AIDSVu.org

Number of persons newly diagnosed with HIV compared with the estimated number of persons with new HIV infection among PLWH aged ≥ 13 years, Los Angeles County 2012-2021



Note: The annual number of **new HIV diagnoses** is the number of PLWH who received an HIV diagnosis in a calendar year. This information is used to monitor trends in new HIV diagnosis and quantify the need for HIV care. A new HIV diagnosis is *not* equivalent to a new infection that was acquired in a calendar year. Many people live with HIV for years before they are diagnosed while some are diagnosed soon after acquiring HIV. Based on local data, the majority of new HIV diagnoses each year were infections acquired over a year ago.

The annual number of **new HIV infections** reflect infections acquired in a calendar year. Some new infections are diagnosed soon after acquiring HIV, but the majority are not. When the number of new HIV infections is high, HIV continues to spread because most people with a new infection are not aware they are living with HIV. New infections provide information on recent transmission and serve as a barometer to assess whether HIV prevention efforts are reducing transmission. Trends in new infections generally track with trends in

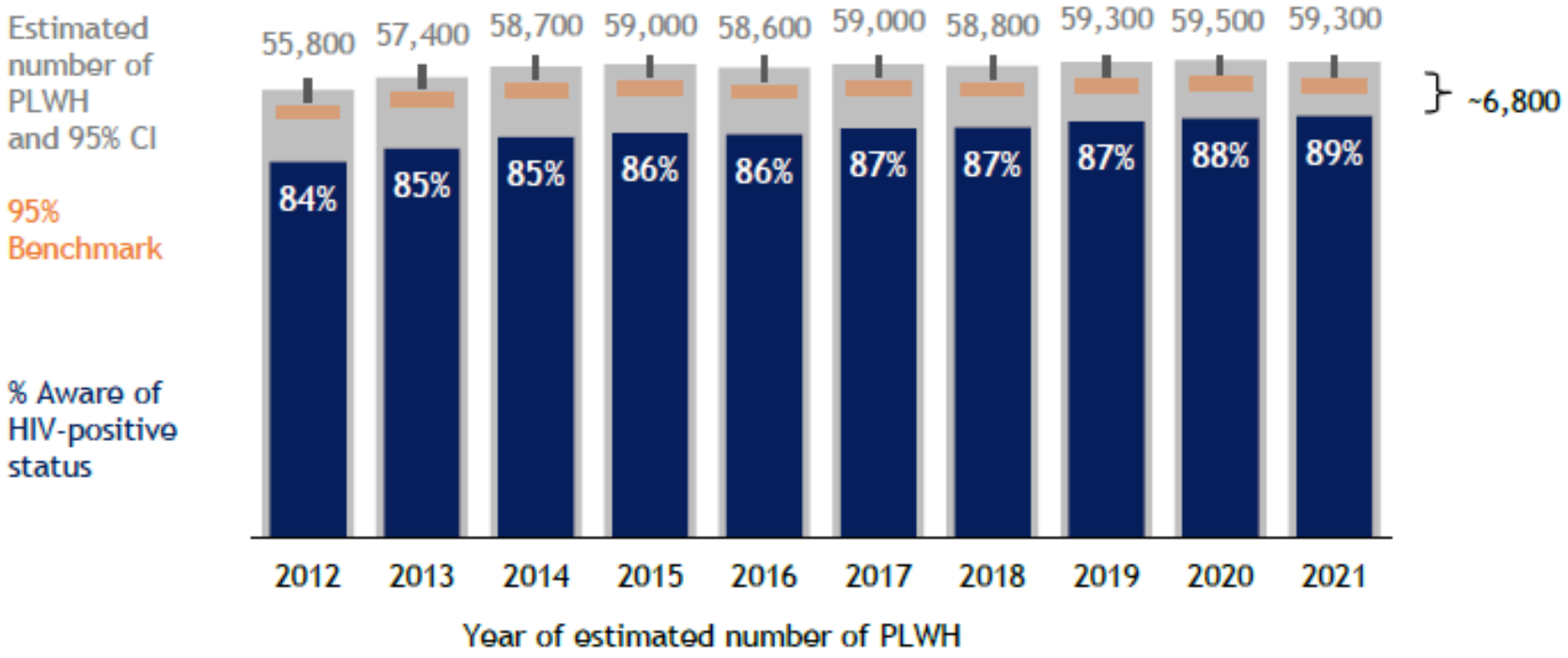
The number of persons newly diagnosed with HIV and the estimated number of persons who acquired HIV (new infection) have declined between 2012 and 2021. In 2021, 1,518 persons were newly diagnosed with HIV, reflecting both new and old infections. An estimated 1,400 persons acquired HIV in 2021, reflecting new infections, some of whom were not diagnosed.

[22] Estimates based on the CD4-Based Model v4.1 developed by CDC, which derived by using HIV surveillance and CD4 data for persons aged ≥ 13 years at diagnosis. Estimates rounded to the nearest 100 for estimates of >1,000 and to the nearest 10 for estimates of ≤ 1,000 to reflect model uncertainty.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Awareness of HIV-positive status among PLWH aged ≥ 13 years, Los Angeles County 2012-2021

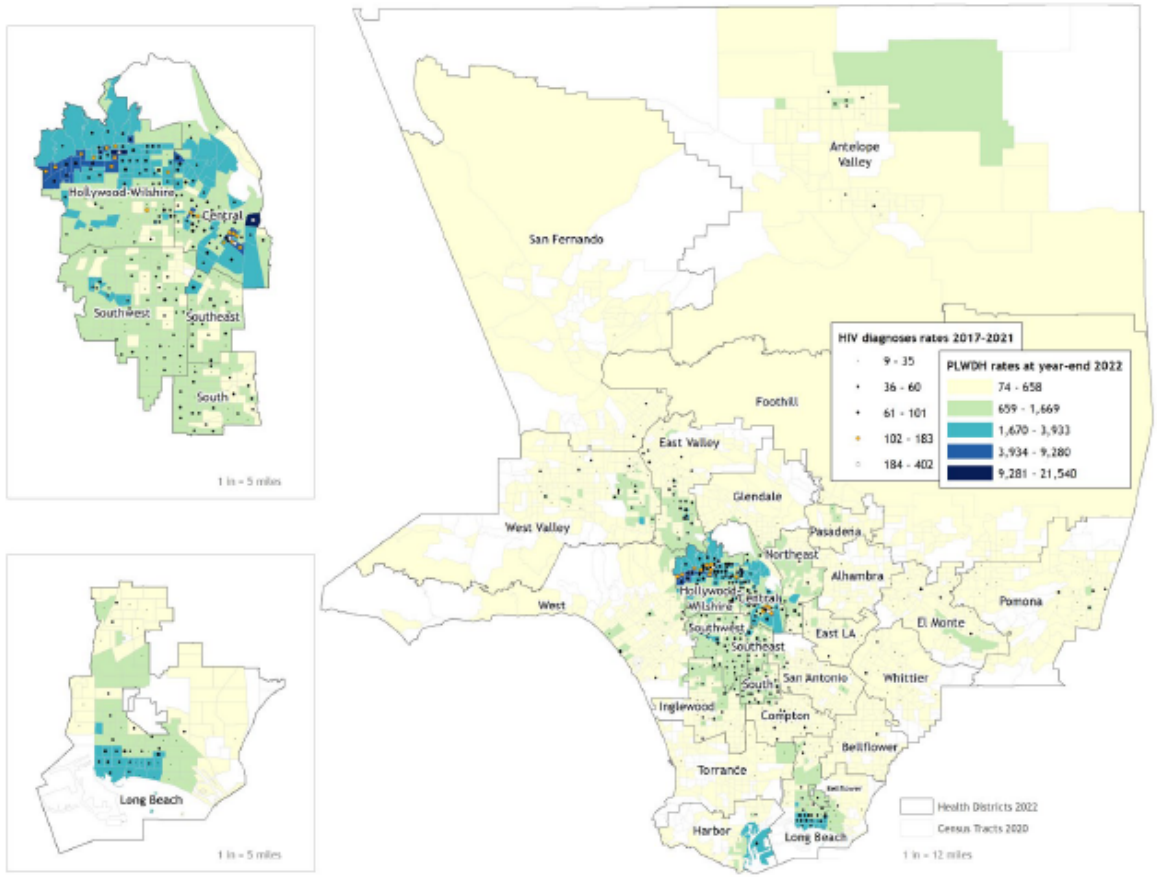
Note: The EHE goal is to increase the percentage of PLWH who know their HIV status to at least 95% by 2025.



In 2021, an estimated 89% of PLWH were aware of their HIV serostatus. Approximately 6,800 PLWH remained unaware of their HIV-positive status.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Geographic distribution of rates per 100,000 population for PLWDH aged ≥ 13 years at year-end 2022 and persons newly diagnosed with HIV in 2017-2021, Los Angeles County



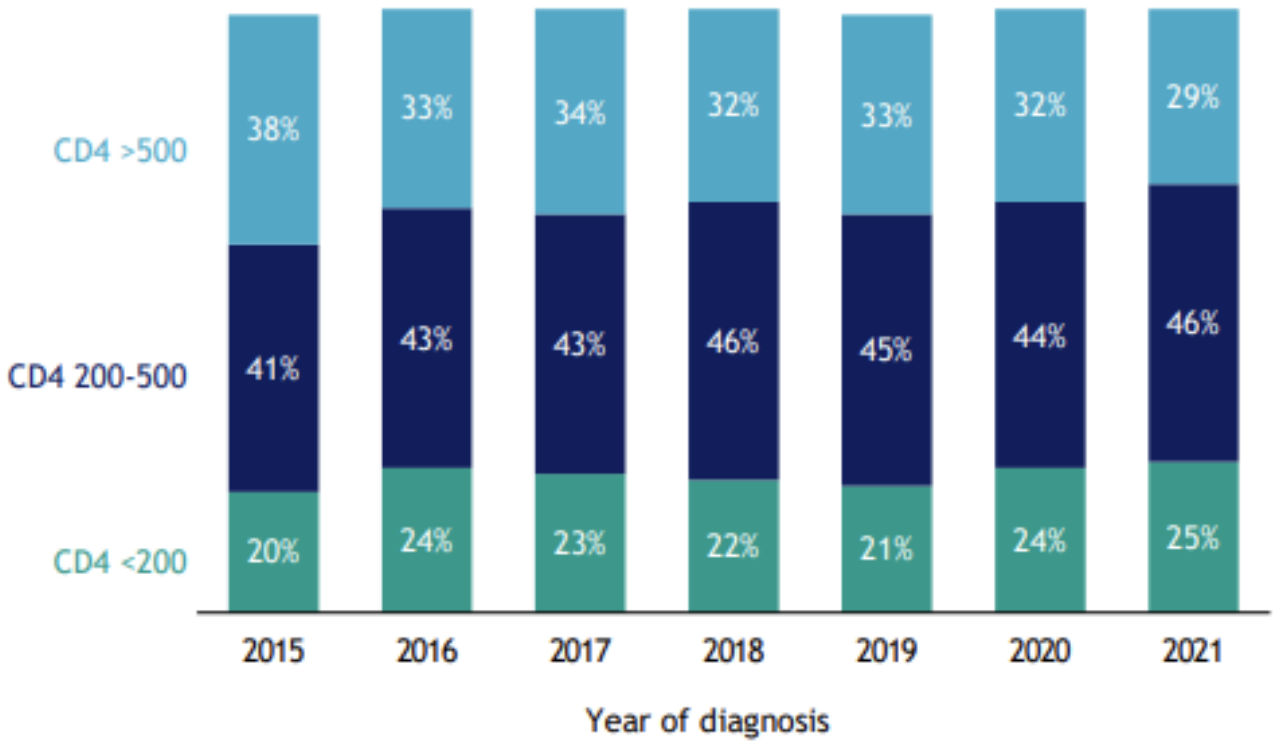
Within LAC, the highest density of new HIV diagnoses occurred in the central and southern regions. Among all 26 Health Districts, the Hollywood-Wilshire, Central, and Long Beach Health Districts were identified as the three epicenters for HIV, reporting the highest rates of new HIV diagnoses in 2017-2021 and persons living with diagnosed HIV at year-end 2022. We have zoomed in on the three epicenters with the highest concentrations of new HIV diagnoses and PLWDH.

[10] Census tract information for new diagnoses is based on projected coordinates of residential addresses at diagnosis, the census tract information for PLWDH is assigned based on projected coordinates of the most recently reported residential addresses. Persons missing valid street address information were aggregated to the census tract level based on corresponding ZIP Codes using the HUD ZIP-TRACT file. PLWDH and diagnoses rates are based on provisional population estimates 2021 and are per 100,000 population, whereby rates for census tracts with < 5 numerator or < 500 population are suppressed. Source: HIV Surveillance data as of December 31, 2022; U.S. Department of Housing and Urban Development (HUD), Office of Policy Development and Research (PD&R). HUD United States Postal Service ZIP Code Crosswalk Files. https://www.huduser.gov/portal/datasets/usps_crosswalk.html; U.S. Census Bureau, Geography Division. 2021. 2021 TIGER/Line Shapefiles: Census Tracts. 2021 TIGER/Line Shapefiles (machine-readable data files). Accessed 12/28/2021. https://www.census.gov/cgi-bin/geo/shapefiles/index.php?year=2021&layergroup=Census+Tracts . County of Los Angeles, Department of Public Health. 2022. Health Districts 2022 (view). County of Los Angeles, California, Enterprise GIS Repository. Accessed 03/21/2023. https://egis-lacounty.hub.arcgis.com/datasets/health-districts-2022-view/; July 1, 2021 Population Estimates (Provisional), prepared by Hedderson Demographic Services for Los Angeles County Internal Services Department, released October 2022. SPA, HD, and SD geographies integrated in by Population Health Assessment Team, Office of Health Assessment and Epidemiology.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Treatment As Prevention

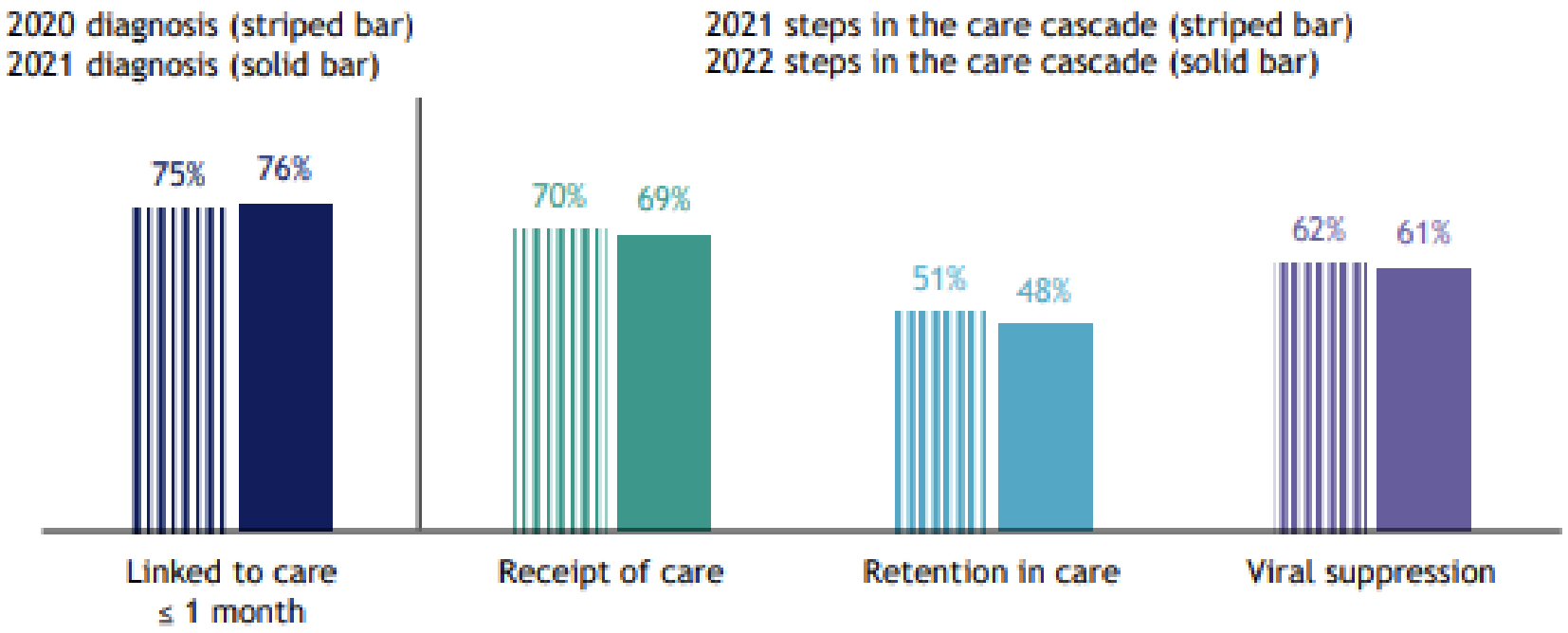
CD4+ T-cell count within 1 month of HIV diagnosis, Los Angeles County 2015-2021



One in four new HIV diagnoses presented with CD4+ T-cells < 200 cells/μL at the time of diagnosis in 2021, indicative of late HIV disease. The percentage of persons presenting with late HIV disease remained at the same level between 2020 and 2021.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

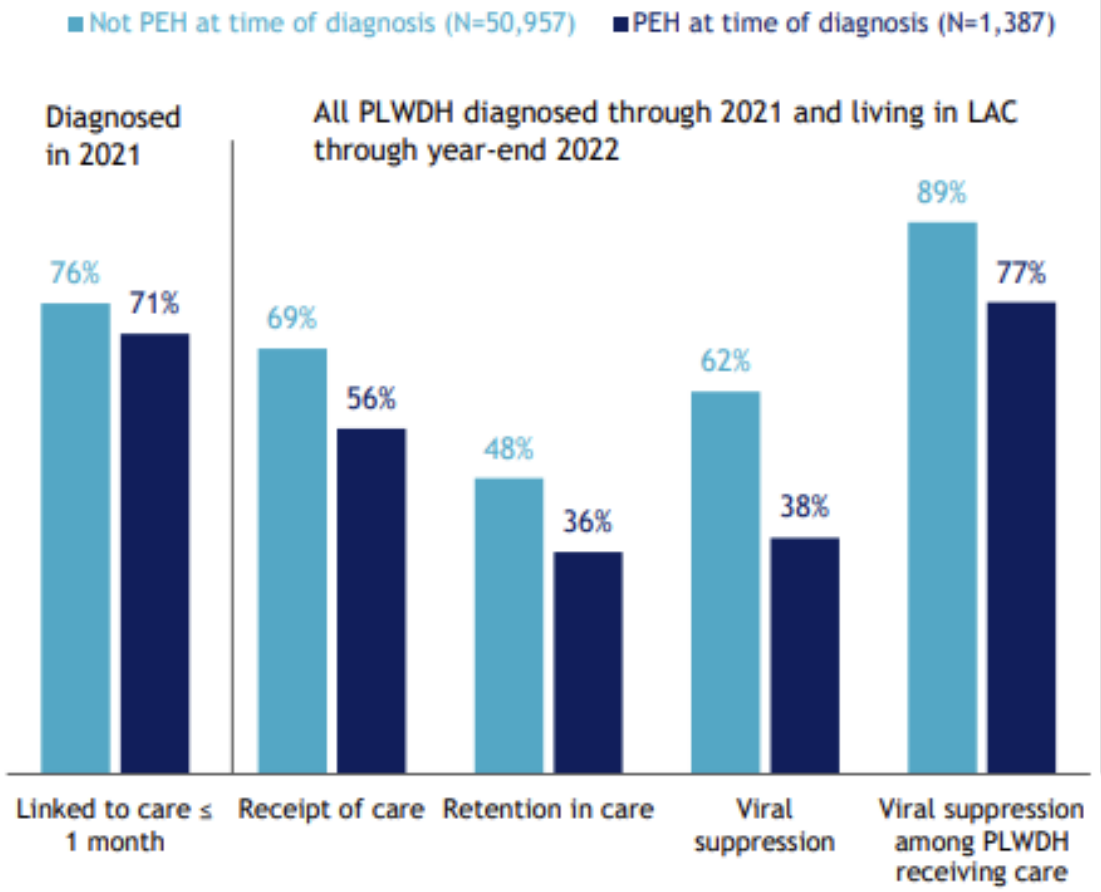
HIV care continuum among persons aged ≥ 13 years, Los Angeles County 2020-2021 and 2021-2022



Linkage to care within 1 month of diagnosis increased modestly from 75% to 76% for persons aged 13 years or older diagnosed with HIV in 2021 compared to persons diagnosed in 2020, but slightly declined along subsequent steps in the care cascade in 2022 compared to 2021.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

HIV care continuum among persons aged ≥ 13 years who were experiencing homelessness at the time of HIV diagnosis, Los Angeles County 2021-2022

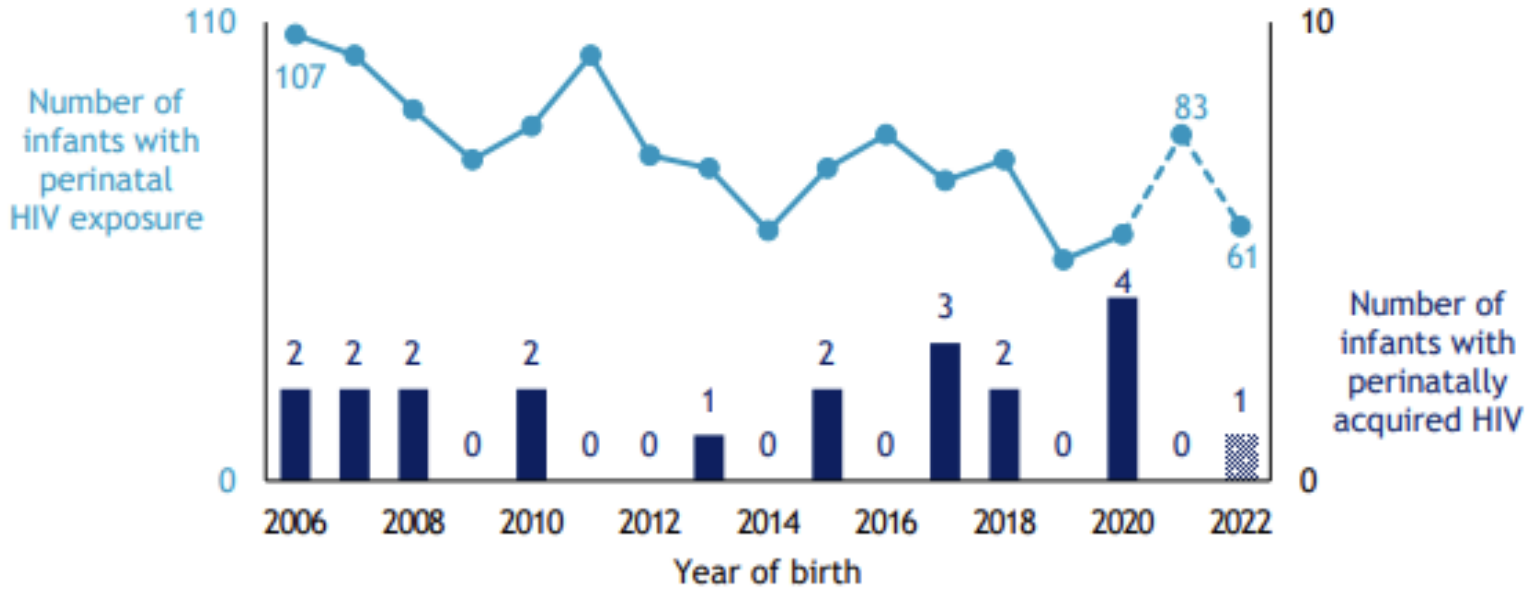


Note: Linkage to care levels were similar by housing status. This may be due to robust support services that are in place to facilitate linkage to care after diagnosis. In LAC this is facilitated by HIV testing providers, Partner Services, linkage and retention programs, and community embedded Disease Intervention Specialists. However, the complexities of a person's life circumstances determine the ability to succeed in subsequent steps in the care cascade.

PEH had much poorer outcomes in the HIV care continuum compared with housed persons, with the greatest disparity observed in viral suppression.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

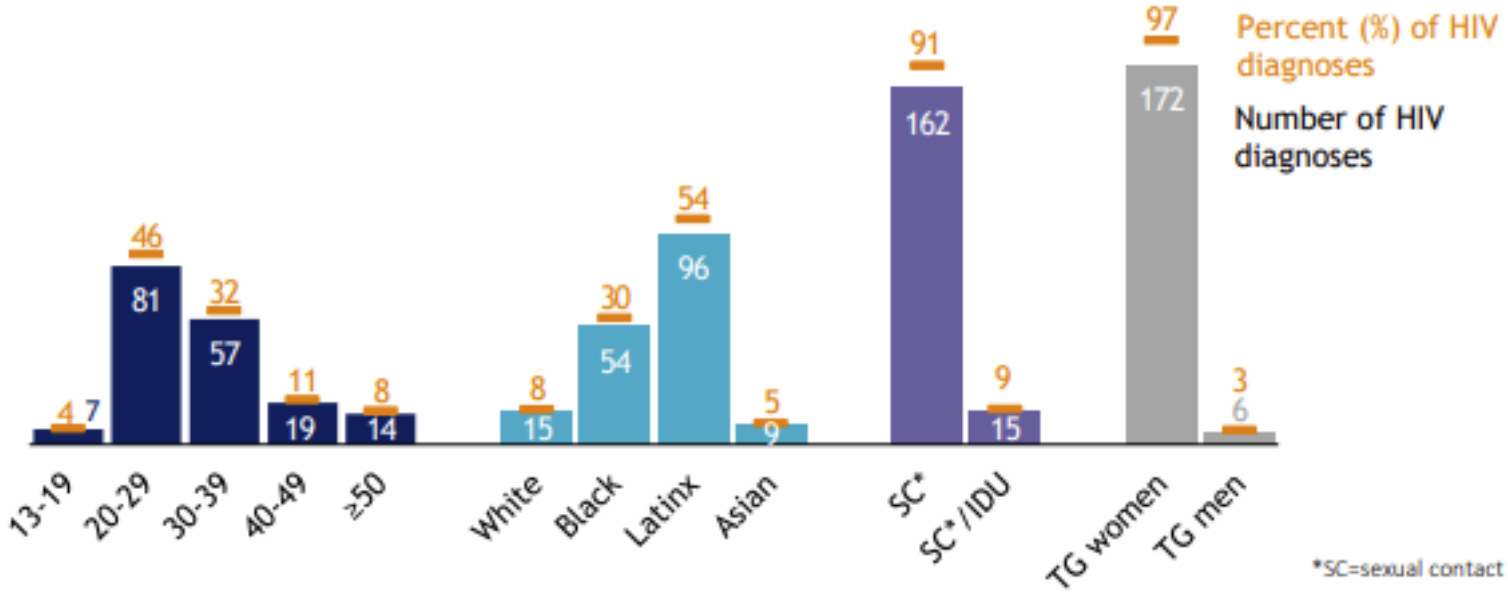
Number of infants with perinatal HIV exposure and perinatally acquired HIV, Los Angeles County 2006-2022



The number of infants with perinatal HIV exposure declined from 2006 to 2022. From 2020 to 2022, the number of perinatal exposures slightly increased from 59 exposures to 61 exposures. At the time of writing, there was one reported transmission of HIV from an infected mother to their baby in 2022.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

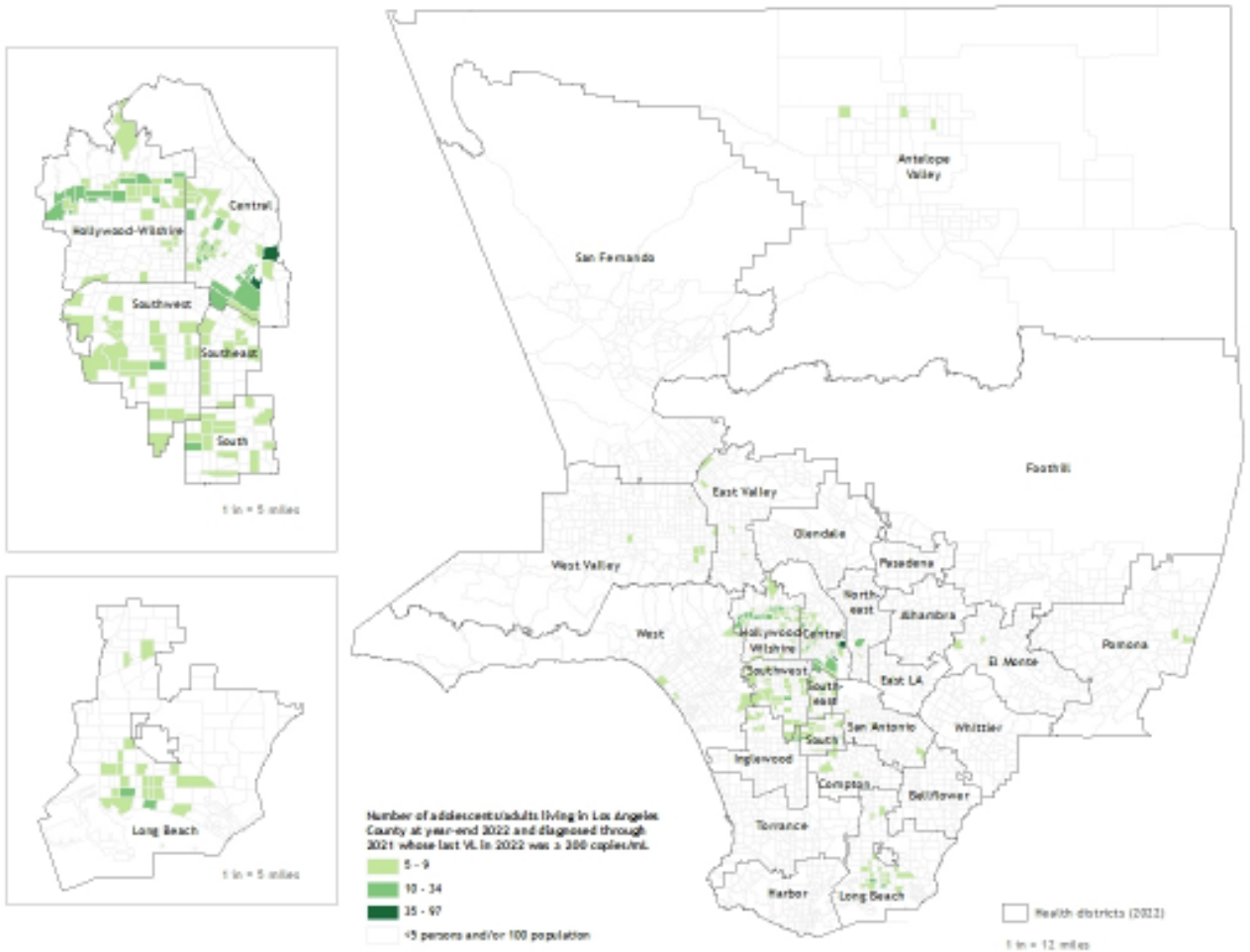
HIV diagnoses among transgender people aged ≥ 13 years by age, race/ethnicity, and transmission category, Los Angeles County 2019-2021



Among persons newly diagnosed in 2019-2021 who identified as transgender at the time of diagnosis, 97% identified as transgender women and 54% as Latinx. Seventy-eight percent (78%) were aged 20-39 years old and sexual contact was the likely transmission route for 91%.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Unsuppressed viral load by census tract among persons aged ≥ 13 years diagnosed through 2021 and living in Los Angeles County at year-end 2022, Los Angeles County 2022

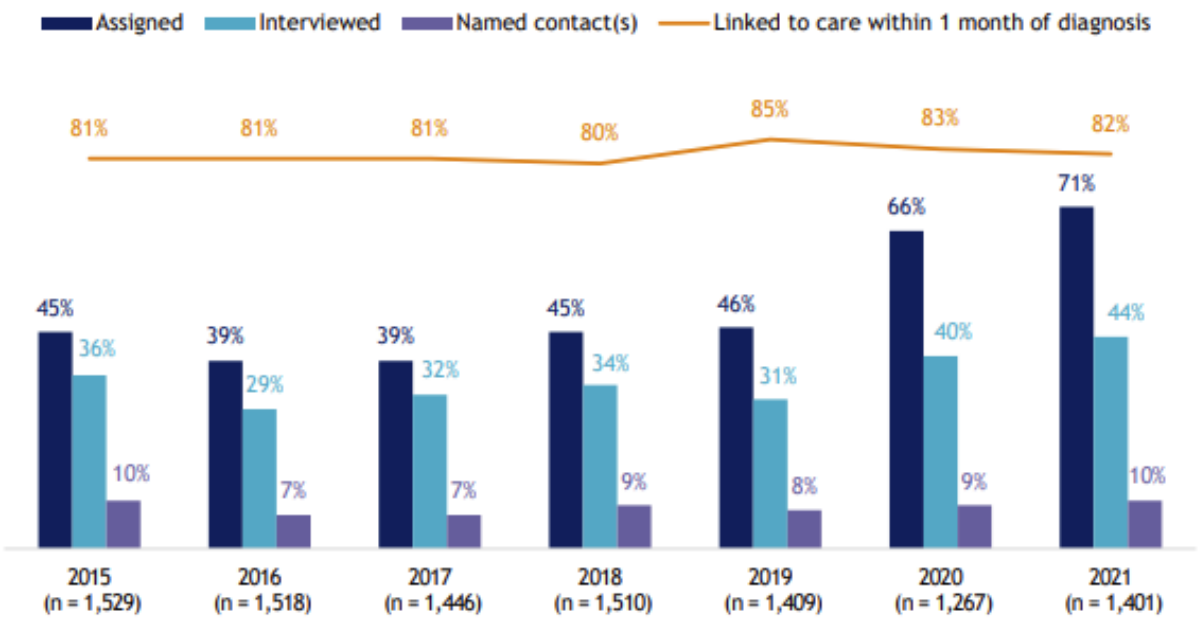


Census tracts located in the Central and Hollywood-Wilshire Health Districts had the highest levels of unsuppressed viral load. These are locations where a robust public health response is needed to identify networks of ongoing transmission and deploy rapid interventions to minimize transmission. Other emerging hotspots of transmission that require close monitoring are in the Southwest, Southeast, South, and Long Beach Health Districts. We have zoomed in on the six HDs with the highest levels of unsuppressed VL in the maps to the left.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

HIV Partner Services continuum among new HIV diagnoses by year, Los Angeles County (excluding Long Beach and Pasadena) 2015-2021

Data in context:
In 2020, the HIV surveillance unit began close coordination and data sharing with the Partner Services unit. This encouraged increases in case assignment and interviews in 2020 and 2021 compared with years prior.



In 2021, 71% of newly diagnosed HIV-positive persons in LAC were assigned for a Partner Services interview and 62% of those persons assigned for Partner Services were interviewed (data not shown). Of all new HIV diagnoses, 44% were interviewed and 10% provided contact information of sexual and/or needle sharing partners. Refusal by the client or inability to locate the client were the primary reasons why assigned cases were not interviewed.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

HIV & STD Testing

HIV Testing Services, Los Angeles County 2022

Total	Test Volume (#)	New Positives by Self–Report	Linked to Care ≤ 7 days	Linked to PrEP
Total	26,441	226 1.1%	98 26%	4,480 34%

Data source: HIV Testing Services database as of 03/20/2023; data is provisional and may only include data processed as of 03/17/2023.
Test volume includes all HIV tests, including self-test records with an unknown test result; self-test records with unknown test result (data not shown) are excluded from below measures.
New positive by self-report: if client does not report a positive HIV test result from their last test, then the current test record is considered a new positive by self-report.
Linked to care: includes all positive tests (new and previous) linked to care as reported by provider or as verified by surveillance data when provider-based information is missing; excludes records for clients that were already in care.
Linked to PrEP is based on a denominator of priority for PrEP services (data not shown): test records where client 1) had a negative/non-reactive HIV test result (and/or one or more STD tests for Long Beach services), 2) was not currently on PrEP, 3) did not refuse referral to a PrEP provider or indicate lack of interest in starting PrEP, and 4) met one or more of the following criteria: a) MSM reporting sex without a condom, b) MSM reporting meth use, c) Black and Latina cisgender heterosexual woman, d) injection drug use, e) youth (13-29 years old), f) transgender person, and/or g) having sex with an HIV-positive partner. All linkages to PrEP navigators/providers for HIV negative testers (not already on PrEP), are also included in priority for PrEP services, even if they do not meet one or more of a-g criteria. Linked to PrEP: includes test records where client was provided with linkage services to a PrEP provider (navigator or medical provider) and/or linked to PrEP services.

Source: Division of HIV and STD Programs STD Provider Meeting, March 20, 2023

HIV Testing Services by Test Category, 2022

	Test Volume (#)	New Positives by Self–Report	Linked to Care ≤ 7 days	Linked to PrEP
Commercial Sex Venues	1,007	18 1.8%	0	81 25%
Long Beach	10,983	89 0.8%	42 39%	1,212 27%
Express Clinics	14,451	119 0.8%	56 37%	3,187 49%

Data source: HIV Testing Services database as of 03/20/2023; data is provisional and may only include data processed as of 03/17/2023.
Test volume includes all HIV tests, including self-test records with an unknown test result; self-test records with unknown test result (data not shown) are excluded from below measures.
New positive by self-report: if client does not report a positive HIV test result from their last test, then the current test record is considered a new positive by self-report.
Linked to care: includes all positive tests (new and previous) linked to care as reported by provider or as verified by surveillance data when provider-based information is missing; excludes records for clients that were already in care.
Linked to PrEP is based on a denominator of priority for PrEP services (data not shown): test records where client 1) had a negative/non-reactive HIV test result (and/or one or more STD tests for Long Beach services), 2) was not currently on PrEP, 3) did not refuse referral to a PrEP provider or indicate lack of interest in starting PrEP, and 4) met one or more of the following criteria: a) MSM reporting sex without a condom, b) MSM reporting meth use, c) Black and Latina cisgender heterosexual woman, d) injection drug use, e) youth (13-29 years old), f) transgender person, and/or g) having sex with an HIV-positive partner. All linkages to PrEP navigators/providers for HIV negative testers (not already on PrEP), are also included in priority for PrEP services, even if they do not meet one or more of a-g criteria. Linked to PrEP: includes test records where client was provided with linkage services to a PrEP provider (navigator or medical provider) and/or linked to PrEP services.

Source: Division of HIV and STD Programs STD Provider Meeting, March 20, 2023

STD Testing Volume and Positivity, Los Angeles County 2022

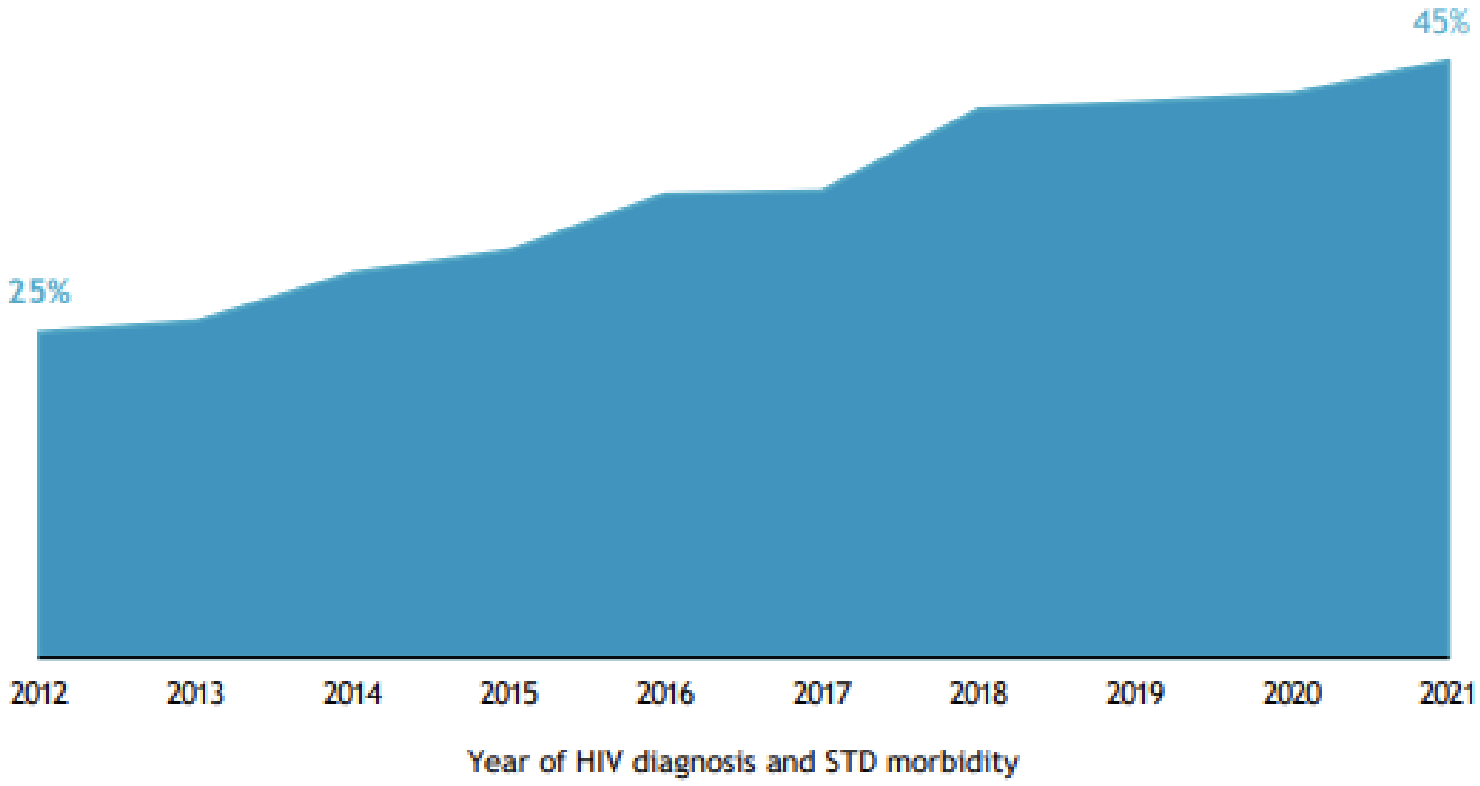
	Chlamydia	Gonorrhea	Syphilis	Hepatitis C
Overall	46,150 6%	46,263 6%	43,325 17%	--
Commercial Sex Venues	0	0	174 25%	--
Express Clinics	18,532 7%	18,545 8%	17,026 11%	--
STD-SDT	21,270 8%	21,352 9%	20,180 15%	--
Long Beach	6,348 9%	6,366 8%	5,945 17%	191 0.6%

Data source: HIV Testing Services database as of 03/20/2023; data is provisional and may only include data processed as of 03/17/2023.
Percent of positive test records are based on tests with a test result, tests missing a result are excluded from positivity calculations.

Source: Division of HIV and STD Programs STD Provider Meeting, March 20, 2023

HIV & STD Diagnoses

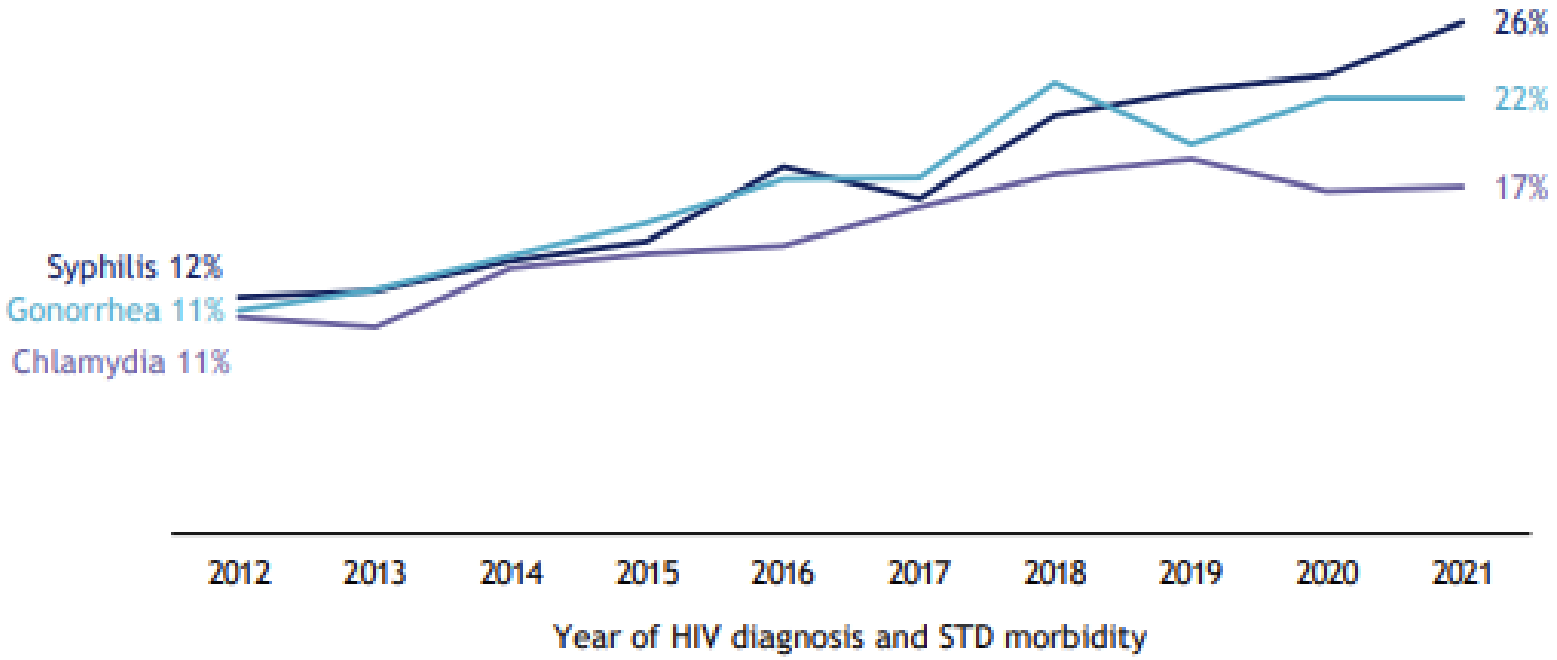
Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, and/or chlamydia in the same calendar year as HIV diagnosis, Los Angeles County (excluding Long Beach and Pasadena) 2012-2021



The percentage of persons newly diagnosed with HIV who were diagnosed with one or more STDs in the same calendar year almost doubled from 25% in 2011 to 45% in 2021. This increasing trend reflects the rise in total STD cases over the same period.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Percentage of persons newly diagnosed with HIV aged ≥ 13 years who had syphilis, gonorrhea, or chlamydia in the same calendar year as HIV diagnosis by STD, Los Angeles County (excluding Long Beach and Pasadena) 2012-2021

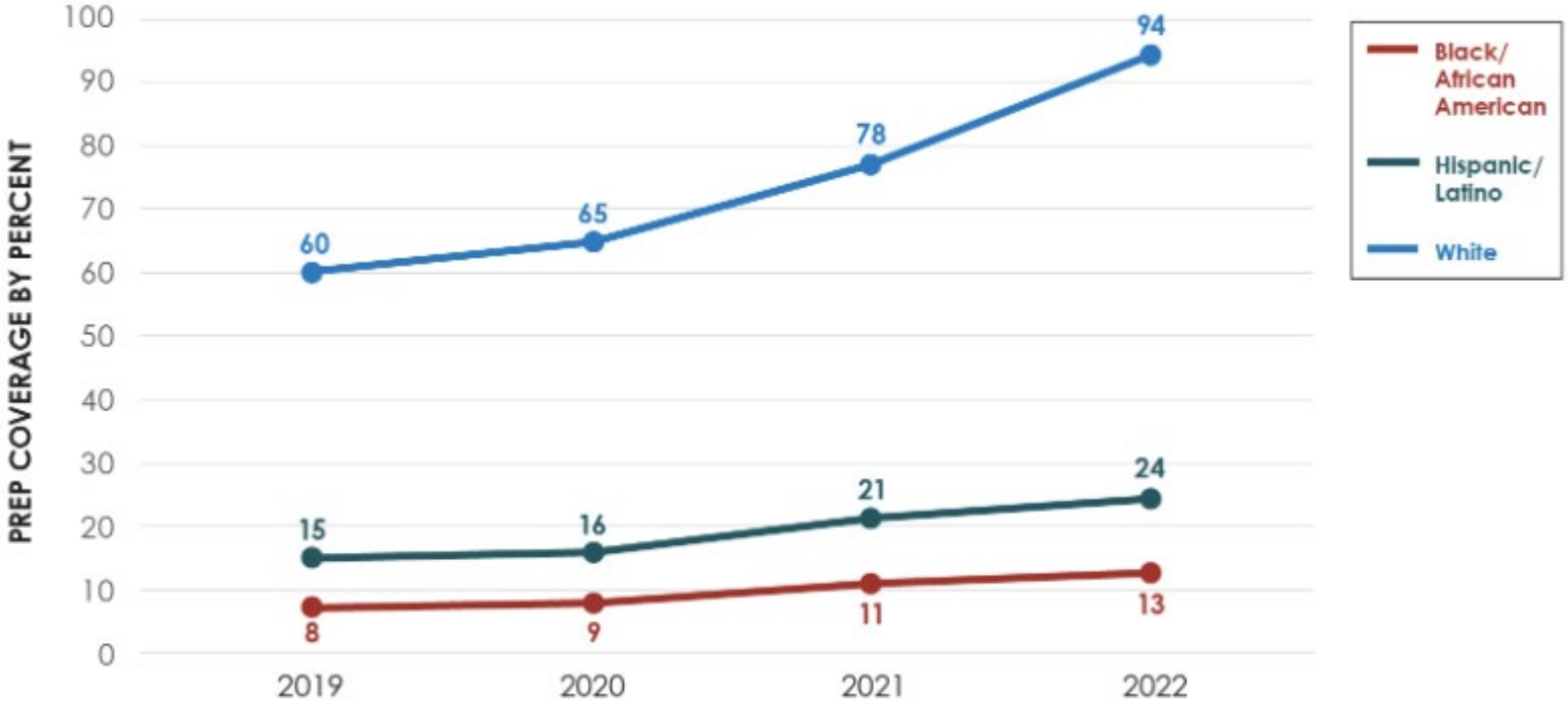


Co-infections for all three STDs showed similar increasing trends from 2012 to 2021. In 2021, syphilis among newly diagnosed HIV cases was the highest at 26%, followed closely by gonorrhea at 22%. This reflects a rapid rise in the total number of syphilis cases in LAC over the same period.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Biomedical Prevention

National trends in PrEP prescriptions among people who could benefit by race/ethnicity, 2019-2022

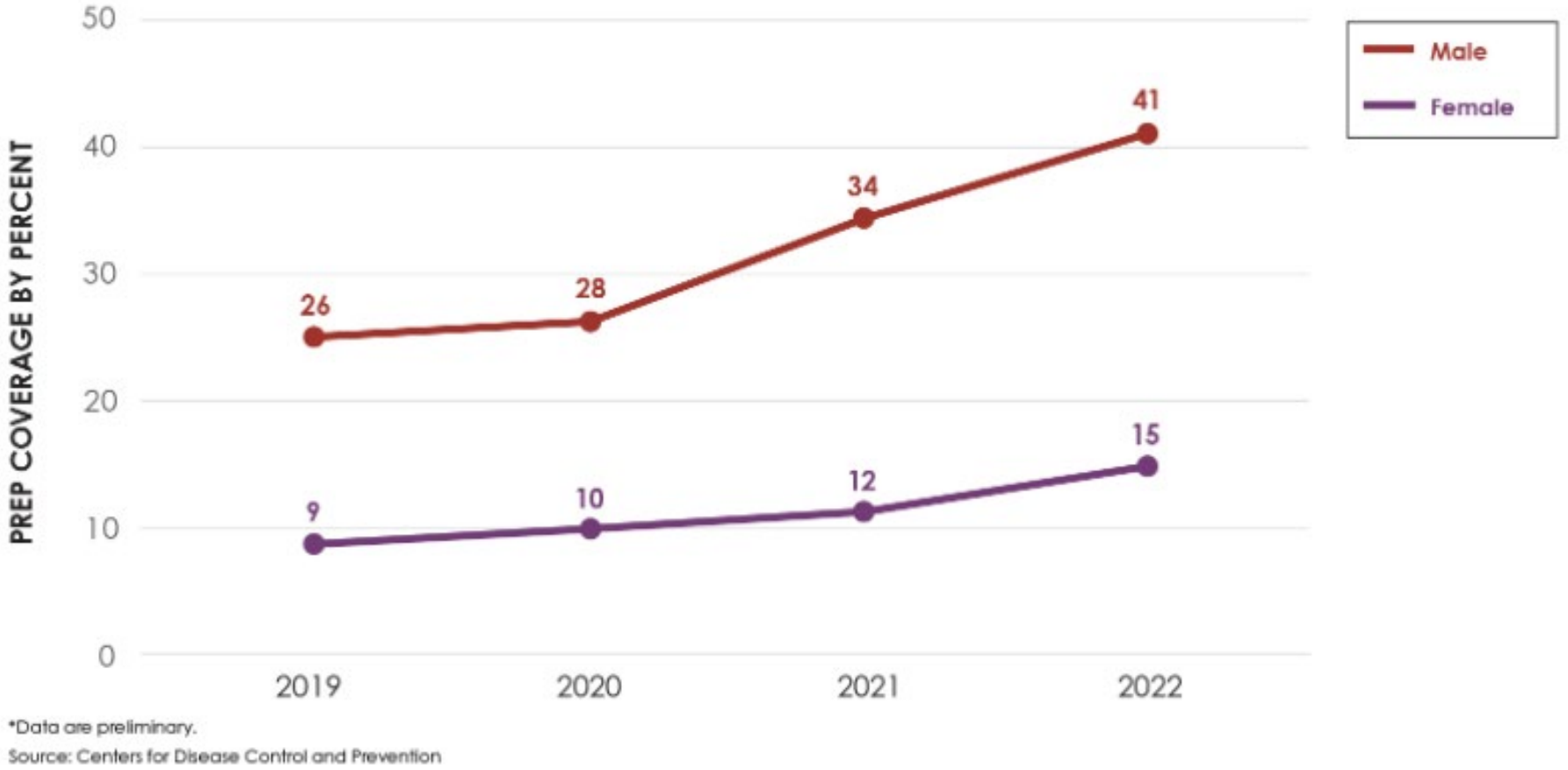


*Data are preliminary. The data on PrEP prescriptions by race and ethnicity are limited, and findings are estimated.

Source: Centers for Disease Control and Prevention

Source: Centers for Disease Control and Prevention. Dear Colleague Letter: Preliminary Data on Pre-Exposure Prophylaxis (PrEP) Coverage, Released October 2023. https://www.cdc.gov/hiv/policies/dear-colleague/dcl/20231017.html

National trends in PrEP prescriptions among people who could benefit, by sex at birth, 2019-2022*



Source: Centers for Disease Control and Prevention. Dear Colleague Letter: Preliminary Data on Pre-Exposure Prophylaxis (PrEP) Coverage, Released October 2023. https://www.cdc.gov/hiv/policies/dear-colleague/dcl/20231017.html

PrEP coverage and number of persons prescribed aged ≥ 13 years, Los Angeles County 2017-2021

Year	Cases	Percent	Population
2021	18,474	27.4	67,450
2020 (COVID-19 Pandemic)	14,750	21.9	67,450
2019	13,730	20.4	67,450
2018	12,161	18.0	67,450
2017	8,736	13.6	64,180

Footnotes: PrEP coverage, reported as a percentage, is calculated as the number of persons aged ≥16 years classified as having been prescribed PrEP divided by the estimated number of persons aged ≥16 years who had indications for PrEP. Number prescribed, or "cases", is defined as the number of persons aged ≥16 years classified as having been prescribed PrEP during the specified year and includes all FDA-approved drugs for PrEP. "Population" is the annual estimated number of persons with PrEP indications. Total includes people categorized by IQVIA as Black, White, Hispanic, or Other race. Race/ethnicity data are adjusted due to large proportion of missing race/ethnicity. To allow for comparison with other HIV indicators, data are presented for ≥13– and 13–24-year-olds, but represent ≥16– and 16–24-years-olds, respectively. Number prescribed are reported through June 2023.
NA - Not Applicable.

Source: Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus

PrEP coverage and number of persons prescribed aged ≥ 13 years by age group and sex assigned at birth, Los Angeles County 2017-2021

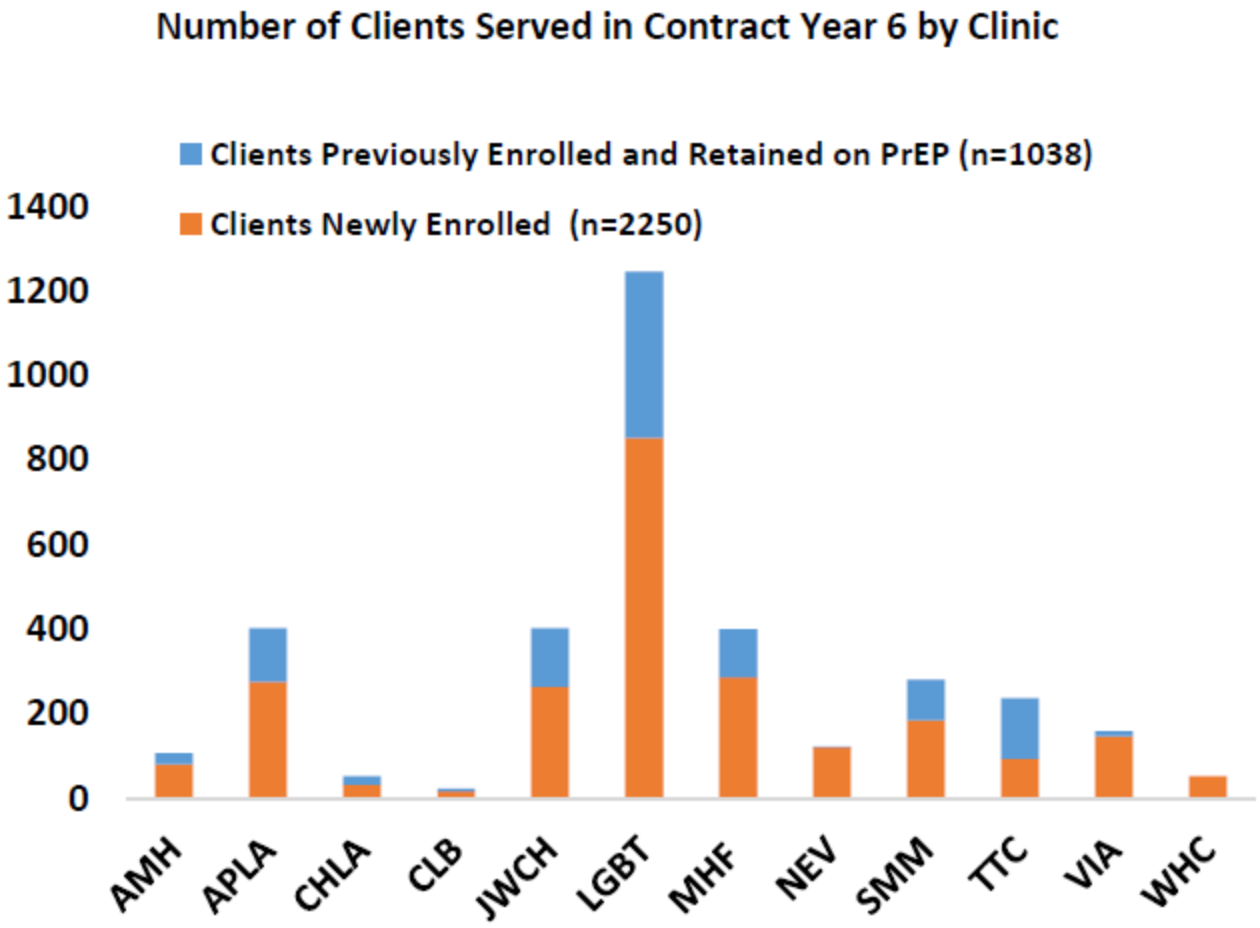
Age Group	Cases	Percent	Population
13-24	1,716	12.5	13,690
25-34	7,612	29.9	25,460
35-44	5,282	39.5	13,370
45-54	2,371	25.3	9,380
55+	1,494	26.9	5,550

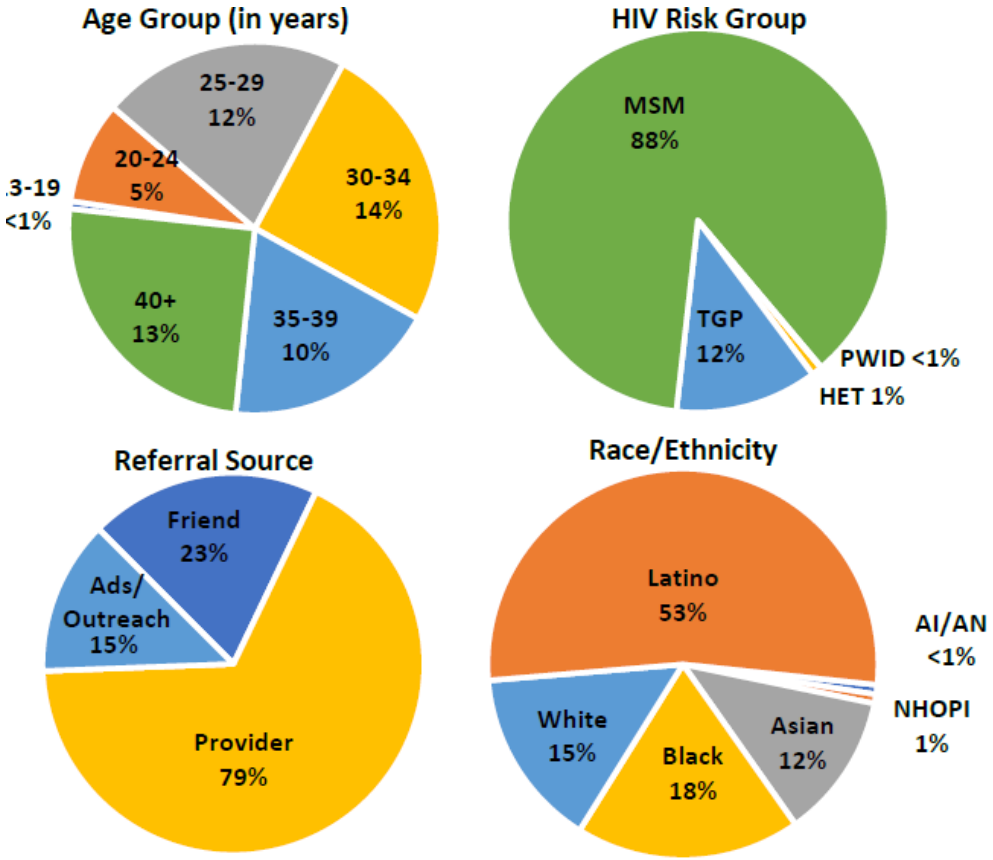
Footnotes: PrEP coverage, reported as a percentage, is calculated as the number of persons aged ≥16 years classified as having been prescribed PrEP divided by the estimated number of persons aged ≥16 years who had indications for PrEP. Number prescribed, or "cases", is defined as the number of persons aged ≥16 years classified as having been prescribed PrEP during the specified year and includes all FDA-approved drugs for PrEP. "Population" is the annual estimated number of persons with PrEP indications. Total includes people categorized by IQVIA as Black, White, Hispanic, or Other race. Race/ethnicity data are adjusted due to large proportion of missing race/ethnicity. To allow for comparison with other HIV indicators, data are presented for ≥13– and 13–24-year-olds, but represent ≥16– and 16–24-years-olds, respectively. Number prescribed are reported through June 2023.
NA - Not Applicable.

Source: Centers for Disease Control and Prevention (CDC) NCHHSTP AtlasPlus

PrEP client demographics, Los Angeles County 2021

3235 clients were prescribed PrEP between July 1, 2020 - June 30, 2021

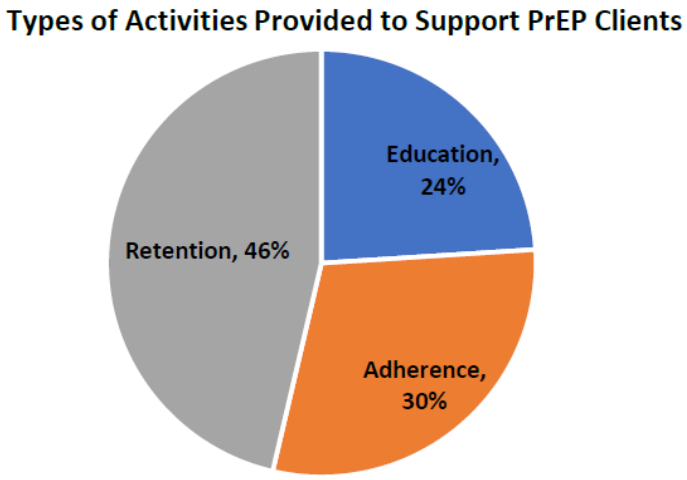


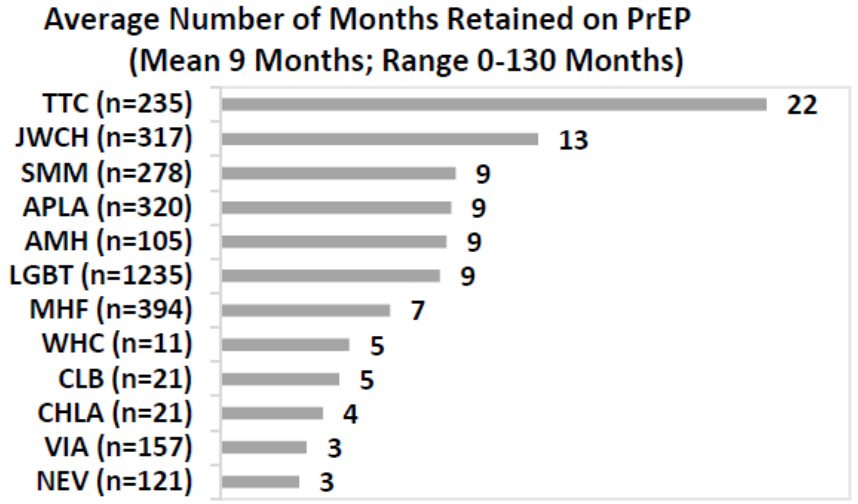


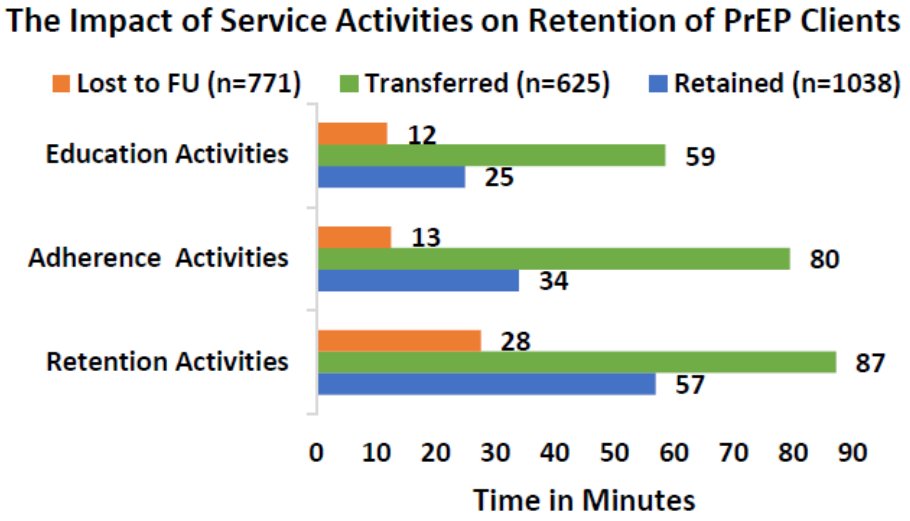
Source: DHSP Biomedical Prevention Services, Year 6 Report

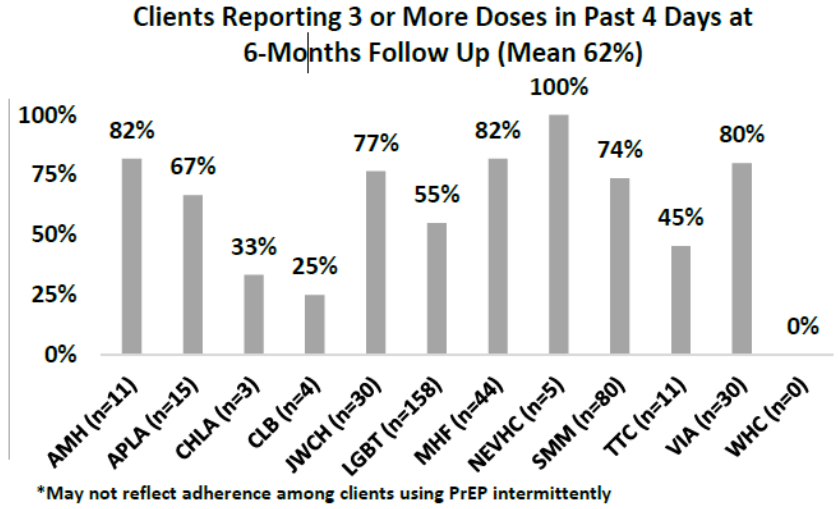
PrEP Retention and Adherence by clinic, Los Angeles County 2021

53% of clients were retained in PrEP services at a COE clinic for > 6 months (n=1310)





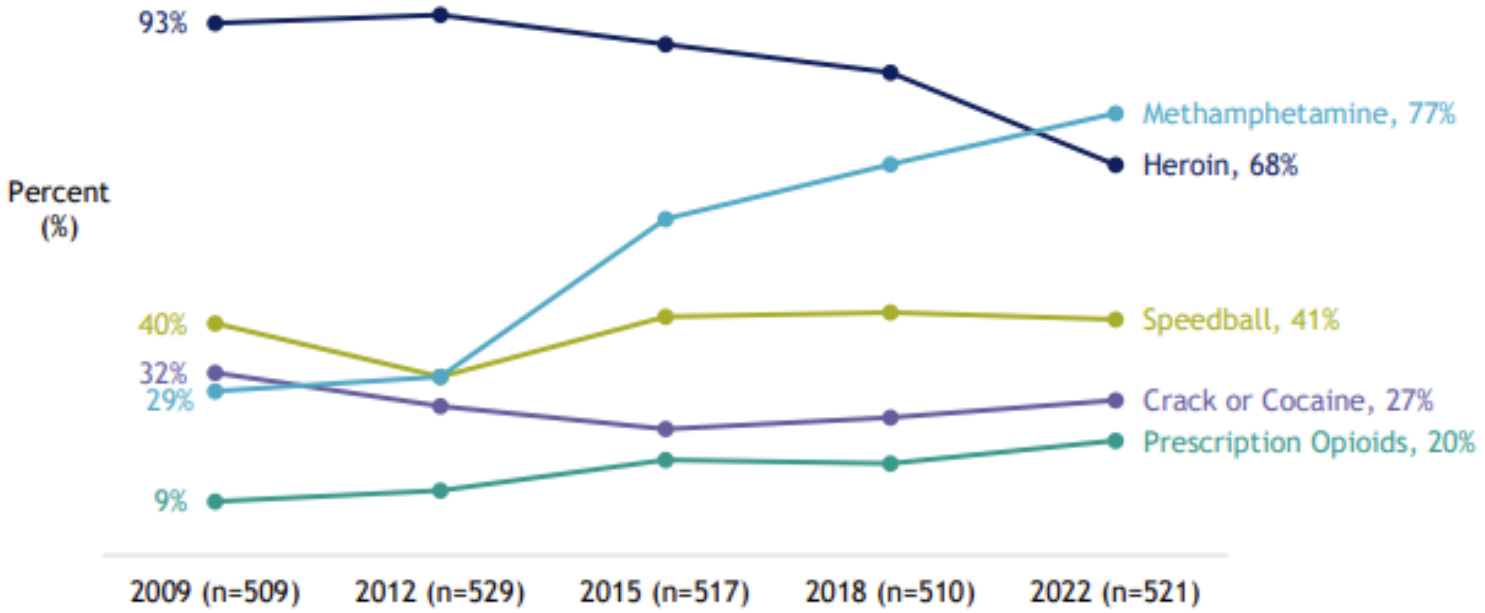




Source: DHSP Biomedical Prevention Services, Year 6 Report

HIV & Substance Use

Drugs injected in the past 12 months among National HIV Behavioral Surveillance (NHBS) People Who Inject Drugs (PWID) participants, Los Angeles County 2009-2022

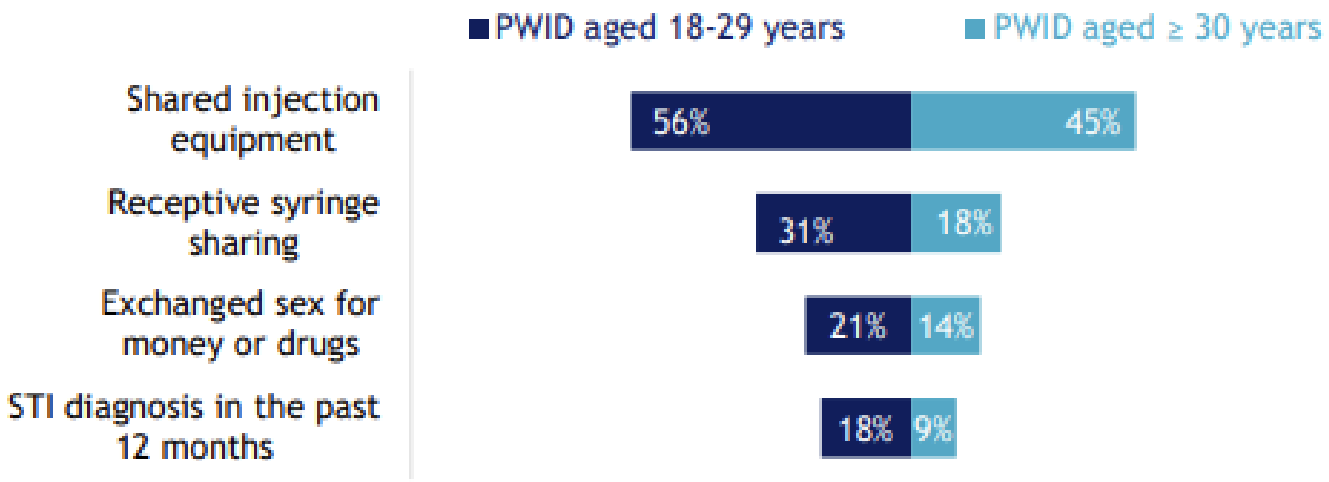


The prevalence of past-year methamphetamine injection increased significantly from 29% in 2009 to 77% in 2022. Among those reporting past-year methamphetamine injection, 56% reported injecting methamphetamine at least once a day in 2022 (data not shown). Reports of heroin injection are on a decreasing trend, from 93% in 2009 to 68% in 2022. Nonetheless, there was a modest increase in prescription opioid injection use.

* National HIV Behavioral Surveillance (NHBS)

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Injection drug use behavior and recent sexual behavior among NHBS-PWID participants by age group, Los Angeles County 2022



Note: In total, 19% of participants reported using a syringe that had been previously used by someone else. Syringe sharing was more common among Young PWID. Sharing syringes puts PWID at high risk for HIV and other infections.

A higher percentage of PWID aged 18-29 years reported sharing injection equipment, sharing syringes receptively, exchanging sex for money or drugs, and receiving a bacterial STI diagnosis (e.g., chlamydia, gonorrhea, or syphilis) within the past 12 months compared with PWID aged ≥30 years.

Source: Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2022

Comprehensive HIV Plan: Situational Analysis (Section Highlights)

1. **Diagnose all People with HIV as early as possible**
   - Routine HIV Testing - Primary Care Clinics, Emergency Departments (EDs), Urgent Care Centers and Hospitals & Sexual & Reproductive Health Clinics
   - Rescreening individuals with elevated HIV risk
   - Self-Test Kits
2. **Treat People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression**
   - Linkage to Care
   - Engagement and Retention in Care
   - CalAIM
   - Addressing the Meth Epidemic
   - Aging with HIV

Comprehensive HIV Plan: Situational Analysis

3. **Prevent New HIV Transmissions by Using Proven Interventions**
   - PrEP/PEP
   - Syringe Services Programs
4. **Respond Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People who Need Them**
   a. Partner Services
   b. Linkage Re-engagement Program
   c. HIV Molecular Cluster Detection
5. **Priority Populations**
6. **Capacity Building & HIV Workforce**

How does the data impact prevention planning?

- What does the data show?
- What data is missing? How will it inform prevention planning?
- What are we doing well?
- Where do we need to improve?

Thank you