



# LOS ANGELES COUNTY HIV/AIDS STRATEGY FOR 2020 AND BEYOND





# LACounty.HIV: Once and *for All*



# CONTENT

INTRODUCTION TO THE LOS ANGELES COUNTY HIV/AIDS STRATEGY FOR 2020 AND BEYOND	4
DESCRIBING THE CHALLENGE	8
LAC HIV/AIDS STRATEGY GOALS	12
ACKNOWLEDGEMENTS	23
DATA TABLES	24

# Los Angeles County HIV/AIDS Strategy for 2020 and Beyond

## INTRODUCTION TO THE LOS ANGELES COUNTY HIV/AIDS STRATEGY FOR 2020 AND BEYOND

More than 36 years ago, Los Angeles County (LAC) was among several major metropolitan areas in the United States to report the first documented cases of what is now known as HIV/AIDS. Since that report in June 1981,<sup>1</sup> an initial group of 5 cases in Los Angeles County would grow to nearly 90,000 diagnosed cases of HIV or AIDS. Almost 30,000 persons diagnosed with HIV/AIDS in Los Angeles County have died. Over that same time, the number of annual new HIV infections reported in LAC would rise to a peak of more than 6,500 and slowly decline to the 1,850 new HIV infections estimated for 2017. The number of residents with undiagnosed HIV infection would grow to more than 15,500 in the early 2000s and slowly decline to an estimated 8,900 (or about 14% of all persons living with HIV) today. There has been steady, deliberate progress, but a public health imperative calls on all of us to do more.

Today, more than 60,000 persons live with HIV in Los Angeles County, and many people living with HIV are effectively managing their infection (as measured by the undetectable levels of HIV in their bloodstream, or viral suppression) with the use of highly active anti-retroviral therapy (ART). Many of our most marginalized and disenfranchised residents can achieve viral suppression through the combined access to life-saving treatment and a menu of services that improves health system navigation and access (including to physical, mental and oral health services, housing stability, food and nutrition services, substance use treatment, care coordination and

transportation services). For tens of thousands of persons in Los Angeles County with either undiagnosed HIV infection or who have been diagnosed, but for a multitude of complex reasons have unmanaged HIV infection, the benefits of scientific progress, public health action, and clinical intervention will be realized if they are diagnosed, linked to care, and treated in a timely manner.

A nearly three-decade old local system of HIV/AIDS treatment and prevention services revealed that social inequities fuel health-related inequities and that a holistic system of care that 1) confronts and addresses uneven access, 2) insists on high standards of care for all, 3) aggressively monitors performance, 4) institutes principles of continuous quality improvement and 5) fully capitalizes on scientific progress is a recipe for public health progress.

Los Angeles County now joins more than three dozen jurisdictions from across the United States that have developed a blueprint to significantly reduce the decades-long impact of HIV/AIDS on the health of their communities. For Los Angeles County, this is a moment for renewed optimism, but one that is tempered by still uneven progress. This is an era of unprecedented opportunity checked by an increasingly volatile and unpredictable political environment that threatens health care systems and health care access patterns. This is a moment of unprecedented prevention progress that is slowed by suboptimal awareness, acceptance,



# 8,500

Number of LAC residents at the end of 2016 who had HIV and didn't know it.

and utilization of overwhelmingly effective HIV prevention tools. As the author and humanitarian Paul Farmer stated, "Equality of access to the fruits of science is the only acceptable goal."

Despite our noted caution, we maintain that the optimism, opportunity, and prevention tools available today will drive a remarkable level of progress in the fight against HIV over the next five years as we refine and fully implement the **Los Angeles County HIV/AIDS Strategy for 2020 and Beyond**.

Consistent with the spirit and intent of the National HIV/AIDS Strategy (NHAS), originally released July 13, 2010 by President Barack Obama and updated and re-released in 2015 by the same Administration, the Los Angeles County HIV/AIDS Strategy (LACHAS) strives to unify and integrate our collective HIV control efforts. Like other documents of its kind, the LACHAS identifies major goals and key objectives. It also builds on a range of planning efforts, actions by local elected officials, municipal level commitments, open and frank dialogue among community stakeholders, and a better understanding of the underlying contributors to HIV-related inequities to shape its content and approach.

This is a strategy that calls on the vast, complex, and formidable private health care delivery system (e.g. health plans, hospitals, federally qualified health centers and community-based organizations) as equally as the publicly-operated hospitals, public health clinics, and comprehensive health centers that

serve the residents of Los Angeles County. This is a strategy that responds to an appeal from the Los Angeles County Commission on HIV (Commission) and hundreds of active and passionate community providers and stakeholders for bold action and a clear vision for ending an epidemic that nears the start of its fifth decade. This is a strategy that introduces an unprecedented level of accountability, and a commitment to the public reporting and monitoring of key performance metrics through a new website: [www.lacounty.hiv](http://www.lacounty.hiv).

This is also a strategy that joins other commitments and campaigns with a shared vision of significant reduction of HIV impact, including the California Office of AIDS' "Laying a Foundation for Getting to Zero" campaign, the City of West Hollywood's "HIV Zero Strategic Plan," and the City of Los Angeles' efforts to frame a "getting to zero" strategy through its AIDS Coordinator's Office. These Strategies are not viewed as conflicting, but rather are synergistic, one enhancing the impact of the other.

Finally, the LACHAS will build on the unfettered commitment of elected officials at the city, County, State and federal levels. While we embrace recent unanimous motions by the County Board of Supervisors calling for the prevention of HIV and reduction of HIV rates among the most impacted populations in our County, we also look to our elected officials in Sacramento for Statewide policy interventions that will further accelerate our efforts.



# 70,000

Estimated number of MSM, trans women, and ciswomen in LAC who would benefit from PrEP.

**Goal I:** Reduce annual HIV infections to 500 by 2022

**Goal II:** Increase the proportion of Persons Living with HIV who are diagnosed to at least 90% by 2022

**Goal III:** Increase the proportion of diagnosed PLWH who are virally suppressed to 90% by 2022

## WHY NOW?

There is no coincidence to the timing of the development and release of the LACHAS. Not since the launch and widespread availability of highly active anti-retroviral therapy (ART) in 1996 that led to the profound life-saving ‘Lazarus effect’ among persons with HIV has there been a coalescing of forces occurring simultaneously to reduce the significant impact of HIV in Los Angeles County – once and for all.

The most notable drivers of the LACHAS are:

1) The significant reach of the Affordable Care Act (ACA) on Los Angeles County residents helping hundreds of thousands of

people, including some of our poorest and most disenfranchised, to dramatically improve health care access patterns, thereby linking residents to critical HIV testing, diagnosis, and treatment opportunities;

2) The development of and increased access to biomedical HIV prevention tools for our highest HIV-risk individuals, including the launch and ongoing support of more than fourteen community-based Biomedical Prevention Centers of Excellence and five County-operated Public Health Clinic biomedical prevention access points, thereby enhancing the potential to avert thousands of new HIV infections in Los Angeles County over the next several years;

3) The launch and expansion of HIV Medical Care Coordination teams co-located in HIV treatment clinics to ensure that all persons living with HIV can realize the full benefits of treatment by assessing and addressing individuals’ complex economic, psychosocial, structural, and behavioral challenges that impact treatment adherence and viral suppression goals;

4) The development and increasing use of geospatial analysis to identify and deploy programs and services to the areas of our County most impacted by HIV, including the health districts where new HIV infections are likely occurring, where persons are most likely to test HIV positive, or where viral suppression rates are suboptimal;

- 5) Once-a-day single drug antiretroviral treatment regimens that have vastly improved treatment adherence and viral suppression rates and that result in the need for fewer medical visits with specialty HIV physicians per year;
- 6) The saturation of social media that allows for critical health message amplification, particularly among social networks and sub-populations most impacted by HIV; and
- 7) The adoption of a Health District model to target our response in discrete, manageable, and familiar geographic areas.

#### **EVOLUTION TO A HEALTH DISTRICT MODEL**

For many years, DHSP has used the Service Planning Area (SPA) model, consisting of eight SPAs, adapted from the Children's Planning Council for geographic or regional planning in LAC among eight SPAs. More recently, as surveillance and service utilization data have become more sophisticated and reliable, DHSP and its planning partners have evolved to a more data-driven approach through syndemic planning, which utilizes data

for both HIV and STDs, and maps disease prevalence in LAC to identify inequities among those geographic areas where disease burden is highest. That change resulted in the mapping and identification of five cluster areas within which more than 80% of the disease burden exists. Despite this mapping evolution, those cluster areas are very large, both in geography and in population size. As a strategy to further refine our planning efforts, DHSP is shifting to planning by twenty-six Health Districts. With such a significant level of variation across the twenty-six Health Districts spread across LAC, this approach will allow for the development of concrete and discrete goals and activities for each health district and ensure that, at the community level, all LACHAS stakeholders, service providers and residents can see how their efforts and progress contribute to the overall achievement of the LACHAS goals described below. Over time and as part of LACHAS, this planning approach will allow all of us to marshal and deploy resources in more discrete areas, including in areas where the burden is highest and the impact will be the greatest.

---

**Despite many advances in HIV prevention and treatment strategies, the annual incidence of HIV in Los Angeles County of 1,750 to 2,000 new infections persists. At the end of 2016, only 60% of all PLWH in LAC were virally suppressed.<sup>2</sup> We now have a complementary set of tools to significantly reduce new infections, but we must amplify key messages and we must act!**

---

# Los Angeles County HIV/AIDS Strategy for 2020 and Beyond

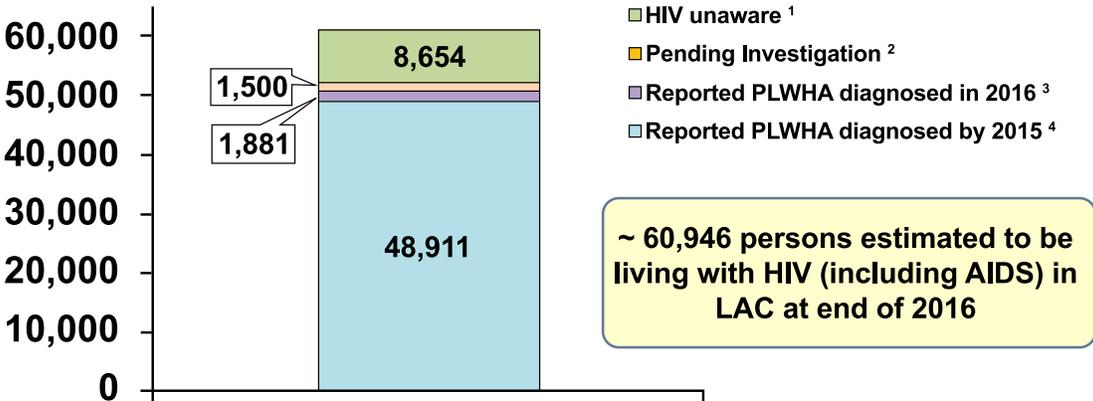
## DESCRIBING THE CHALLENGE

Los Angeles County (LAC) spans over 4,000 square miles and includes 88 cities, 26 health districts, and a mix of urban, suburban and rural areas. With a population of 10.2 million residents, including a large number of immigrants, LAC is among the most ethnically and economically diverse regions in the nation.

Although more people have access to health insurance than ever before, the complexities of navigating the health care system have also increased. The challenge of providing HIV prevention and care services throughout LAC is compounded by its sheer

size. The Department of Public Health’s Division of HIV and STD Programs (DHSP), charged with developing and managing public health surveillance and a programmatic response to HIV in LAC, estimates that 61,000 people were living with HIV in LAC at the end of 2016; of those, 8,654 were unaware of their infection.<sup>2</sup> In 2016, 1,881 HIV cases were newly diagnosed; 84% were men who have sex with men (MSM).<sup>2</sup> The epidemic continues to be driven by sexual activity between males. HIV incidence is highest among MSM of color, young MSM (YMSM) ages 18 to 29, and transgender persons.

Figure 1. Estimated Number of Persons Living with HIV and AIDS in LAC at the End of 2016<sup>2</sup>



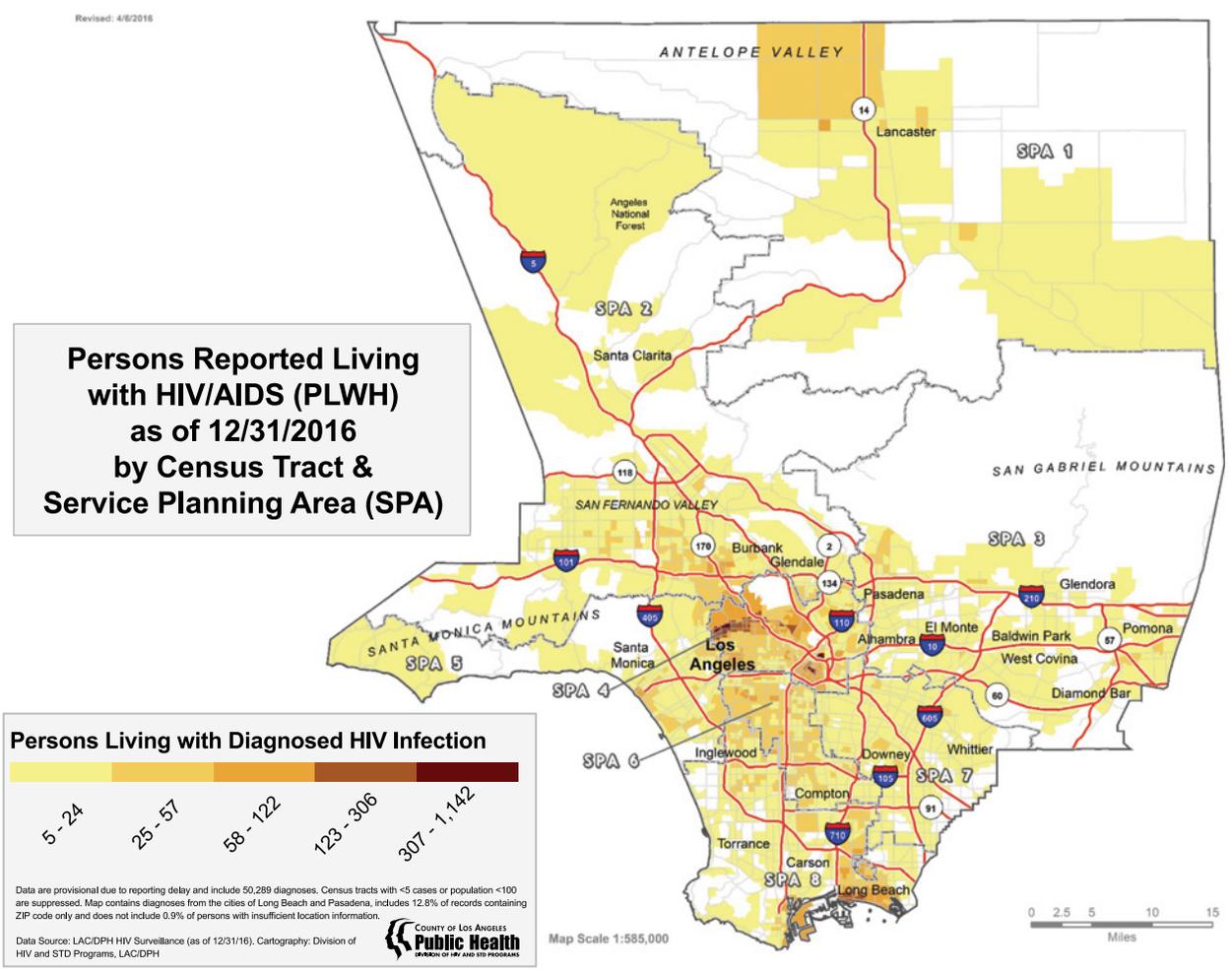
<sup>1</sup> It was estimated that 14.2% of PLWH were unaware of their infection in 2016. This was projected from 2014 estimate of 15.0% for California according to CDC’s new methods using HIV case surveillance data and CD4 test results (see CROI 2017)  
<sup>2</sup> Total estimated 1,500 lab reports pending investigation likely to result in unduplicated cases.  
<sup>3</sup> Includes persons newly diagnosed with HIV infection in 2016. Data based on residence at diagnosis.  
<sup>4</sup> Includes persons diagnosed with HIV infection by 12/31/2015 and living as of 12/31/2016. Data based on most recently reported residential address.

Source: HIV Surveillance data as of September 2017



PrEP is available at no or low cost throughout the County at 14 PrEP Centers of Excellence.

Figure 2. Annual Diagnoses of HIV Infection, Stage 3 HIV Infection (AIDS), PLWH, and Deaths among Persons Diagnosed with HIV Infection, LAC, 2002-2014. Persons Living with a Diagnosis of HIV Infection as of 12/31/16 by Census Tract & Service Planning Area (SPA), Los Angeles County



## Trend Data

Although there has been a decline in the number of new infections, diagnoses of AIDS, and number of deaths since 2002 (see Figure 3), the decrease in recent years is not dramatic, despite the development of new HIV screening technologies, treatment regimens, and biomedical interventions. For epidemiology data tables, refer to Appendix A, Tables 1-7.

Overall there were 1,561 non-AIDS HIV and 711 late-stage or AIDS diagnoses in 2016; and compared to 2014, this represents an 8.9% decrease in non-AIDS diagnoses and a 9.2% decrease in AIDS defined diagnoses.<sup>2</sup> Between 2014 and 2016 there was a 5.6% increase in non-AIDS HIV prevalence and a 3.1% decrease in AIDS prevalence.<sup>2</sup> Approximately 600 deaths among PLWH were reported in 2014 (most recent data available), and 270 were attributed to HIV disease or opportunistic infections. The number of deaths attributed to HIV is likely to decrease for 2016 since viral suppression levels have increased between 2014 and 2016. Five-year trend data for non-AIDS HIV and AIDS prevalence, new diagnoses, number of PLWH and relevant HIV care continuum data are all included in Appendix A, Tables 1 and 3.

## Subpopulations with Increased Burden

New positivity rates among African-American and Latino MSM, young MSM 18-29 and transgender women of color are much higher than the overall rate of 1.1% observed across all DHSP-supported testing efforts (see Appendix A, Tables 1 and 4), indicating that our targeted testing efforts are effective. Among YMSM the new positivity rate was 1.9%; among Latino MSM the positivity rate was 2.1%; the positivity rate was 2.4% for transgender individuals and the new positivity rate was nearly three times higher for African-American MSM (3.8%), compared to the positivity observed among all testers across Los Angeles County. In 2015, the documented 90-day linkage to care rate among individuals newly diagnosed at County-funded testing sites was 68.5%.<sup>3</sup> Approximately 68.6% of Latino and African-American MSM, 76.2% of YMSM and 61.4% of transgender individuals were successfully linked to care within 90 days of diagnosis.<sup>3</sup>

## DHSP and Federal Partners

In LAC, DHSP manages an important portion of the entire

public response to HIV and STDs, including surveillance, prevention, care and treatment. Partnerships with community based organizations (CBOs) and other health care providers and institutions are crucial in implementing LACHAS. In addition to the longstanding HIV community providers, partnerships beyond the HIV service arena have contributed to the increased awareness and availability of HIV tests at more than 200 sites. These include Public Health community clinics; the County's Substance Abuse Prevention and Control program; Los Angeles County Sheriff's Department; and the County's Department of Health Services (DHS) to facilitate HIV testing in County jails, detention centers, public hospitals (both emergency rooms and outpatient clinics) and health centers; and social service agencies. Partnerships with private hospitals in high-impact areas have broadened the reach of routine HIV testing. For organizations that do not have contractual relationships with DHSP, numerous executive-level meetings have occurred in the past two years to provide technical assistance and other support for implementation of routine HIV screening and linkage to care.

All Parts (A, B, C, F, and MAI) of the local Ryan White Program (RWP) in LAC have played an instrumental role in the support and delivery of a robust menu of HIV services and, in recent years, have enhanced the facilitation of linkage to medical care for individuals newly diagnosed with HIV. As part of LACHAS, we will place even more emphasis on linkage to care, including actively facilitating the connections and contacts between the DHSP-funded HIV Testing Services and Medical Care Coordination (MCC) providers through periodic integrated provider meetings. Many RWP-funded medical clinics are Federally Qualified Health Centers (FQHCs) that serve as both HIV clinics and general primary care clinics. They partner with DHSP to support and champion routine testing in clinical settings within their own institutions. DHSP staff work with FQHC medical and administrative leadership to provide technical support for implementing routine HIV testing in the primary care clinics and to incorporate the testing process into the clinic flow. Ryan White programs within the County DHS system facilitate routine HIV testing in hospitals, emergency departments, urgent care centers and primary care clinics in a similar way, through educating the institution leaders and executives about the importance of routine HIV testing and the best practices for incorporating HIV screening into clinical settings.

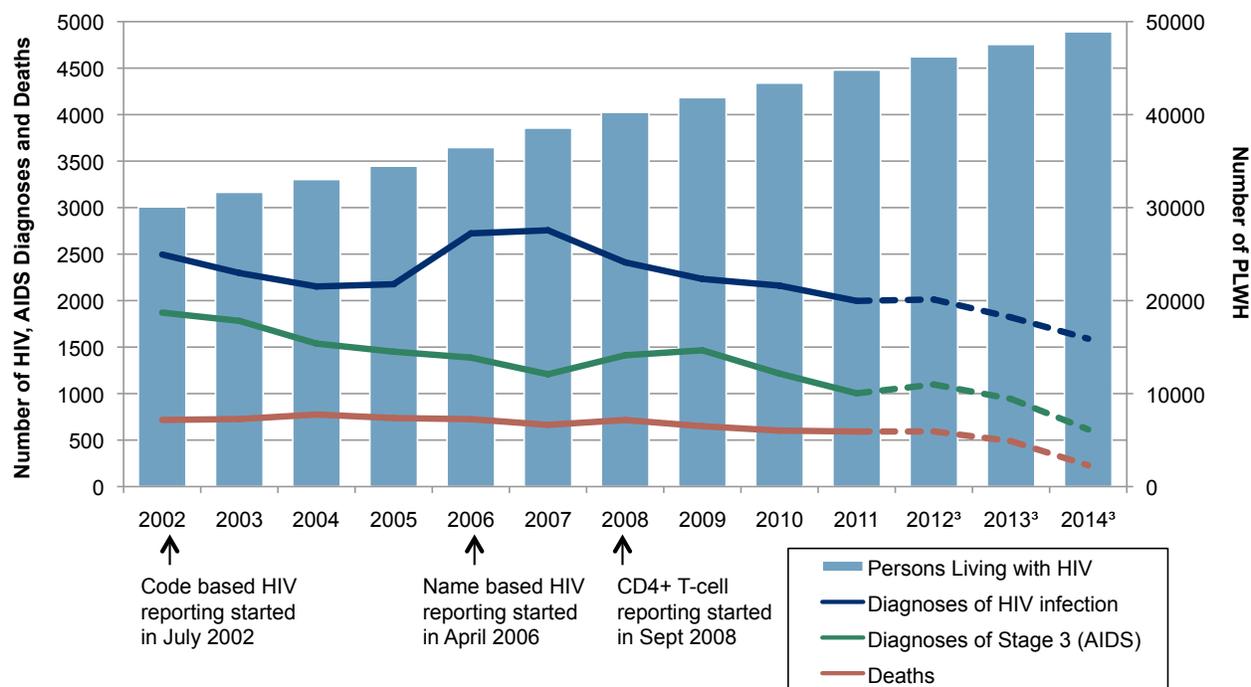
LAC is one of 12 metropolitan areas in the country to be directly funded by the CDC for HIV and STD prevention services. DHSP also receives CDC funding for both HIV and STD surveillance. CDC-funded prevention services include targeted and routine rapid HIV testing, health education and risk reduction (risk reduction activities), partner services, social marketing, condom distribution, outreach, and biomedical interventions, including non-occupational post-exposure prophylaxis (nPEP) and pre-exposure prophylaxis (PrEP).

DHSP implements CDC-funded partner services and social network testing at RWP-funded medical outpatient sites to identify undiagnosed infections. Routine testing supported by CDC funds is in place at primary care sites to promote direct linkage into affiliated RWP care clinics. CDC also directly funds eight community based organizations in LAC to provide outreach, HIV testing, and health education to persons of color and young MSM—an important complement to local investments. These

efforts help identify undiagnosed PLWH and increase awareness of services available.

Through CDC and Health Resources and Services Administration (HRSA) initiatives, services are coordinated with common goals laid out in the NHAS. The Los Angeles County Commission on HIV (Commission) serves as the local Board of Supervisors-ordinanced and HRSA and CDC-mandated HIV prevention, care, and treatment planning body. At the community planning level, the Commission is now a unified body conducting planning for the entire HIV care continuum, after undergoing a thoughtful process to integrate its planning several years ago. This integrated planning effort helps leverage available funding for improved outcomes throughout the stages of the HIV care continuum. The Commission works closely with DHSP for the planning, allocation, coordination, and delivery of HIV/AIDS services countywide.

**Figure 3. Annual Diagnoses of HIV Infection<sup>1</sup>, Stage 3 HIV Infection (AIDS), Persons Living with HIV, and Deaths<sup>2</sup> among Persons Diagnosed with HIV Infection (PLWH), Los Angeles County, 2002-2014**



<sup>1</sup> Based on named reports for persons with a diagnosis of HIV infection regardless of the disease stage at time of diagnosis.

<sup>2</sup> The number of deaths among persons with HIV infection is based on the date of death report when the actual year of death is unknown.

<sup>3</sup> Data are provisional due to reporting delay.

# Los Angeles County HIV/AIDS Strategy for 2020 and Beyond

## LAC HIV/AIDS STRATEGY GOALS

Data drive the development and ongoing measurement of the goals for the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond. Each goal sets a benchmark to be achieved by 2022, describes the strategies that will lead to achievement of the goals, lists social determinants of health to be considered, policy recommendations to be explored, a brief discussion of resources needed, and suggests metrics for measuring progress.

To promote planning at the most granular level, profiles have been created for each of the twenty-six Health Districts. Each profile contains a map of the Health District with key health provider sites and graphs that show how the district performs for three main performance indicators (proportion of PLWH living in the Health District who have been diagnosed; estimated PrEP enrollment among district residents; and viral suppression of district residents). A baseline and goal is provided for each indicator. Key focus areas are also outlined for the district based on the data provided so that planners can see how their efforts can make progress within each Health District to meet the goals for the district. The Health District profiles are provided separately but as a supplement to this document, and are located on the LACHAS website at [LACounty.HIV](http://LACounty.HIV).

### **GOAL I: Reduce annual HIV Infections to 500 by 2022**

#### **HOW ARE WE GOING TO ACHIEVE THIS?**

**A. Increase Access to Biomedical Prevention.** DHSP is

directly funded by the Centers for Disease Control and Prevention (CDC) to expand access to Pre-Exposure Prophylaxis (PrEP) and non-Occupational Post-Exposure Prophylaxis (nPEP) services and increase awareness of the efficacy of PrEP among groups most at risk for HIV infection and the clinicians who provide their care. Expanded awareness of and access to PrEP and PEP is key, as DHSP estimates that over 70,000 people at elevated risk for HIV in LAC could benefit from these biomedical interventions available at nearly twenty sites countywide. In addition to increasing awareness and supporting access through existing DHSP providers, DHSP also supports public health detailing that provides onsite education about PrEP and sexual health to over 400 clinical providers with a history of diagnosing or treating HIV, syphilis, or gonorrhea in LAC.

**B. Target HIV response in high-risk, high-prevalence geographic areas using epidemiologic evidence.** LAC's targeted HIV prevention strategy is based on geospatial analysis of multiple co-occurring health and socio-economic conditions to identify health districts with residents at increased risk for HIV. DHSP uses spatial epidemiology to examine disease burden and the interrelationship between two or more diseases or outcomes along the HIV care continuum (i.e. not engaged in care, not virally suppressed). Surveillance data for HIV, syphilis, gonorrhea, and chlamydia, as well as HIV testing and care services data are mapped in layers to identify geographic areas where the nexus of diseases is especially evident. Testing resources are targeted to high-risk populations within these areas to focus

efforts where HIV is more likely to be undiagnosed and positivity rates are higher. Using clinic and surveillance data, DHSP staff estimate countywide rates of suppressed HIV viral load, ART coverage, and PLWH out of care to identify geographic areas and subpopulations that require intensive interventions. The geographic response also includes ensuring access to free condoms in areas with increased disease burden, and in areas where people at higher risk for infection socially congregate.

**C. Promote resiliency and protective factors.** Identifying and addressing social determinants of health among African-American and Latino YMSM is imperative, but it's just as important to simultaneously promote resiliency and protective factors. Resilience is "an individual's ability to recover from or adjust to misfortune, adversity, or change."<sup>4</sup> Resilience becomes essential to African-American and Latino YMSM as they have reported dealing with homophobia (internal and external), machismo, racism, prejudice, and injustices along with other 'minority stressors' on a constant basis.<sup>5</sup> Lesbian, gay, bisexual, and transgender (LGBT) youth in particular continue to experience higher rates of victimization and criminalization compared to their non-LGBT counterparts.<sup>4</sup> These types of experiences as part of 'minority stress' can result in psychological distress that can lead to risky sexual behaviors putting this population at higher risk for HIV and STDs.<sup>6</sup>

Protective factors are certain characteristics (social, structural, cultural, individual) that can protect African-American and Latino YMSM from becoming infected with HIV or other STDs. Among the key protective factors for youth, including LGBT youth, are: family/peer support, positive peer groups, a connection to spirituality/religiosity, strong sense of self and self-esteem, along with effective engagement in school and community activities.<sup>7</sup> CDC's Injury Prevention Center adds connection with parents, ability to discuss problems with parents/adults, along with a consistent parental presence in the home offers important protective benefits.

**D. Address workforce issues regarding capacity, burnout, and minimum expectations to uphold principles of sex positivity, equity, and social justice.** To achieve the goals of this LACHAS, it is essential that the workforce is skilled and demonstrates cultural humility; this includes providers across

roles and disciplines such as peer navigators, social workers, nurses, doctors, case managers, pharmacists, coordinators, and managers. Key priorities for improving outcomes along the care continuum include: 1) supporting the workforce in reducing burnout by providing appropriate tools, clinical supervision, and decision-making opportunities; 2) provide ongoing training and education around cultural humility to better serve clients based on their age, race/ethnicity, gender and gender identity, sexual orientation, or socio-economic backgrounds; and 3) increase capacity around the principles of sex positivity, equity, and social justice in order for these to be implemented across the service continuum.

Meaningful improvement in health outcomes requires adoption of policies that will produce a diverse workforce across roles, including in decision making positions. The aging and maturation of the longstanding HIV service provider workforce demands that we start creating transition plans to develop new leaders who reflect the diversity of the epidemic today, including younger people, people of trans experience, and people of color.

**E. Recognize and address the importance of cultural humility among service providers and advocates.** Cultural humility can only be achieved when organizations working with the most HIV-impacted sub-populations acknowledge and understand that a host of social and environmental factors contribute to HIV/STD risks among racial/ethnic communities and sexual and gender minorities.

Cultural humility must consider concerns over deportation and language barriers as additional contributors to the HIV epidemic in LAC. According to the 2011 American Community Survey (ACS), approximately 35% of LAC residents are foreign born, and 53% of foreign born residents are undocumented.<sup>8</sup> The ACS also reports that 57% of LAC's population over five years old speaks a language other than English at home, and 26% of this population speaks English less than "very well."<sup>8</sup> It is crucial that these populations are able to access health care services and have a level of health literacy that allows them to understand and acknowledge health care information and instructions. Therefore, interventions with specific target populations must consider possible language barriers that inhibit health literacy and access to testing, treatment, and care.



Free HIV treatment is available  
throughout LAC at more than  
**30** DHSP-funded clinics.

**F. Decrease the burden of Syphilis and Gonorrhea among groups at high risk for HIV.** Over the past several years, DHSP has refined its syndemic spatial analysis that continues to show an epidemiologic link between the local HIV, syphilis and gonorrhea epidemics. 60 percent of MSM diagnosed with early syphilis in 2015 also had HIV. Given the physiologic role that STDs play in enhancing HIV transmission, we must acknowledge that maximizing HIV prevention impact will also require a significant reduction in syphilis and gonorrhea cases, particularly among MSM, transgender persons and women of color. Continued promotion and expansion of condom use will help mitigate new infections of STDs and HIV, and the ongoing work of the DPH Center for Health Equity around STD prevention and treatment is vital to ensuring reduction in STD infections.

#### **THE UNMISTAKABLE ROLE OF SOCIAL ADVERSITY IN HIV PREVENTION**

##### ***Racism, Stigma, Homophobia, and Transphobia***

Evidence continues to show that racism, HIV-related stigma and discrimination, homophobia and transphobia have a profound impact on HIV prevention efforts and exacerbate the fear and unease that our most vulnerable residents face accessing information, services, and prevention tools that can keep them HIV-negative. Collectively, these adversities are also associated with a fear of violence, and are barriers that preclude people

living with HIV from sharing their status with family members or sexual partners and diminish the likelihood of being able and willing to access and adhere to treatment. In the end, while difficult to quantify, the underlying stigma and discrimination pervasive in many parts of Los Angeles County negatively impact the ability of individuals and communities to prevent new HIV infections and for people living with HIV to achieve and maintain optimal health.

HIV-related stigma is often intertwined with and exacerbated by prejudice experienced by marginalized communities. These communities include people who use substances, experience mental health issues, and those who engage in sex work, as well as those who are marginalized based on their sexual orientation, gender, gender identity, or race/ethnicity.

Too frequently, social stigma is manifested by imposing blame on people who acquire HIV, and even on those who actively seek to remain HIV negative. It is crucial that we work to create safe spaces where people are accepted, respected, and celebrated to increase the likelihood that more people will get tested for HIV, start PrEP if HIV-negative, or enter and stay in care if diagnosed with HIV. As part of LACHAS, we have a shared responsibility to instigate positive social change and action that confronts and challenges stigma faced by people vulnerable to or living with HIV.

## THE ROLE OF HEALTH INEQUITIES IN THE HIV EPIDEMIC

Transmission and viral suppression of HIV are closely associated with a multitude of inequities among LAC's communities. To address health inequities, the Department of Public Health has established the Center for Health Equity. The Center's guiding principles are to 1) Drive action with data and stories; 2) Amplify community voices; 3) Build partnerships; and 4) Transform the Health Agency. The Center's efforts span the entire Health Agency (made up of the Department of Public Health, the Department of Mental Health, and the Department of Health Services) of LAC, and will focus on five areas: Infant Mortality, Sexually Transmitted Infections, Environmental Justice, Health Neighborhoods, and Cultural and Linguistic Competency. Through this work, the Center will consider many factors that affect HIV and STD transmission and risk, such as the impact of structural racism; ongoing lack of social support; exposure to environmental hazards; residential segregation; inequities in access to medical care and treatment; and chronic stress. These all play a role in an individual's ability to thrive, and are important considerations for LACHAS.

## POLICY RECOMMENDATIONS

- **Increase State funding for the California PrEP Assistance Program to meet the biomedical HIV prevention needs of residents at high risk for HIV infection.**

In 2017, California allocated funding to create a statewide PrEP Assistance Program. For individuals with annual incomes below 500 percent of the federal poverty level, the program will cover 1) PrEP-related medical costs for uninsured clients and 2) PrEP-related medical co-pays, co-insurance, deductibles, and drug costs not covered by a client's health insurance plan or the manufacturer's co-payment assistance

program for insured clients. The State must ensure that the PrEP Assistance Program, much like the successful State ADAP model, is adequately funded and must prioritize additional funding for outreach and enrollment activities.

- **Develop a treatment as prevention media campaign.**

Prevention Access Campaign's Undetectable = Untransmittable (U=U) is a growing global community of HIV advocates, activists, researchers, and nearly 400 community partners from 60 countries uniting to clarify and disseminate the revolutionary but largely unknown fact that people living with HIV on effective treatment and who are virally suppressed do not transmit HIV. A countywide campaign that targets both people living with HIV and HIV-negative individuals would promote treatment as prevention and serve to improve treatment adherence for people living with HIV. The campaign should also target health care providers to increase their cultural humility and reduce the stigma that patients experience while in care.

## Allocate funding for community-driven PrEP and nPEP outreach and marketing.

Considerable education remains to be done with providers and consumers, most especially those who should be prescribing PrEP and nPEP. Similarly, we must ensure that persons most at risk for HIV infection should consider fully benefiting from this revolutionary prevention tool. Current campaigns have helped to raise awareness about PrEP and nPEP, but may not resonate with some populations at high risk, including women, gay and bisexual men of color and transgender individuals. Special care must be taken to ensure that these populations are reached in the most effective way.



**Ongoing political engagement.** A successful strategy will require adamant political will, and the Board of Supervisors, along with local Mayors, City Councilpersons, members of LAC's Congressional delegation and State legislative leaders have a unique role influencing the progress of LACHAS. In the first year of implementation they will be called to action to champion LACHAS as part of their leadership agendas, including consideration of policy and legislative solutions to advance its goals.

#### **WHAT RESOURCES ARE NEEDED TO ACHIEVE THIS HIV PREVENTION GOAL?**

It is widely accepted that our historic HIV prevention investments have helped avert thousands of new HIV infections locally, including those investments tied to HIV testing, behavioral interventions, condom distribution, syringe exchange programs, STD treatment and partner notification services. More recently, it has become evident that Treatment as Prevention (Undetectable = Untransmittable) and biomedical HIV prevention efforts have the potential to dramatically accelerate HIV prevention progress if they are brought to scale.

Over the last several decades, the treatment of persons living with HIV has been the single largest HIV related expense made by both the public and private sector. The investment in state-of-the-art HIV treatment must continue as we strive to achieve much higher levels of viral suppression.

Separately, but complementarily, new and more significant investments in biomedical HIV prevention programs are needed to achieve a level of scale to avert thousands of new HIV infections over the next 5 years. The costs associated with comprehensive biomedical HIV prevention services are not insignificant and will require a diverse set of funding streams to

ensure maximum reach, including from local, State and federal partners, as well as private and public health plans.

To achieve our PrEP and nPEP goals, we must be prepared to increase our investment levels in biomedical HIV services through 1) the leveraging of all available funding streams, 2) the re-direction of a proportion of existing HIV prevention resources, and 3) the allocation of new resources from a diverse set of partners.

As part of an enhanced HIV prevention effort, we must all leverage existing and new resources to support media campaigns and marketing strategies to enhance awareness and spur action tied to HIV treatment, HIV testing, biomedical HIV prevention, and condom availability.

DHSP has begun to quantify the costs associated with these HIV prevention enhancements based on a limited set of program cost information. In the first part of 2018, we will work with a range of health program funders, providers and stakeholders to refine our program enhancement cost estimates and subsequently determine how best to spearhead a new investment strategy.

#### **HOW ARE WE GOING TO MEASURE OUR PROGRESS?**

DHSP will partner with the UCLA Center for HIV Identification, Prevention and Treatment Services (CHIPTS) and a range of partners from the public and private sector to develop reliable and uniform evaluation and performance metrics across a range of local health systems tied to reduction of new HIV infections. DHSP and CHIPTS will also jointly enlist a panel of experts among our stakeholder partners to deliberate and refine these metrics.

### **GOAL II: Increase the Proportion of Persons Living with HIV who are Diagnosed to at least 90% by 2022**

#### **HOW ARE WE GOING TO ACHIEVE THIS?**

**Normalize HIV Testing.** Since stigma surrounding HIV persists and many HIV infections occur because of unrecognized, underestimated, or ignored risks, normalizing HIV testing among at-risk communities is crucial and must become a routine part of regular health care. LAC supports HIV diagnosis efforts primarily

## **EACH ONE REACH ONE**

**If you're on PrEP, find someone who isn't and help us teach them about PrEP.**

**If you're on HIV treatment, find others who need treatment and help us link them to HIV medical care.**



# 1,975,000

Number of HIV tests needed in the next 5 years to diagnose all undiagnosed HIV infections in LAC.

with funding from CDC to support targeted HIV testing, routine opt-out testing at health care facilities, social network testing, and other testing initiatives that aim to enhance HIV testing coverage. Separately, we support HIV testing-related social media strategies that aim to promote testing while reducing the fear and stigma associated with HIV testing. LAC's strategy for normalizing testing includes increasing the number of sites where testing is available; targeting testing messages among high-risk communities in geographic areas with high HIV prevalence; and increasing the number of medical clinics and emergency departments that include HIV screening as a part of the routine battery of tests for all patients. By normalizing HIV testing through targeted testing in non-healthcare settings, LAC has seen consistent progress in reducing the number of undiagnosed persons with HIV.

As a critical enhancement to HIV testing efforts, DHSP incentivizes linkage to HIV and STD care among contracted providers, and will incentivize documented referral to PrEP programs for high-risk negative testers. These incentives may increase the reimbursement rate for HIV tests, and promote testing of high-risk individuals in high HIV burden areas.

### **SOCIAL DETERMINANTS TO CONSIDER**

*Stigma, violence, homophobia, fear of rejection, discrimination, and racism continue to be pervasive forces and all deplete health in multiple ways.*

A person who faces racism and experiences discrimination may engage in high risk behaviors for HIV/STDs, may undertake sex work as a means of survival, may not seek healthcare when needed, and can suffer from psychological distress. Racism also has oppressive effects on sexuality. PLWH who experience racism and discrimination may not feel comfortable seeking/receiving needed care, education, and services to manage their HIV infection and prevent further transmission.<sup>9</sup>

For young MSM, family rejection and domestic violence can result in immediate homelessness. Stigma, discrimination, and internalized homophobia have also been associated with higher rates of unprotected sexual intercourse.<sup>5,6</sup> Further, higher levels of this stigma have been associated with not being tested for HIV, inaccurately assessing one's risk for HIV, and not participating in HIV prevention programs.<sup>5,10</sup>

The fear of being associated with homosexuality among MSM who do not identify themselves as gay or bisexual may strongly inhibit health promoting and health seeking behaviors. Those who experience greater levels of homophobia have reported taking sexual risk behaviors.<sup>10</sup> Societal homophobia creates disconnections between people and their sexual desires by causing men to view same-sex relations negatively, which can lead to self-loathing. High levels of experienced homophobia and racism have been associated with more depression and suicidal thoughts amongst Latino gay men.<sup>6,11</sup> These experiences of



# 60%

Percentage of MSM diagnosed with early syphilis in 2015 who also have HIV.

homophobia along with other stress can result in psychological distress which can lead to suicide, anxiety, and guilt.

Acknowledgement and understanding of these multiple social factors in the lives of racial/ethnic communities and sexual and gender minorities will help improve cultural humility and lead to innovative strategies to combat this epidemic in these populations.

### POLICY RECOMMENDATIONS

- **Make routine HIV testing truly routine.** In 2013, California passed legislation requiring every patient who has blood drawn at a primary care clinic and who has consented to a health screen be offered an HIV test consistent with the United States Preventive Services Task Force recommendations for screening. Unfortunately, compliance with this law is poor.<sup>12</sup> In 2016, California passed legislation creating a pilot program for routine HIV testing in the emergency departments of four hospitals across the state. Los Angeles County should ensure that these laws are fully implemented and expand upon existing law by requiring all emergency departments, urgent care, and walk-in clinics to offer routine HIV testing.
- **Implement mandatory routine opt-out HIV testing in key public and private hospitals and health clinics operating in California for a time-limited basis through 2022.**

### WHAT RESOURCES ARE NEEDED TO SUPPORT THESE ACTIVITIES?

DHSP estimates that, to diagnose 90% of the existing undiagnosed and 90% of new infections over a 5-year period, 1,975,000 routine and targeted HIV tests will need to be conducted. This estimate assumes an overall positivity rate of 0.5%. The estimated cost of this effort is between \$60 and \$79 million. The exact cost will be influenced by the distribution of lower yield but much less expensive routine HIV testing compared to the higher yield but more expensive targeted testing efforts. To achieve this HIV diagnosis goal over the next five years, it is crucial that we increase the number of routine HIV testing partners locally, including in both the public and private sectors.

The implementation of a statewide mandatory routine opt-out testing program will require a small increase in the overall costs tied to comprehensive health screening and should be covered by existing public and private health plans and revenue streams.

### HOW ARE WE GOING TO MEASURE THIS?

DHSP will partner with UCLA CHIPTS to develop reliable and uniform HIV testing performance metrics across a range of local health systems. DHSP and CHIPTS will also jointly enlist a panel of experts among our stakeholder partners to deliberate and refine these metrics.

### **GOAL III: Increase the Proportion of Diagnosed PLWH who are Virally Suppressed to 90% by 2022**

#### **HOW ARE WE GOING TO ACHIEVE THIS?**

##### ***A. Seamless testing, disclosure and linkage to care.***

LACHAS targets efforts at various points throughout the service continuum where individuals are affected by HIV. To close the gap in awareness of HIV infection, a key strategy is to create a seamless testing, disclosure and linkage to care pathway to foster testing and diagnosis within an optimal timeframe. LAC strives to achieve 100% disclosure of test results to patients, 100% referral to partner services, 100% referral to medical care, and at least a 95% linkage to care for newly diagnosed individuals within 30 days of diagnosis. These efforts include innovative testing strategies and initiatives (e.g., rapid testing algorithm [RTA] and 4th generation test); incentive payments for testing providers who can document timely linkage to care for positive testers; and strengthened partnerships between testing sites and medical providers. In addition, HIV surveillance data are used to transition clients from pilot projects into services ensuring clients continue to access care.

##### ***B. Comprehensive, coordinated HIV medical treatment.***

While the total number of Ryan White Program (RWP) clients has decreased in recent years due to Medicaid expansion and patient enrollment in insurance exchanges, the current political climate and ongoing discourse around immigration and repeal of the ACA have dampened utilization of public health services, particularly among immigrants. Given the significant size of the immigrant population in LAC, DHSP predicts that RWP services will become increasingly crucial in providing stigma-free access to life-saving HIV treatment for hundreds of PLWH who may have accessed insurance or other public benefits over the past several years. Prior to ACA, LAC's RWP served more than 25,000 clients annually by providing various medical and support services to eligible clients. Outreach, linkage, and retention programs need to be expanded to avoid potentially disastrous decreases in the number of PLWH who are successfully retained in high quality HIV care. Expanded Benefits Screening and Enrollment services identify and link clients to public benefits and insurance payers for which they are eligible. Medical providers who face challenges in achieving HIV viral suppression of at least 90%

of their HIV patients will be identified through HIV surveillance data and provided with technical assistance to improve health outcomes among their patient populations.

##### ***C. Medical Care Coordination that recognizes the successes of holistic treatment to mitigate the effects of homelessness, poor mental health, and substance abuse.***

The evidence of service effectiveness from Medical Care Coordination (MCC) program evaluation data indicates that PLWH who utilize RWP medical care and MCC see significantly improved health outcomes when compared to other PLWH in the County. This has led to the expansion of MCC services to patients served in clinics that have not historically been part of the RWP network. As the distribution of MCC providers continues to increase, so too will the number of patients who have access to MCC services in their HIV medical homes. With MCC expansion, medical case management is now the single largest investment in HIV services supported by DHSP. To increase overall retention in care and reduce HIV viral load in LAC, additional resources will be identified to continue MCC optimization, and to support outreach efforts among the provider community to make them aware of the benefits of offering MCC services to patients with multiple co-morbidities.

##### ***D. Support programming that specifically addresses the magnitude of the challenges posed by institutional poverty and incarceration.***

Approximately 1.2 million adults, or 12.2% of County residents lived in poverty in 2015, not including an additional 600,000 children and youth (less than 18 years of age).<sup>13</sup> In 2015, poverty was defined as an income of \$24,250 per year for a family of 4.<sup>14</sup> As such, many residents are incapable of meeting their family's necessities such as food, housing, transportation, and health care. In addition, 53% of LAC's working-age population, or 3.8 million people, have low literacy skills, a serious barrier to employability and workforce productivity.<sup>13</sup> Low literacy is also associated with incarceration; LAC's prison population rate of 612/100,000 is significantly higher than for the State's rate of 483/100,000.<sup>15</sup>

LAC bears a tremendous burden in providing services for formerly incarcerated PLWH who often experience extreme economic and health challenges. PLWH released from jail or prison often require more expensive, more complex HIV care once

they re-enter the community. Most parolees have no medical insurance or stable sources of health care, often because they lack appropriate identification or any permanent address. As recently incarcerated people re-enter communities, a majority return to the most impoverished regions in the County—which are also the areas with the highest concentrations of PLWH—heightening the serious health care problems experienced in those communities.<sup>16</sup> Incarceration destabilizes communities, disrupts family relationships, and magnifies the accumulation of health and social disadvantage for already marginalized populations. Incarceration is associated with harmful effects on viral suppression, lower CD4/T-cell counts, and accelerated disease progression.<sup>17,18</sup>

## **SOCIAL DETERMINANTS, CO-OCCURRING DISORDERS, AND THEIR INFLUENCE ON VIRAL SUPPRESSION**

### ***Housing/Homelessness***

With over 57,000 homeless persons on any given night, Los Angeles County is the homeless capital of the nation.<sup>19</sup> The most recent homeless count (2017) revealed a 23% increase in homelessness compared to two years ago.<sup>19</sup> Almost 75% of the homeless were unsheltered, living on the streets, or in their cars rather than staying at homeless shelters.<sup>19</sup> Nearly half (45%) of the homeless people were found in Hollywood, Downtown and South Los Angeles, areas with the highest rates of HIV/AIDS, poverty, and uninsured. Thirty percent of LAC's homeless were chronically homeless; 2% had HIV/AIDS; 18% had a substance abuse problem; 30% were mentally ill; 9% were children under 18; 8% were veterans; and 39% were survivors of domestic violence.<sup>19</sup> Of the 15,164 current RWP clients, 7.4% are homeless.<sup>20</sup>

### ***Mental Illness***

Mental illness can affect the progression of HIV disease, medication adherence, and the likelihood of engaging in high-risk behaviors that may result in HIV transmission.<sup>21</sup> It is estimated that approximately half of HIV-positive patients have major depressive symptoms and 20%–25% meet diagnostic criteria for a depressive disorder.<sup>22</sup> Approximately 19.6% of Medical Monitoring Project (MMP) respondents reported ever being diagnosed with a depressive disorder.<sup>23</sup> An estimated 9,587 PLWH in LAC are suffering from depression (MMP extrapolated to PLWH).<sup>23</sup> Because mental illness is highly prevalent among

PLWH in LAC, especially among vulnerable populations like substance users and the homeless, it requires investment in addition to the cost of HIV treatment.

### ***Substance Abuse***

The nexus between substance use and HIV in LAC centers on unsafe sex while under the influence of alcohol or other drugs is particularly acute in LAC. According to the MMP, it is estimated that 16.1% of PLWH in LAC are non-injection substance users.<sup>23</sup> Approximately 5.3% of PLWH in LAC are classified as having contracted HIV via injection drug use (IDU) and an additional 5.9% are classified as MSM/IDU, for a total of 11.2% of all PLWH.<sup>2</sup> Substance abuse interferes with both adherence to medication regimens and treatment efficacy. Injection drug users had the lowest HIV care engagement, retention and viral suppression rates compared to PLWH who acquired HIV through other transmission modes.<sup>2</sup> However, analysis of IDU alone does not characterize the impact of substance abuse on HIV infection in LAC. In LAC, aside from injecting illicit drugs, syringes are also shared by transgender individuals to administer steroids, vitamins, and hormones.

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

## **POLICY RECOMMENDATIONS**

- **Increase public and private health plan incentives for providers who achieve viral suppression among sub-populations with the lowest rates of suppression.**
- **Boost health care coverage enrollment.** Enrollment in health care coverage continues to lag for eligible single young men in California (compared to young single women) even after the implementation of the Affordable Care Act. The uninsured rate among single men ages 18-24 in California

dropped only slightly from 2012 through 2014, from 27.7 to 25.8 percent. The comparable uninsured rate for single women in the same age range dropped from 19.4 to 13.5 percent. Given that on-going access to health care is essential to viral suppression as well as PrEP uptake, resources need to be directed at increasing enrollment in health coverage, especially Medi-Cal, for at risk young women and men especially in communities of color.

- **Modify current policies that allow data sharing and eliminate barriers that prevent robust information exchange (e.g. County data sharing with agencies for re-engagement purposes)**
- **Mandate that all health plans under Department of Managed Health Care and Department of Insurance share de-identified data on viral load, retention, and PrEP with County health departments and the California Office of AIDS**
- **Enhance collaboration with County housing services to prioritize people living with HIV into housing.** Stable affordable housing is one of the most important interventions for PLWH to remain in care and achieve optimal health outcomes, and is a successful method to prevent new infections. A focus on access to housing and homeless services for people living with and at risk for HIV is a critical piece to ending the epidemic.

#### **WHAT RESOURCES ARE NEEDED TO SUPPORT THESE ACTIVITIES?**

DHSP will continue ongoing discussions with the Commission on HIV, public and private health plans, and other stakeholders to determine the identification and distribution of resources to optimize viral suppression.

#### **HOW ARE WE GOING TO MEASURE THIS?**

DHSP will partner with UCLA CHIPTS to develop reliable and uniform performance metrics across a range of local health systems, including surveillance data. DHSP and CHIPTS will also jointly enlist a panel of experts among our stakeholder partners to deliberate and refine these metrics.

#### **ONGOING COMMUNITY ENGAGEMENT AND CALL TO ACTION**

Much like how the Presidential Advisory Council on HIV/AIDS monitors and advises the federal government on the

**What happens when HIV is undetectable in a population?**  
**NO NEW INFECTIONS OCCUR!**  
**UNDETECTABLE=UNTRANSMITTABLE**

implementation of the National HIV/AIDS Strategy, the Commission will monitor and advise the Board of Supervisors on the implementation of the Los Angeles County HIV/AIDS Strategy. The success of LACHAS necessitates frequent and intentional communication and collaboration between the Commission and DHSP.

To facilitate a coordinated governmental response, DHSP will convene a LACHAS Interagency Working Group, which will be comprised of representatives of multiple government stakeholders at the state, County and city level. The Working Group will focus on developing individual and collaborative actions, both within and across government agencies.

In January 2018, DHSP and the Commission will jointly convene planners and stakeholders to identify a process for engaging stakeholders at the Health District level to begin the important work of bringing key stakeholders from Health Districts together to discuss ways to meet LACHAS goals and metrics at the Health District level. All LACHAS stakeholders should refer to the 26 Health District profiles supplied as a complement to this document, begin familiarizing themselves with the Health Districts in which they reside and/or undertake HIV efforts, and commit to engaging in joint DHSP/Commission activities related to this new planning process.

While we work to forge new relationships and re-commit ourselves to strengthening long-standing partnerships with health plans, health systems, academia, private corporations, philanthropic organizations, elected and non-elected officials, and other government institutions, we must share a commitment to openly and constructively outlining the issues that impede our shared progress. In anticipation of that, we seek continued

thoughtful review and feedback from our community partners and other stakeholders, including through the feedback mechanism built in to the LACounty.HIV website. We expect the LACHAS to steadily evolve as bright, dedicated people continue to bring their best thinking to the table for improvement of HIV services and the health outcomes of those living with or at risk for HIV.

As individuals and as a community far too long impacted by HIV disease, we are on the threshold of being able to make significant strides toward the day when we can truly say that we have ended the epidemic **once and for all**. We call on you to play your part in realizing the LACHAS goals, for it is only with the collective strength of a wide range of stakeholders, using this strategy as a vehicle and a vision, that we can be successful.

## TIMELINE

- **December 1, 2017** – LACHAS Launch Event
- **January to April 2018** – With the Commission on HIV, convene Health District work groups to identify key partners and champions, solidify specific target populations and benchmarks, and develop concrete plans for achieving the LACHAS goals
- **May 2018 and ongoing** – Health District work groups continue to meet quarterly to refine goals and provide updates on progress
- **January to July 2018** – Ongoing community input and engagement
- **December 1, 2018** – Progress Report
- **December 1, 2019** – Progress Report
- **December 1, 2020** – Progress Report
- **December 1, 2021** – Progress Report
- **December 1, 2022** – Progress Report

## I. REFERENCES

1. Centers for Disease Control and Prevention (CDC). (1981, June 5). Pneumocystis Pneumonia-Los Angeles. *Morbidity and Mortality Weekly Report*, 30(21), 250-252.
2. Division of HIV and STD Programs (DHSP). (2017). 2012-2016 HIV Surveillance data from eHARS. Unpublished provisional raw data.
3. Division of HIV and STD Programs (DHSP). (2015). 2015 HTS data from HIV Testing Services data system. Unpublished provisional raw data.
4. Herrick, A. L., Lim, S. H., Wei, C., Smith, H., Guadamuz, T., Friedman, M.S., & Stall, R. (2011). Resilience as an untapped resource in behavioral intervention design for gay men. *AIDS Behav.*, 15 (Suppl 1), S25-9. <http://doi:10.1007/s10461-011-9895-0>.
5. Division of HIV and STD Programs (DHSP). (2012). Listening sessions with young gay Men of color. Unpublished data.
6. Diaz, R. M., Ayala, G., Bein, E., Henne, J., & Marin, B. V. (2001). The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: findings from 3 US cities. *Am J Public Health*, 91(6), 927–32.
7. Department of Health and Human Services, Office of Adolescent Health. (2012). *LGB Youth : Challenges , risks and protective factors*. Retrieved from [http://www.hhs.gov/ash/oah/oahinitiatives/teen\\_pregnancy/training\\_tip\\_sheets/lgb-youth-508.pdf](http://www.hhs.gov/ash/oah/oahinitiatives/teen_pregnancy/training_tip_sheets/lgb-youth-508.pdf).
8. United States Census Bureau. American Community Survey (ACS). (2011). Retrieved from <https://www.census.gov/programs-surveys/acs/>.
9. Rock Wohl, A., Galvan, F. H., Myers, H. F., Garland, W., George, S., Witt, M., Cadden, J., ...Lee, M. L. (2011). Do social support, stress, disclosure and stigma influence retention in HIV care for Latino and African American men who have sex with men and women? *AIDS and Behavior*, 15(6), 1098-1110.
10. Forney, J. C. & Miller, R. L. (2012). Risk and protective factors related to HIV-risk behavior: a comparison between HIV-positive and HIV-negative young men who have sex with men. *AIDS Care*, 24(5), 544–52. <https://doi:10.1080/09540121.2011.630341>.
11. Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009) Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1),346–52. <https://doi:10.1542/peds.2007-3524>.
12. Leibowitz, A. A., Garcia-Aguilar, A. T., & Farrell, K. (2015). Initial health assessments and HIV screening under the Affordable Care Act. *PLoS one*, 10(9), e0139361.
13. United States Census Bureau, American Community Survey, 1-Year Estimates. Retrieved from [https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_15\\_5YR\\_S1703&prodType=table](https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_5YR_S1703&prodType=table)
14. U.S. Census Bureau, American Community Survey, 1-Year Estimates 2008; Poverty rate is determined by the HHS (Health and Human Services Poverty Guidelines). Retrieved from <https://aspe.hhs.gov/2015-poverty-guidelines>.
15. California Sentencing Institute. (2017). All counties Los Angeles County state prison population 2015. Retrieved from <http://casi.cjcj.org/Adult/Los-Angeles>.
16. Division of HIV and STD Programs (DHSP). (2016). Comprehensive HIV Plan (2017-2021), Retrieved from <http://publichealth.lacounty.gov/dhsp/>.
17. Springer, S. A., Friedland, G. H., Doros, G., Pesanti, E., & Altice, F. L. (2007). Antiretroviral treatment regimen outcomes among HIV-positive prisoners. *HIV Clin. Trials*, 8(4),205-212.
18. Stephenson, B. L., Wohl, D. A., Golin, C. E., Tien, H. C., Stewart, P., & Kaplan, A. H. (2005). Effect of release from prison and re-incarceration on the viral loads of HIV-infected individuals. *Public Health Report*, 120(1), 84-88.
19. Los Angeles Homeless Services Authority. (2017). The Greater Los Angeles Homeless Count, 2017. Retrieved from <https://www.lahsa.org/homelesscount/>
20. Division of HIV and STD Programs (DHSP). (2017). Provisional 2016 Ryan White Casewatch Data. Unpublished provisional raw data.
21. Flaming, D., Burns, P., & Matsunaga, M. (2009). Where we sleep costs when homeless and housed in Los Angeles 2009. Retrieved from [https://economicrct.org/wp-content/uploads/2009/11/Where\\_We\\_Sleep\\_2009.pdf](https://economicrct.org/wp-content/uploads/2009/11/Where_We_Sleep_2009.pdf)
22. Pence, B. W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/ AIDS. *J. Antimicrob. Chemother*, 63(4), 636-640.
23. Division of HIV and STD Programs (DHSP). (2017) Medical Monitoring Project, 2013-2014. Unpublished provisional data.



**DO YOUR PART:  
SPREAD THE WORD  
ABOUT LACHAS!**

---

## Acknowledgements

---

The Division of HIV and STD Programs (DHSP) would like to thank the following people for their many contributions to the Los Angeles County HIV/AIDS Strategy (LACHAS), from the earliest planning stages to the release of the strategy.

**County of Los Angeles Board of Supervisors:**

Hilda L. Solis, *First District*  
Mark Ridley-Thomas, *Chairman, Second District*  
Sheila Kuehl, *Chair Pro Tem, Third District*  
Janice Hahn, *Fourth District*  
Kathryn Barger, *Fifth District*

**DHSP staff:**

Mario J. Pérez  
Kyle Baker  
Maria Orozco  
  
Wendy Garland  
Michael Green  
Mike Janson  
Sonali Kulkarni  
Leo Moore  
And the rest of the DHSP Senior Management Team  
  
Katie Branson  
Janice Casil  
Juli-Ann Carlos Henderson  
Pamela Ogata  
Zhijuan Sheng

**Department of Public Health:**

Dr. Barbara Ferrer  
Dr. Jeffrey Gunzenhauser

**LACHAS Community Co-chairs:**

Grissel Granados  
Terry Smith

**Los Angeles County Commission on HIV:**

Cheryl Barrit  
Brad Land  
Ricky Rosales  
HIV Commissioners

**Community Stakeholders and Other Partners:**

René Bennet  
Phil Curtis  
Aaron Fox  
Katja Nelson  
Craig Pulsipher  
UCLA CHIPTS

Special thanks to Hershey Cause Communications and KCBS.

Thanks in advance to all future partners and stakeholders who will help implement this strategy over the next five years and make it a success.

# Los Angeles County HIV/AIDS Strategy for 2020 and Beyond

## EPIDEMIOLOGICAL OVERVIEW DEMOGRAPHIC TABLES

Appendix A

Table 1: AIDS Prevalence and HIV (Non-AIDS) prevalence Data By Demographic Group and Exposure Category

Demographic Group/Exposure Category	2014 <sup>(1)</sup>				2015 <sup>(2)</sup>				2016 <sup>(3)</sup>			
	HIV		AIDS		HIV		AIDS		HIV		AIDS	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<b>Race/Ethnicity</b>												
White	7,175	32.4	8,635	30.5	7,247	31.6	8,362	29.9	7,138	30.6	7,999	29.2
African American	4,637	21.0	5,612	19.8	4,825	21.1	5,555	19.8	4,990	21.4	5,458	19.9
Latino	8,785	39.7	12,451	44.0	9,262	40.4	12,460	44.5	9,613	41.2	12,369	45.1
Asian/PI	846	3.8	857	3.0	890	3.9	869	3.1	932	4.0	867	3.2
Native American	153	<1	158	<1	154	<1	161	<1	150	<1	156	<1
Multi-race	510	2.3	578	2.0	519	2.3	583	2.1	514	2.2	576	2.1
Unknown/Unspecified	13	<1	<5	<1	14	<1	<5	<1	16	<1	<5	<1
<b>Gender</b>												
Male	19,158	86.6	24,887	88.0	19,689	86.7	24,581	87.8	20,274	86.8	24,039	87.6
Female	2,607	11.8	3,032	10.7	2,668	11.7	3,034	10.8	2,701	11.6	3,006	11.0
Transgender	354	1.6	375	1.3	374	1.6	378	1.4	378	1.6	383	1.4
<b>Current Age</b>												
<18 years	76	<1	18	<1	71	<1	14	<1	56	<1	15	<1
18 - 29 years	3,710	16.8	1,047	3.7	3,789	16.5	954	3.4	3,718	15.9	855	3.1
30 - 39 years	5,777	26.1	3,615	12.8	6,021	26.3	3,488	12.5	6,220	26.6	3,361	12.3
40 - 49 years	6,118	27.7	8,725	30.8	6,020	26.3	7,916	28.3	5,976	25.6	7,093	25.9
50 - 59 years	4,648	21.0	10,302	36.4	5,004	21.8	10,553	37.7	5,154	22.1	10,521	38.4
60+ years	1,790	8.1	4,587	16.2	2,006	8.8	5,068	18.1	2,229	9.5	5,583	20.4
<b>Exposure Category</b>												
MSM	17,776	80.4	21,125	74.7	18,518	80.8	20,923	74.7	18,972	81.2	20,547	74.9
Injection Drug Use	882	4.0	1,836	6.5	907	4.0	1,798	6.4	923	4.0	1,742	6.4
MSM-IDU	1,033	4.7	2,140	7.6	1,009	4.4	2,079	7.4	963	4.1	1,984	7.2
Heterosexual	2,265	10.2	2,938	10.4	2,310	10.1	2,941	10.5	2,337	10.0	2,903	10.6
Other Blood-borne	22	<1	104	<1	21	<1	100	<1	20	<1	101	<1
Maternal HIV Risk	97	<1	137	<1	103	<1	141	<1	98	<1	136	<1
Pediatric	30	<1	5	<1	27	<1	<5	<1	23	<1	6	<1
Other/Unknown	14	<1	9	<1	16	<1	8	<1	17	<1	9	<1
<b>TOTAL</b>	<b>22,119</b>		<b>28,294</b>		<b>22,911</b>		<b>27,993</b>		<b>23,353</b>		<b>27,428</b>	

Data Sources: <sup>(1)</sup> 2014 HIV Surveillance Report. <sup>(2)</sup> 2015 HIV Surveillance Report. <sup>(3)</sup> eHARS HIV Surveillance Data ran on 9/25/2017. Data Note: Column percentages may not add to 100 due to rounding or missing data

**Table 2: 2015 New Positive Tests, Newly Diagnosed Persons Living with HIV in 2016, and 2016 HIV Prevalence by Demographic Characteristics**

Demographic Characteristics	General Population <sup>(1)</sup>		HIV New-Positive Tests <sup>(2)</sup>	Newly Diagnosed PLWH <sup>(3)</sup>			PLWH <sup>(4)</sup>		
	Number	%	%	Number	%	Rate <sup>(5)</sup>	Number	%	Rate <sup>(5)</sup>
	10,227,450	100%	1.1%	1,881	100%	18	48,911	100%	478
<b>Race/Ethnicity</b>									
African American	865,330	8.5%	1.4%	485	25.8%	56	9,962	20.4%	1,151
Latino	4,987,274	48.8%	1.1%	888	47.2%	18	21,095	43.1%	423
Asian/Pacific Islander	1,488,107	14.6%	0.9%	87	4.6%	6	1,710	3.5%	115
American Indian/Alaskan Native	19,200	<1%	1.8%	12	<1%	63	294	<1%	1,531
White	2,867,539	28.0%	0.9%	367	19.5%	13	14,778	30.2%	515
Multi-Racial/Unknown	----	----	1.3%	42	2.2%	----	1,072	2.2%	----
<b>Gender/Gender Identity</b>									
Male	5,048,390	49.4%	1.4%	1,658	88.1%	34	42,665	87.2%	845
Female	5,179,060	50.6%	0.3%	188	10.0%	4	5,519	11.3%	107
Transgender	N/A	N/A	2.4%	35	1.9%	----	727	1.5%	----
<b>Age</b>									
<18	2,303,782	22.5%	0%	12	<1%	1	80	<1%	3
18-29	1,834,934	17.9%	1.4%	727	38.6%	40	4,627	9.5%	252
30-39	1,477,828	14.4%	1.1%	541	28.8%	37	9,191	18.8%	622
40-49	1,409,996	13.8%	1.3%	351	18.7%	25	13,408	27.4%	951
50-59	1,340,720	13.1%	1.3%	205	10.9%	15	14,848	30.4%	1,107
>=60	1,860,190	18.2%	0.7%	45	2.4%	2	6,757	13.8%	363
<b>Service Planning Area (SPA)</b>									
SPA 1: Antelope Valley	392,410	3.8%	0.4%	37	2.0%	8	504	1.0%	128
SPA 2: San Fernando Valley	2,239,081	21.9%	0.8%	272	14.5%	12	4,956	10.1%	221
SPA 3: San Gabriel	1,786,640	17.5%	0.9%	161	8.6%	9	2,588	5.3%	145
SPA 4: Metro	1,182,534	11.6%	1.7%	539	28.7%	52	13,104	26.8%	1,108
SPA 5: West	663,935	6.5%	0.9%	56	3.0%	13	1,841	3.8%	277
SPA 6: South	1,068,960	10.5%	1.6%	318	16.9%	29	4,186	8.6%	392
SPA 7: East	1,312,015	12.8%	1.9%	165	8.8%	12	2,507	5.1%	191
SPA 8: South Bay	1,580,939	15.5%	1.1%	252	13.4%	16	5,426	11.1%	343

Data Notes and Sources: Column percentages may not add to 100 due to rounding or missing data .

<sup>(1)</sup> 2016 population estimates provided by LAC Internal Services Department and contracted through Hedderson Demographic Services. <sup>(2)</sup> DHSP HIV Testing Services (HTS) Database. Data ran on 9/1/2016.

<sup>(3)</sup> eHARS Surveillance Data ran on 9/25/2017. Based on new diagnoses in 2015 and living in EMA as of 12/31/2016. <sup>(4)</sup> eHARS Surveillance Data ran on 9/25/2017. Based on persons living in EMA as of 12/31/2016. <sup>(5)</sup> eHARS Surveillance Data as of 9/28/2016. <sup>(6)</sup> Rate per 100,000 population

**Table 3: HIV New Diagnoses and PLWH 2012-2016**

	2012	2013	2014	2015	2016 <sup>(3)</sup>
<b>New HIV Positive Tests (Positivity Rate)<sup>(1)</sup></b>	1.03%	0.78%	1.06%	1.11%	----
<b>New HIV Diagnoses<sup>(2)</sup></b>	2,023	1,788	2,057	1,952	1,881
<b>Number of Persons Living with HIV (any stage)<sup>(2)</sup></b>	45,146	47,048	48,022	48,825	48,911
<b>Viral Suppression</b>	55.8%	58.8%	60.1%	60.8%	60.3%

Data Sources: <sup>(1)</sup> HIV Testing, HTS Summary Reports. <sup>(2)</sup> eHARS Surveillance Data as of 9/25/17. <sup>(3)</sup> 2016 HTS data are not available

Table 4: EIIHA Data for all HIV Tests conducted for Three Target Populations in Los Angeles County (January 1, 2015 to December 31, 2015)

	Overall	Latino & African American MSM	Young MSM (18-29)	Transgender Individuals
<b>a. TOTAL HIV TEST EVENTS</b>	<b>155,625</b>	<b>19,174</b>	<b>16,219</b>	<b>1,852</b>
<b>b. Newly Diagnosed Positive HIV Test Events<sup>(1)</sup></b>	<b>1,661</b>	<b>484</b>	<b>315</b>	<b>44</b>
c. Newly diagnosed positive test events with client linked to HIV medical care	1,137	332	240	27
d. Newly diagnosed confirmed positive test events <sup>(1)</sup>	1,404	434	285	36
e. Newly diagnosed confirmed positive test events with client interviewed for partner services	1,270	426	278	35
f. Newly diagnosed confirmed positive test events with client referred to prevention services	489	161	119	17
g. Newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing <sup>(1)</sup>	1,170	382	245	<5
<b>a. Previously Diagnosed Positive HIV Test Events<sup>(1)</sup></b>	<b>309</b>	<b>39</b>	<b>8</b>	<b>13</b>
b. Previously diagnosed Positive HIV Test Events with client re-engaged in HIV medical care	205	25	8	<5
c. Previously diagnosed confirmed positive test events	218	27	8	7
d. Previously diagnosed confirmed positive test events with client interviewed for Partner Services	188	26	8	5
e. Previously diagnosed confirmed positive test events with client referred to Prevention Services	46	12	6	<5
f. Previously diagnosed confirmed positive test events who received CD4 cell count and viral load testing <sup>(2)</sup>	201	24	8	<5

(1) CDC definitions were used for this data (2) Data are provisional given time required to do surveillance match

Data Source: DHSP HIV Testing Services (HTS) System as of 6/24/2016 for overall and as of 10/3/2016 for positive data

Table 5: 2016 HIV Care Continuum Outcomes by Demographic Characteristics among PLWH in Los Angeles County

Demographic Characteristics	Diagnosed/Living with HIV (N)	Linked to Care ≤30 days	Engaged in Care	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
<b>Race/Ethnicity</b>						
African American	9,962	54.2%	65.9%	49.7%	50.3%	53.0%
Latino	21,095	65.4%	68.3%	55.7%	44.3%	59.7%
Asian/Pacific Islander	1,710	80.5%	74.6%	60.5%	39.5%	68.5%
American Indian/Alaskan Native	294	75.0%	70.1%	54.1%	45.9%	52.4%
White	14,778	75.2%	71.6%	54.5%	45.5%	64.9%
<b>Gender/Gender Identity</b>						
Male	42,665	66.4%	69.6%	54.4%	45.6%	60.8%
Female	5,519	55.9%	66.9%	53.5%	46.5%	56.6%
Transgender	727	68.6%	68.4%	56.8%	43.2%	53.8%
<b>Age</b>						
<18	80	75%	86.3%	76.3%	23.7%	80.0%
18-29	4,627	69.9%	69.1%	49.1%	50.9%	54.1%
30-39	9,191	66.7%	67.3%	49.8%	50.2%	55.8%
40-49	13,408	58.1%	68.3%	53.1%	46.9%	59.2%
50-59	14,848	55.1%	71.1%	57.1%	42.9%	63.9%
60+	6,757	77.8%	70.2%	60.2%	39.8%	64.6%
<b>Transmission Categories</b>						
Injection Drug Use	2,582	58.7%	60.7%	46.9%	53.1%	49.3%
MSM-IDU	2,897	55.3%	70.6%	54.9%	45.1%	55.4%
Heterosexual	5,084	54.0%	66.5%	54.2%	45.8%	57.7%
<b>Service Planning Area</b>						
SPA 1: Antelope Valley	504	64.9%	65.9%	49.0%	51.0%	55.6%
SPA 2: San Fernando Valley	4,956	76.1%	72.9%	66.5%	33.5%	66.5%
SPA 3: San Gabriel	2,588	72.7%	73.8%	66.2%	33.8%	66.2%
SPA 4: Metro	13,104	62.5%	64.4%	57.1%	42.9%	57.1%
SPA 5: West	1,841	82.1%	70.9%	65.3%	34.7%	65.3%
SPA 6: South	4,186	57.5%	68.8%	56.8%	43.2%	56.8%
SPA 7: West	2,507	69.1%	71.6%	64.1%	35.9%	64.1%
SPA 8: South Bay	5,426	65.1%	68.6%	60.4%	39.6%	60.4%

Current Unmet Need=Not engaged in care or not having a lab test or medical visit in the past 12 months. (2) New Unmet Need=100%-Retained in Care. Data Source: eHARS surveillance data as of 9/25/2017 Column percentages may not add to 100 due to rounding or missing data.

Table 6: Ryan White-funded Services: Socioeconomic Data, 2016 (n=15,164)

Characteristic	Overall		≤ Federal Poverty Level		Homeless		No Insurance		Incarcerated ≤ 24 mo.	
	n	%	n	%	n	%	n	%	n	%
<b>Total</b>	15,164	100%	9,730	64.2%	1,123	7.4%	6,632	43.7%	1,437	9.5%
<b>Race/Ethnicity</b>										
African American	3,281	21.6%	2,424	24.9%	422	37.6%	717	10.8%	610	42.4%
Latino	8,151	53.8%	5,349	55.0%	405	36.1%	4,870	73.4%	497	34.6%
Asian/Pacific Islander	551	3.6%	305	3.1%	27	2.4%	266	4.0%	24	1.7%
White	3,138	20.7%	1,618	16.6%	258	23.0%	771	11.6%	295	20.5%
American Indian/Alaskan Native	34	<1%	27	<1%	9	<1%	7	<1%	10	<1%
<b>Gender Identity</b>										
Male	12,962	85.5%	7,957	81.8%	943	84.0%	5,681	85.7%	1,267	88.2%
Female	1,893	12.5%	1,533	15.7%	138	12.3%	803	12.1%	120	8.3%
Transgender	309	2.0%	240	2.5%	42	3.7%	148	2.2%	50	3.5%
<b>Transmission Category</b>										
<b>MSM</b>	10,479	69.1%	6,161	63.3%	704	62.7%	4,621	69.7%	862	60.0%
African American	1,931	18.4%	1,328	21.6%	250	35.5%	433	9.4%	317	36.8%
Latino	5,623	53.7%	3,451	56.0%	253	35.9%	3,354	72.6%	335	38.9%
White	2,500	23.9%	1,170	19.0%	175	24.9%	630	13.6%	185	21.5%

Data Source: HIV Casewatch as of 10/25/2017. Column percentages may not add to 100 due to rounding or missing data.

Table 7: 2016 HIV Care Continuum Outcomes by Demographic Characteristics among RW Clients in Los Angeles County (N=15,164)

Demographic Characteristics	Diagnosed/Living with HIV (N)	Linked to Care ≤30 days	Retained in Care	New Unmet Need (Not Retained)	Virally Suppressed
<b>Race/Ethnicity</b>					
African American	3,281	92.6%	80.1%	19.9%	74.0%
Latino	8,151	86.0%	88.2%	11.8%	83.3%
Asian/Pacific Islander	551	91.0%	86.9%	13.1%	87.6%
American Indian/Alaskan Native	34	92.3%	84.6%	15.4%	57.7%
White	3,138	92.8%	82.6%	17.4%	79.6%
<b>Gender/Gender Identity</b>					
Male	12,962	89.3%	81.3%	18.7%	78.5%
Female	1,893	86.9%	82.8%	17.2%	78.6%
Transgender	309	79.0%	81.6%	18.4%	73.5%
<b>Age</b>					
<18	8	75.0%	75.0%	25.0%	75.0%
18-29	1,522	86.9%	68.9%	31.1%	66.2%
30-39	3,263	86.5%	78.2%	21.8%	75.0%
40-49	3,959	87.3%	83.3%	16.7%	78.7%
50-59	4,338	91.1%	85.0%	15.0%	81.7%
60+	2,074	91.8%	85.5%	14.5%	85.7%
<b>Transmission Categories</b>					
MSM	10,091	89.5%	82.0%	18.0%	79.6%
Injection Drug Use	380	92.9%	78.2%	21.8%	71.3%
MSM-IDU	388	92.3%	78.1%	21.9%	65.5%
Heterosexual	3,547	87.1%	84.4%	15.6%	80.5%
<b>Service Planning Area</b>					
SPA 1: Antelope Valley	209	96.2%	76.6%	23.4%	71.8%
SPA 2: San Fernando Valley	2,384	88.3%	82.9%	17.1%	79.2%
SPA 3: San Gabriel	842	91.2%	87.1%	12.9%	85.5%
SPA 4: Metro	7,731	88.8%	80.9%	19.1%	77.2%
SPA 5: West	809	90.6%	78.1%	21.9%	81.5%
SPA 6: South	1,147	88.9%	82.6%	17.4%	77.4%
SPA 7: West	563	87.2%	77.1%	22.9%	77.4%
SPA 8: South Bay	1,474	86.3%	82.4%	17.6%	80.3%

Data Source: HIV Casewatch as of 10/25/2017. Column percentages may not add to 100 due to rounding or missing data.

Visit [LACounty.hiv](http://LACounty.hiv) for more information.

