COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

MEGAN McCLAIRE, M.S.P.H.
Chief Deputy Director

RITA SINGHAL, M.D., M.P.H.
Director, Disease Control Bureau

313 North Figueroa Street, Suite 227
Los Angeles, California 90012
TEL (213) 989-7269 • FAX (213) 481-9853

www.publichealth.lacounty.gov

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April 1, 2022

TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

SUBJECT: **ADDRESSING THE STD CRISIS IN LOS ANGELES COUNTY (ITEM 14, BOARD AGENDA OF SEPTEMBER 28, 2021)**

This is in response to your September 28, 2021 motion directing the Department of Public Health (Public Health), in collaboration with the Department of Health Services (DHS), Department of Mental Health (DMH), the Alliance for Health Integration (AHI), and the Chief Executive Office's (CEO) Anti-Racism, Diversity and Inclusion Initiative (ARDI), to report back within 120 days with an updated plan of action to address this crisis, incorporating progress and ongoing challenges outlined in the quarterly STD reports and progress to date on goals included in the Center for Health Equity's (CHE) STD focus area.

Background

Los Angeles (LA) County is experiencing the highest ever annual reported cases of syphilis, congenital syphilis, gonorrhea, and chlamydia. This trend is consistent with the rise in STD rates that have been reported over the last decade across the United States, many parts of California and LA County. Among the most troubling trends in LA County are the increases in syphilis and congenital syphilis. As noted in your Board's September 28, 2021, motion, there has been a 450% increase in syphilis rates among females and a 235% increase in males in the last decade. Congenital syphilis rates have increased by more than 1100% in less than a decade, with 122 congenital syphilis cases reported county-wide in 2020 (9 cases reported by the Long Beach Department of Health and Human Services and 113 cases reported in the rest of the County) compared to 88 in 2019, and just 10 in 2010.

Appendix A reports the STD morbidity in LA County over the last 10 years in more detail, with a focus on geographic areas and historically disproportionately impacted subpopulations, including African American persons, Latinx women and newborns.

It is important to note that social inequities (beyond those impacting health care access and quality), including but not limited to economic stability, education access and quality, neighborhood safety and built environment, and social and community factors, have influenced the rise in STDs over the last decade. These factors have contributed to sharper increases in morbidity more recently, including among women of color, pregnant women, newborns, persons who inject drugs and persons experiencing methamphetamine use disorder.

A comprehensive STD prevention and control response must acknowledge and address these determinants in greater depth alongside the broad set of sectors that influence and shape them.

Since 2018, Public Health has consistently provided STD updates to your Board through the Quarterly STD Reporting process. Reports over the last two years have noted: 1) the significant impact COVID-19 and associated safety concerns among individuals and service providers have had on local STD control efforts including service disruptions and suspensions, 2) staff redirection to COVID-19 response efforts, 3) troubling increases in morbidity among specific sub-populations, and 4) changes in federal or State support for STD control efforts.

However, the year-to-year increases in STD morbidity that we have consistently reported to your Board long pre-date the arrival of COVID-19. In fact, many of the upward trends we experience today began a decade or more ago. Unlike the historic domestic response to HIV/AIDS or the recent national response to COVID-19, the STD crisis has not had the benefit of 1) year-to-year increases in federal or state appropriations commensurate with the increase in morbidity, 2) large new investments of federal funds made available as part of the launch of new national strategies or initiatives (e.g., National HIV/AID Strategy (NHAS) in 2010, Updated NHAS in 2015, and the Ending the HIV Epidemic Initiative in 2019), 3) disease elimination efforts with longevity (the Centers for Disease Control and Prevention [CDC]'s 2008 Syphilis Elimination Program only lasted two years before funding was suspended in the midst of the recession), and 4) infusion of resources to undergird more than one part of the STD control efforts (the 2020 CDC Disease Intervention Specialist (DIS) Infrastructure funds made available through federal STD grants with States and Counties/Cities are intended to enhance only disease investigation areas while resources to support other core STD control infrastructure areas (e.g., surveillance, testing technology, social marketing, provider detailing) remain elusive).

As part of the national COVID-19 response, we witnessed an unprecedented marshalling of public and human resources to combat the pandemic. Key areas of COVID-19 response infrastructure building have been tied to surveillance and epidemiology (including, but not limited to enhanced tools, enhanced geo-mapping and publicly reported daily updates tied to hospitalizations, positivity rates, R_0 calculations, deaths, vaccination patterns, outbreak events), the rapid development and use of new COVID-19 testing technology (PCR, antigen, laboratory, rapid, home testing), the significant expansion of contact tracing, public information campaigns and different testing modalities and policies (e.g., PODS, clinic-based testing, school-based testing, testing mandates, public service announcements, and media advertisements.)

As we explore the critical elements of an enhanced STD control effort for our vast, diverse, and populous County, a newly adopted STD 2.0 model must clearly align with the sustained national HIV response and the COVID-19 1.0 model we have witnessed over the last two years if we are to make deliberate and sustained progress against this sexual health crisis that has deeply

rooted patterns of inequity and stigma, contributes to infertility, and is increasingly leading to infant mortality.

I. Analysis of all existing funding streams, including federal, state, and local resources currently utilized or available for STD response

The largest payors of sexual health and STD related services are public (e.g., Medi-Cal, L.A Care) and commercial health plans (e.g., Kaiser Permanente, HealthNet) that cover millions of residents in LA County as part of largely employer-based HMO and PPO arrangements. This line of services may include treatment of genital herpes (a viral infection and the most common STD) and screening, diagnosis, treatment services for the most common bacterial STDs (syphilis, gonorrhea, and chlamydia), human papilloma virus vaccination services, and treatment of other less common infections. The frequency and comprehensiveness of these screening, treatment, and vaccination services varies considerably across health plans and across sub-populations.

As a complement to STD services delivered by a person's health plan-based primary medical home, there is a vast and diverse set of additional partners who, like public and commercial health plans, deliver services with significant levels of variability. These include:

- Federally Qualified Health Centers (FQHCs) and Community Health Centers that provide services to low-income residents throughout LA County;
- Health care providers that provide sexual health services to persons seeking family planning services financed by California's Family PACT program;
- Public Health's Public Health Clinics;
- DHS-operated ambulatory care, comprehensive health center and hospital-based clinics;
- Ryan White Program-supported providers that deliver services to persons living with HIV;
- Community-based specialty STD providers that provide low-barrier walk-in STD screening, diagnosis, and treatment services;
- Jail-based STD services delivered by DHS and Public Health;
- Street medicine and mobile testing unit-based STD services to persons experiencing homelessness;
- School-based Wellness Centers that provide access to screening, diagnosis, and treatment services for gonorrhea and chlamydia.

Services delivered across these partners vary by volume, by the proportion of clients who need and actually receive the services, by comprehensiveness (e.g., screening for genital gonorrhea only when genital, rectal and pharyngeal screening is the expected practice), by capacity and level of completeness to diagnose and treat (e.g., some providers are able to diagnose chlamydia and gonorrhea but not syphilis or some are able to diagnose syphilis but not treat syphilis due to Bicillin not being on hand).

In most of these instances, Public Health is not involved in the financing of these services nor is Public Health able to easily influence their responsiveness, completeness, or accessibility. In areas where we do have a financial role, we are more easily able to influence these factors (e.g., ensuring that all Ryan White Program eligible clients are screened for syphilis annually). As part of our shared STD control priorities outlined in this report, Public Health will seek to align

the efforts of the networks of providers mentioned above, create and support efforts to monitor performance, and ultimately improve the adoption of evidence-based and best practices to control STDs until they become routine.

Public Health understands that not all persons diagnosed with or at risk for STDs access sexual health services through a health plan, in their medical home, or through a County-operated health care provider. In these instances, it is crucial for Public Health to support models of care and interventions targeted to sub-populations at elevated risk for STDs or poor STD-related health outcomes in alternate service delivery sites that best meet community needs.

These efforts rely on categorical STD program funding to enhance the reach and improve the effectiveness of these highly targeted interventions. The table below offers a summary of the categorical funding streams managed by Public Health that are designed to complement STD control efforts supported by Health Plans, public programs like California's FPACT program, or federally supported health centers. Increasingly, these funds are used to support syphilis and congenital syphilis control efforts (versus gonorrhea and chlamydia focused services) and the funding levels are outpaced by the scope of the problem.

Table 1: Summary of Current STD Control Resources Managed by Public Health

Source	Grant Name/ Funding Source	Term	Annual Amount	Target or Focus Areas
Federal (CDC)	Strengthening STD Prevention and Control for Health Departments (PCHD)	January 1, 2022 – December 31, 2022	$3,371,049	Support health department-based STD services
Federal (CDC)	Gonococcal Isolate Surveillance Project (GISP)	January 1, 2022 – December 31, 2022	$15,000	Lab support to detect levels of gonococcal resistance to antibiotics
State (CDPH)	California STD Control Branch – Core STD Program Management	July 1, 2021 – June 30, 2022	$547,050	Personnel, Training, Patient Delivered Partner Therapy, Education, Essential Access Health (EAH)
State (CDPH)	California STD Control Branch – STD Management and Collaboration	July 1, 2021 – June 30, 2022	$497,400	Rapid Tests Kits, STD SDTS Contracts, STD Casewatch, Condoms
County DPH (DHSP)	STD Net County Cost	July 1, 2021 – June 30, 2022	$9,800,000	Personnel, service contracts
County DPH (SAPC)	Federal Substance Abuse Block Grant	July 1, 2021 – June 30, 2022	$9,150,000	School-based Wellness Centers
Resources with Partial STD Focus				
Federal (CDC)	CDC Disease Investigation Specialist (DIS) Infrastructure for COVID, HIV, STD, TB, and Hepatitis (via PCHD Grant)	January 1, 2021 – December 31, 2022	TBD (STD-related investment out of $6,598,516 total)	DIS, Training, Mapping, Evaluation
County DPH (Clinic Services)	Net County Cost	July 1, 2021 – June 30, 2022	$25,300,000 (STD-related investment out of $63,250,000)	Public Health STD Clinic Services

II. Establishing a planning process to ensure coordination of efforts

Consistent with the spirit and instructions in your Board's motion, Public Health convened several workgroups and facilitated several topic-specific meetings with a wide range of County leaders, service providers, subject matter experts, policy partners, academic partners, community planners and other stakeholders to guide, inform and develop this report. The groups convened and meetings held are described below:

Internal LA County STD Workgroup
This group included representatives from DHS, Public Health, DMH, AHI, ARDI and CEO Legislative Affairs and Intergovernmental Relations (CEO-LAIR). The workgroup Executive Sponsors were Dr. Barbara Ferrer (Director of Public Health) and Dr. Muntu Davis (County Health Officer) and the workgroup Champions were Dr. Rita Singhal (Director of Public Health's Disease Control Bureau), Dr. Deborah Allen (Director of Public Health's Health Promotion Bureau), Dr. Paul Giboney (Associate Chief Medical Officer of DHS), and Jaclyn Baucum (Executive Director of AHI.) Please see Appendix B1 for full roster of this workgroup and please see below for key recommendations from this workgroup.

Key Recommendations:
The workgroup recommended a range of focus areas and goals that should be considered as LA County evolves its response to the STD crisis:

- Differentiate between STD progress and STD elimination; initial goal should be to flatten the curves
- Focus on congenital syphilis and perinatal HIV transmission
- Identify interim and long-term goals and benchmarks and convene a Metrics and Milestone sub-workgroup
- Identify clinical practices as an area of focus (e.g., syphilis screening during pregnancy)
- Describe intersecting program areas and strategies to ensure that we are maximizing opportunities
- Ensure broader access to Bicillin for syphilis treatment and Expedited Partner Therapy (EPT) to expand gonorrhea and chlamydia treatment
- Review and address the intersection between STDs and racism
- Review how we are collecting data and measuring progress

Internal/External STD Policy Workgroup
This workgroup was made up of representatives from within and outside of the County and informed the recommendations related to STD budget and policy proposals tied to this report. Please see Appendix B2 for full roster of this workgroup and please see below for key recommendations from this workgroup.

Key Recommendations:
In lieu of creating and promoting new policies, the workgroup agreed to focus policy-related efforts on ensuring compliance with existing program guidelines, policies, and performance expectations. The workgroup members recommended potential areas for measuring compliance levels and exploring consequence cycles for low performance.

Examples included:

- 1st and 3rd Trimester Syphilis Screening of Pregnant Persons: California has signaled that 1st and 3rd trimester syphilis screening is needed to reduce the incidence of congenital syphilis but there is not a statewide systematic mechanism to measure compliance, nor is there a clear consequence if screening rates remain low. We need policy solutions to address these gaps.
- Physician/Pharmacist Engagement: Physicians and pharmacists are key to advancing STD control efforts. We need strategies to compel their full and consistent participation in STD control efforts.
- EPT Uptake: Uptake of EPT has been slow and, despite liability protections, providers are still reluctant to prescribe EPT. There is a need to more broadly communicate the liability protections for clinicians who facilitate access to EPT, and incentives are needed to enlist more EPT clinical and pharmacy partners.

STD Metrics and Milestones Workgroup
This workgroup was made up of representative from within the County and helped inform the selection of shared performance metrics that are recommended in this report. Please see Appendix B3 for full roster of this workgroup and please see below for key recommendations from this workgroup.

Key Recommendations:
The workgroup recommended that we focus on a small number of discreet measures that are both easily quantifiable and universally shared and adopted by all STD control partners. The workgroup reviewed the fourteen metrics identified in the Federal STI Strategic Plan and agreed that we should first focus on the four following areas:

- Reduce the rate of primary and second syphilis
- Reduce the rate of congenital syphilis
- Reduce primary and secondary syphilis among men who have sex with men (MSM)
- Reduce the rate of Gonorrhea among African-Americans

Developing a New Publicly Facing STD Dashboard
Public Health also convened experts to inform the refinement of the publicly facing STD Dashboard developed by Public Health's Division of HIV and STD Programs (DHSP). As part of this exercise, leaders from Public Health, its Bureau of Disease Control, the Office of Health Assessment and Epidemiology, the Quality Improvement & Accreditation Program, and ARDI informed the refinement of this new tool.

Key Recommendations:

- Discuss and identify the best way to frame the relationship between substance use disorder (SUD) issues and STD rates when mapping and presenting data.
- Explore opportunities to incorporate additional tools in future iterations of the dashboard to optimize the functionality including Equity Explorer, features of the Clear Impact Scorecard and Story Mapping Technology.
- Enlist County Department leaders to arrange for postings of links to the dashboard from their Departmental websites when it is released.

Exploring the Role of Pharmacists in Expanded STD Control Efforts
Public Health hosted a meeting to elicit input from academic- and community-based pharmacists with expertise, experience and a commitment to STD and HIV control efforts. The discussion reviewed the level of knowledge, practice patterns, and perceptions among pharmacists on new policy changes that allow them to prescribe EPT for partners of persons diagnosed with gonorrhea and chlamydia. The workgroup agreed that more targeted education was needed to increase antibiotic prescribing practices and to inform pharmacists of new liability protection rules.

Key Recommendations:
Support a Pharmacy Detailing Program to improve awareness of EPT for gonorrhea and chlamydia and Pre-Exposure Prophylaxis (PrEP) for HIV.

- Identify community-based pharmacies in areas of highest STD morbidity and target them for the first phase of the Pharmacy Detailing Program.
- Identify opportunities and leverage existing resources to enhance pharmacy-focused education and training.

Collaboration with the Center for Health Equity (CHE) and Anti-Racism, Diversity, and Inclusion Initiative (ARDI)
To ensure that our county-wide STD prevention and control activities are informed and guided by an equity lens and to fully consider the role that multiple social determinants of health play in the disproportionate rate of sexually transmitted infection among women of color, men who have sex with men, African-American men, transgender individuals and young persons, consulting with CHE and ARDI will remain a cornerstone of our multi-sector approach. While CHE's efforts began in early 2018, the more recent inclusion of ARDI to address disparity and inequity in the STD crisis will accelerate efforts to align program priorities, direction, and capacity throughout multiple sectors of the County. In partnership with ARDI, Public Health has identified key areas for support to reduce racial disparities and target populations most in need. In the future, Public Health and its DHSP will continue to provide ongoing leadership and strategic oversight on STD programming as subject matter experts. CHE will prioritize building supportive infrastructure across Public Health, and ARDI will assist with infusing equity considerations into the policies and practices utilized to inform cross-departmental programmatic efforts.

III. Analysis of community capacity and infrastructure needs to respond to the STD crisis, including identifying key populations that are disproportionately impacted and least resourced, and an outline of key steps to build capacity for communities to respond, as well as strategies for working with ARDI to address the intersection of racism, stigma, and sexual health

Community Capacity and Infrastructure Needs
LA County's STD prevention and control response exists in a highly diverse, dynamic, social service and health service landscape. Programs and services designed to respond to the STD crisis also confront health disparities fueled by structural racism, social inequity, and economic inequality. With these social determinants of health in mind, coupled with limited human and financial resources, Public Health strives to support interventions based on core public health principles and functions that can have the greatest impact. This list of STD-focused interventions offered in this document has evolved over time based on data and science, evidence of effectiveness, new technologies, our understanding for the need of a robust and

comprehensive sexual health education, and available resources. Although these prevention and control strategies follow primary, secondary, and tertiary prevention efforts, they stem from an understanding that individual health behaviors are influenced by societal, structural, community, interpersonal and individual constructs.

The table below highlights current STD programming within LA County and describes the level of intensity or support for each. The darker shaded interventions designate activities that are more widely implemented; conversely the lighter shaded activities are implemented on a more limited scale. For each of the four morbidity areas we have identified the three areas in intervention that are the highest priority for expansion, which are outlined in red.

Table 2: Summary of Interventions: Current Outreach, Education and Other Program Efforts

Implementation Level

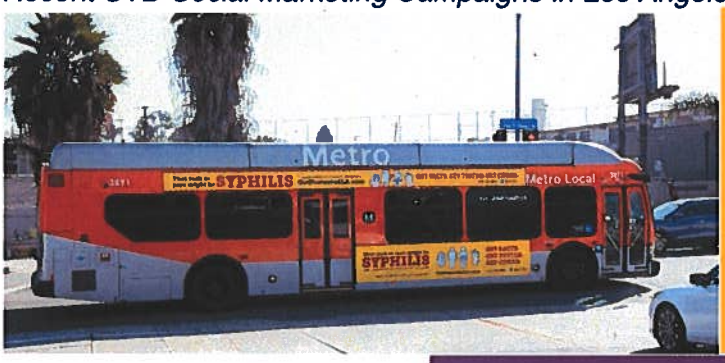
No implementation due to limited funding
Low level implementation
Medium level of implementation
High level of implementation
Service Not Applicable
Highly Recommended Intervention

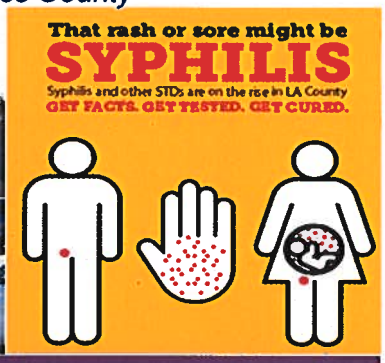
Congenital Syphilis Focused Interventions	Syphilis Focused Interventions	Gonorrhea Focused Interventions	Chlamydia Focused Interventions
Social Marketing	Social Marketing	Social Marketing	Social Marketing
Community Engagement	Community Engagement	Community Engagement	Community Engagement
Provider Outreach/ Public Health Detailing	**Provider Outreach/ Public Health Detailing**	Provider Outreach/Public Health Detailing	Provider Outreach/Public Health Detailing
Clinical Provider Education and Training	Clinical Provider Education and Training	Clinical Provider Education and Training	Clinical Provider Education and Training
	Condom Distribution	Condom Distribution	Condom Distribution
	Sexual Health Education	**Sexual Health Education**	**Sexual Health Education**
		School-Based Well-being Centers	School-Based Well-being Centers
Syphilis Screening During Pregnancy and Delivery	**Screening, Diagnosis, and Treatment Services**	**Screening, Diagnosis and Treatment Services**	**Screening, Diagnosis and Treatment Services**
Pre-natal Care for Pregnant Persons			
Bicillin Delivery Program	Bicillin Delivery Program		
		Expedited Partner Therapy	**Expedited Partner Therapy**
Treatment Verification	Treatment Verification	Treatment Verification	Treatment Verification
Partner Elicitation and Notification Services	**Partner Elicitation and Notification Services**	Partner Elicitation and Notification Services	Partner Elicitation and Notification Services
Intensive client case management	Intensive client case management	Intensive client case management	

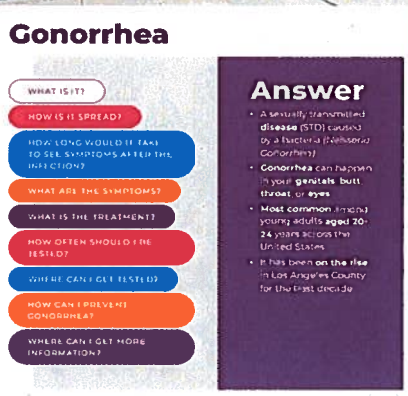
Intervention Descriptions

Social Marketing: Social Marketing is the use of marketing theory, skills, and practice to achieve social change, promote health, raise awareness, and lead to changes in behavior. In recent years, STD-focused social marketing campaigns in LA County have included the "Think Syphilis" campaign, Syphilis Provider Detailing and an update to GetProtectedLA.com (a public facing HIV and STD resource website).

Recent STD Social Marketing Campaigns in Los Angeles County







Community Engagement: Community engagement efforts are achieved when community members work together in equal partnership with health and social service professionals to determine program goals and objectives, implementation methods, and the evaluation of outcomes. These activities are focused on achieving health equity and involve community-level initiatives such as community forums, faith-based programs, and community mobilization campaigns.

Currently, Public Health contracts with Coachman Moore and Associates (CMA) to lead South Los Angeles-focused community engagement efforts which resulted in a variety of initiatives including but not limited to: community forum/panels regarding STD prevention in South Los Angeles, faith-based community forums, youth-led conferences (e.g., Spring into Love), and partnering with Public Health to develop and disseminate a youth-focused sexual health services resource guide listing vetted, youth-friendly clinics that follow CDC recommendations (i.e. www.PocketGuideLA.org). CMA is completing a retrospective review of past community engagement activities; a tool that will help inform future community engagement efforts.

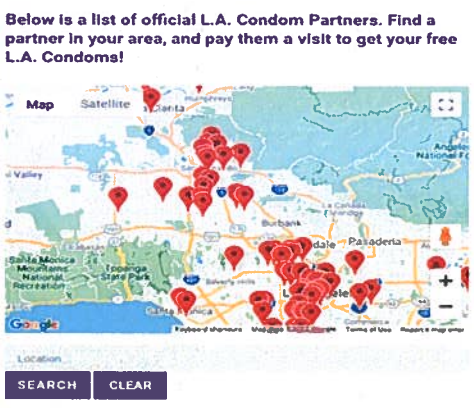
Provider Outreach/Public Health Detailing: Public Health Detailing (PHD) is an intervention used by local health departments to effectively communicate with health care providers about new or best practices. Like academic detailing, public health detailing builds on some of the techniques used by medical industry representatives to gain access to health care providers for a brief encounter and tutorial, advance key public health insights and recommendations and change provider behavior.

In response to a rise in congenital syphilis cases, Public Health issued more rigorous syphilis screening guidelines that included universal third trimester screening and screening at delivery. We launched a Public Health Detailing Campaign to raise provider awareness about the trends in syphilis in women and disseminate key recommendations. The campaign began in May 2018 and ran for 8 weeks. Public Health Detailers delivered 4 key recommendations issued by Public Health: 1) screen all women of reproductive age for syphilis at least once, 2) screen all pregnant women for syphilis during the first trimester or at their initial prenatal visit, 3) Re-screen pregnant women for syphilis early in the third trimester (28-32 weeks) and again at delivery, and 4) stage syphilis correctly to treat syphilis correctly. A total of 798 provider visits were conducted (432 initial visits and 366 follow-up visits). There were notable increases in provider knowledge in syphilis trends and treatment guidelines. Most significantly, on a follow-up assessment, the pre-natal care providers self-reported that their use of third trimester screening increased from 40% of eligible patients at baseline to 74% of eligible patients. Public Health will continue to support this intervention as resources becomes available.

Clinical Provider Education and Training: Provider education and training courses (live or on-demand) are designed to enhance the knowledge base of health professionals serving persons with STDs. Public Health clinical experts present STD-related clinical treatment updates to health care professionals and clinicians who diagnose, treat, and manage patients with STDs. These sessions are offered by local, state, or national training/capacity building organizations and are either in person or online continuing medical education (CME) courses or informational sessions for providers and healthcare professionals.

Condom Distribution: Condom distribution programs are a core HIV and STD prevention strategy and widely increase the availability, accessibility, and acceptability of condoms to prevent the spread of HIV and STDs. Public Health provides condoms to STD prevention partner agencies via the LA Condom Program where bulk orders are fulfilled and distributed.

Condom Distribution in LA County



Sexual Health Education: Sexual Health Education (SHE) Programs are school based programs that provide students with the essential knowledge and critical skills needed to help them to promote their sexual health and decrease sexual risk behaviors to help prevent HIV, STDs, and unintended pregnancy. A SHE curriculum includes medically accurate, developmentally appropriate, and culturally relevant content and skills that target key behavioral outcomes and promote healthy sexual development.

The California Healthy Youth Act, which took effect in January 2016, requires school districts throughout the State to provide students with comprehensive sexual health education, along with information about HIV prevention, at least once in middle school and once in high school. The State's statute allows school districts to offer age-appropriate sexual health education in earlier grades if they choose to do so. In California, parents can opt out of comprehensive sexual health education, and local districts choose which curriculum and instructional resources (including textbooks and worksheets) they will use to teach comprehensive sexual health education to their students.

School-Based Well-Being Centers (WBC): In partnership with your Board, Public Health and DMH, local school districts and Planned Parenthood Los Angeles (PPLA), launched 40 Student Wellbeing Centers (WBC) beginning in December 2019. Every site offers confidential STD screening and treatment as well as activities aimed at equipping teens with information about substance use prevention, behavioral health, and sexual health; skills students need to have healthy relationships, protect their health, and plan for the future.

Update: Due to the COVID-19 pandemic, schools and school sites have been largely closed thus precluding the delivery of services at these Student WBCs. While schools were closed to many external programs throughout the 2020-2021 school year and through the 2021 summer, Public Health was able to maintain access to sexual health information and services for high school students through a Wellbeing Center call-line operated in partnership with PPLA. The call-line resulted in students booking appointments at PPLA. In 2022, Public Health will resume delivering in-person services at 10 Wellbeing Center high school campuses, including STD prevention education, testing and treatment services.

Screening, Diagnosis, and Treatment Services: STD screening, diagnosis and treatment services delivered in health care settings is a cornerstone to treating and preventing STDs. Screening and diagnostic testing are important to detect asymptomatic or confirm suspected infections. Screening for asymptomatic STDs is important for early detection and prevention of STDs. Because many STDs are asymptomatic, testing is the only method to diagnose these infections. Results from these screening tests can be used to identify persons at risk for STDs. The CDC's *Recommendations for Providing Quality Sexually Transmitted Diseases Clinical Services, 2020* provides screening recommendations for women, pregnant women, men, MSM, and persons with HIV (https://www.cdc.gov/std/treatment-guidelines/). Public Health is working to improve screening rates and build screening capacity across several health delivery systems. Public Health is also collaborating with health care delivery partners, health systems, and health plans to establish baseline screening rates for sub-populations at elevated rates for STDs since baseline screening rates are not yet available across all systems and for the most disproportionately impacted groups.

Prenatal Care for Pregnant Persons: Prenatal care involves the delivery of care to a pregnant person to optimize their health and the health of the newborn. Babies of pregnant persons who

do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to pregnant persons who do receive care. In LA County, over one third of congenital syphilis cases involve a pregnant person who has not had a history of prenatal care.

Syphilis Screening During Pregnancy and Delivery: In response to the alarming rise of congenital syphilis, the California Department of Public Health (CDPH) recognized an urgent need to expand syphilis detection among people who are or could become pregnant to ensure detection, timely treatment, and subsequent congenital syphilis prevention. California STD screening recommendations to date have aligned with national guidelines, which recommend that all pregnant patients receive syphilis screening at the first prenatal visit, with additional screening in the third trimester and at delivery for those with identified risk, including in communities and populations with high syphilis prevalence.

Public Health supports the CDPH Sexually Transmitted Disease Control Branch-issued Expanded Syphilis Screening Recommendations for the Prevention of Congenital Syphilis (CS) guidance. To promote understanding of and adherence to this guidance, Public Health has met with all prenatal care providers and birthing hospitals that have reported a CS case to offer and provide technical assistance, review the expanded screening recommendations and review missed opportunities to prevent CS. Additional program outreach efforts will be implemented once Public Health resources become available. Consistent with the importance of this intervention, please see the recent message from CDPH regarding screening for syphilis (Appendix C).

Bicillin Delivery Program: The Bicillin Delivery Program is a Public Health Department-led medication delivery program for providers with patients who tested positive for syphilis and are unable to obtain Bicillin (penicillin G benzathine) for their patients due to cost and/or limited availability at their medical practice or pharmacy. Bicillin is the recommended treatment for syphilis and the only recommended treatment for pregnant women infected with or exposed to syphilis.

Public Health continues to prioritize interventions targeted to persons of childbearing age diagnosed with syphilis. Consistent with this priority, Public Health delivers approximately 240 does of medication per year to providers who do not have Bicillin in stock at their clinical practices as part of the Bicillin Delivery Program as a strategy to ensure prompt treatment of syphilis. In addition to serving persons of childbearing age, this program also supports clinicians who serve men and persons outside of childbearing age.

Expedited Partner Therapy (EPT) (also known as Patient-Delivered Partner Therapy): This intervention involves the delivery of medication to treat STDs by the sexual partners of patients diagnosed with chlamydia or gonorrhea. The medication is prescribed to the patient diagnosed with an STD and without the health care provider examining the sexual partners.

Public Health funds and partners with Essential Access Health (EAH) to promote the availability and use of EPT services, particularly for young persons diagnosed with gonorrhea and chlamydia. This online chlamydia (CT)/gonorrhea (GC) EPT Distribution Program supplies LA County clinic sites with free medication to dispense, when appropriate, to their patients diagnosed with CT and/or GC. Patients deliver the medication to their sexual partners without the partners needing to be examined or evaluated by a clinician prior to treatment.

The goal of EAH's PDPT Program is to ensure that exposed sex partners of patients diagnosed with CT and/or GC infection receive timely treatment to prevent repeat infection. Although EPT is not intended as a first-line disease management strategy, it is an evidence-based alternative for treatment of sexual partners who are unable to and/or unlikely to visit a sexual health provider. In 2021, over 6,000 doses of EPT to treat gonorrhea and chlamydia were distributed via EAH's EPT program portal. The adoption and use of this disease control intervention remains low, but Public Health continues to explore new approaches and opportunities to increase EPT awareness and use, particularly among County-based and community-based clinicians and pharmacists.

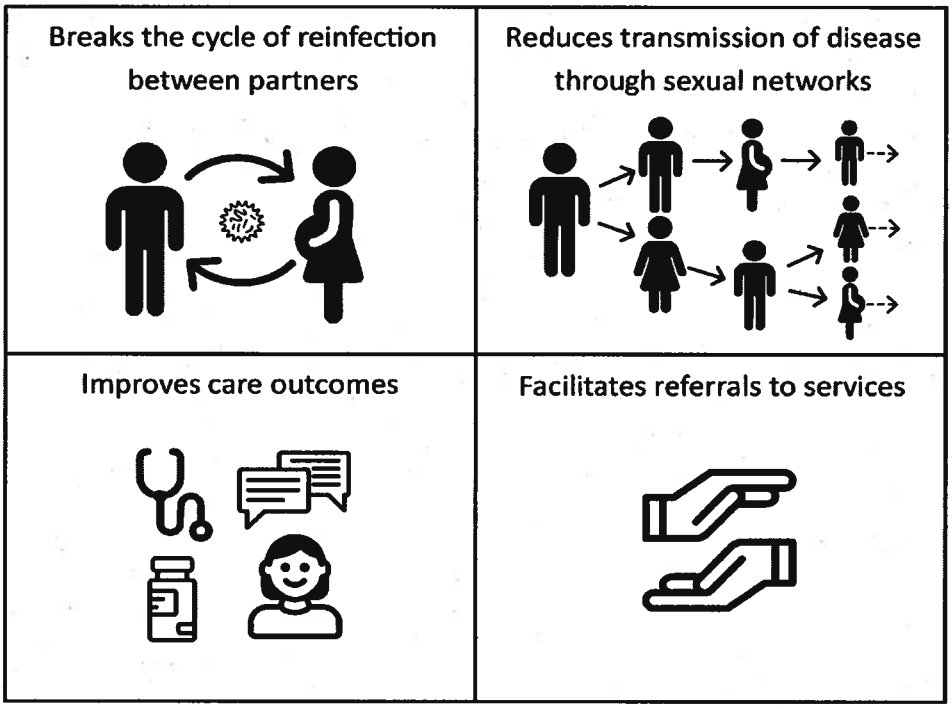
Treatment Verification: While many bacterial STDs can be treated and cured with antibiotics, the long-term effects of untreated STDs can lead to infertility, pregnancy complications, cervical cancer, pelvic inflammatory disease, birth defects and a three- to five-fold increased risk of HIV transmission. Verifying that an individual diagnosed with an STD was properly treated will avoid negative consequences associated with untreated STDs and decrease transmission of STDs. Public Health staff verify treatment by receiving provider reports or actively contacting providers. All providers are required to report treatment for syphilis, gonorrhea, and HIV. As stated earlier, provider reporting of CT diagnosis and treatment events is no longer required in California.

Partner Elicitation and Partner Notification (Partner Services or Contact Tracing): These services are offered to people diagnosed with an STD, to their partners, and to other people who are at increased risk for infection to prevent transmission of these infections and to reduce suffering from their complications. Eliciting partner names from those who have been diagnosed with a disease is intended to stop transmission by early intervention and treatment of infected partners. Partner Notification services are offered by Public Health Investigators (PHIs) when patients need assistance with notifying their partners anonymously.

As shared in this report, there has been a steady increase in the total number of syphilis, GC and CT cases reported in LA County over the last decade. In response to this steady increase, coupled by the increasingly scarce resources available to aggressively investigate all cases and interrupt the transmission of new infections, Public Health employs a priority-setting process for local disease investigation efforts. The rising volume of syphilis, GC, and CT cases has significantly outpaced Public Health's ability to investigate cases in a timely manner, particularly as other infectious diseases, like the COVID-19 pandemic, demand our attention. It is broadly understood in the public health and clinical sectors that both HIV and syphilis lead to serious negative health outcomes among untreated persons and the consequence of untreated syphilis among pregnant females can lead to cases of congenital syphilis and even stillbirth. In contrast to the relatively short incubation periods for GC and CT, an individual with syphilis does not become infectious until approximately three weeks after exposure. As such, timely and effective partner elicitation and notification services to interrupt disease transmission may be more effective for syphilis (compared to both GC and CT) as partners can be identified and treated within its longer incubation period. Locally, statewide, and nationally, partner elicitation and notification efforts have increasingly focused on syphilis and HIV.

Partner Services Impact on STD Transmission

How does Partner Services reduce STD transmission?



Intensive Client Case Management: More intensive than partner elicitation and partner notification services, intensive client case management services are delivered to clients who are facing a complex set of issues (e.g., substance use, mental health, homelessness) that preclude them from adopting health promotion behaviors and/or successfully linking to critical prevention and treatment services.

Public Health staff employ intensive case management services in addition to partner elicitation and partner notification services for individuals with multiple needs. These services demand collaboration and coordination across various sectors and among persons with different areas of expertise including social workers, medical care providers, community health workers, Public Health Investigators and Public Health Nurses.

Addressing the Intersection of Racism, Stigma, and Sexual Health

As mentioned earlier in this report, social inequities, social ills, racism, and other forms of discrimination that negatively impact health care access and quality, income, housing, education, and stigma, among others, contribute to persistent and increasing rates of STD morbidity and STD-related mortality among a range of sub-populations in LA County.

Public Health Center for Health Equity (CHE)
On January 12, 2018, CHE and DHSP co-hosted a community forum focused on STDs designed to inform community-based partners of the STD-related efforts of CHE and to elicit their recommendations on the strategic approach of this work. Separately, CHE and Public Health leaders engaged the Community Clinic Association of Los Angeles County (CCALAC) and its members to identify opportunities for enhanced partnership tied to STDs. On October 30, 2018, DHSP, CCALAC and EAH co-sponsored an event designed to increase awareness of local STD rates and offer tools and information to a broad cross-section of community-based partners. These STD-focused community partner outreach and engagement efforts helped CHE refine its focus areas, particularly with non-geographically concentrated populations, including gay, bisexual, and transgender communities, American Indian and Alaska Native individuals, and people with disabilities. CHE finalized its Action Plan (with STDs as a key area of focus) in February of 2019 following a vetting process with external stakeholders, Health Agency Department Heads, and Public Health leadership.

CEO Anti-Racism, Diversity, and Inclusion Initiative (ARDI)
ARDI and Public Health have identified several opportunities for collaboration to address the intersections of racism, stigma, and sexual health. ARDI has joined the Internal LA County Workgroup to Address the STD Crisis and has served in a consultative role in this process. Separately, ARDI has recently conducted key stakeholder interviews with members of the ARDI Community Input Advisory Board who have specific expertise in sexual and reproductive health and has elicited feedback to inform the STD recommendation setting process. Among the key STD programmatic recommendations advanced by ARDI thus far are:

- Increase contracting incentives and target outreach programs to black and other women of color;
- Increase the inclusion of people with lived experience and more diverse service providers as participants in STD peer networking and program planning meetings;
- Expand workforce training to ensure staff can identify and address sexual health needs of highly impacted populations, including youth and women of color;
- Increase access to and utilization of STD services by integrating sexual health and STD prevention programming through community partners and schools in communal spaces;
- Provide training that addresses racism, transphobia, homophobia, and other biases among providers that perpetuate stigma and shame among clients.

ARDI will continue to partner with Public Health to leverage current county-wide activities that effect system change and build infrastructure to increase internal and external stakeholder capacity to reduce the disproportionate rates of STDs among highly impacted communities, including efforts that:

- Support the utilization of equitable contracting practices to increase the eligibility and capacity of diverse organizations that are led by and serve disproportionately impacted communities to contract with LA County;
- Provide guidance and reporting support to disaggregate data by race and ethnicity and normalize data collection and reporting of sexual orientation and gender identities;
- Facilitate collaboration among multiple County partners to reduce siloed efforts; and
- Incorporate data with the Equity Explorer to display geographic concentrations of STD infections, increase awareness of geographic need amongst partners and drive investment and collaboration.

IV. Training opportunities to develop skills to provide culturally humble and linguistically appropriate outreach, education, and marketing

There remains a significant need for training across a wide range of public and private sectors related to STDs and their impact on personal and public health, screening and treatment guidelines, the importance and strategies for conducting complete sexual histories, STD-related inequities tied to race, gender, gender identity, geography, and sexual orientation, changes in State laws related to STD and sexual health [e.g. California Healthy Youth Act (2016), Senate Bill 306 (Expanded STD Services, 2021)], opportunities for STD control through Expedited Partner Therapy, updates to STD screening and treatment guidelines, medical mistrust, STD testing technology and home testing options as well as STD-related clinic performance measures and expected practices, among other topics. These trainings are needed to improve sexual health service access patterns, screening rates, treatment rates and the use of partner service and EPT to reduce the number of new infections. The training modalities that are needed include, but are not limited to, intensive provider detailing (targeted to clinicians and pharmacists), provider and consumer training seminars, specialized outreach events, social marketing, and messaging. As resources become available, Public Health will directly address or support the most pressing STD related training needs. In the interim, Public Health will continue to partner with regional, State, and national capacity building training centers to help meet these training needs. Separately, we will support and monitor compliance of school districts to comply with CHYA training requirements. Finally, Public Health is expanding its partnership with trade groups and pharmacist leaders to support and launch a pharmacist-targeted training program on EPT and biomedical HIV prevention opportunities.

V. Framework and timeline, including key metrics and milestone goals, for ending the STD crisis in LA County

Metrics and Milestones

In December 2020, the White House released the first ever Federal STI National Strategic Plan 2021-2025 for the United States (Strategic Plan) and outlined five main goals: 1) Prevent New STIs, 2) Improve the Health of People by Reducing Adverse Outcomes of STIs, 3) Accelerate Progress in STI Research and Innovation, 4) Reduce STI-Related Health Disparities and Health Inequities, and 5) Achieve Integrated, Coordinated Efforts that Address the STI Epidemic. These 5 goals are supported by 15 objectives.

As part of the Strategic Plan, the White House also identified fourteen performance metrics with targets in 2025 and 2030 (please see Appendix C). The Strategic Plan and approach are similar to the federal efforts tied to address the domestic HIV epidemic (e.g., 2010 National HIV/AIDS Strategy (NHAS), 2015 NHAS, 2019 Ending the HIV Epidemic Initiative), absent a significant marshalling of new resources to carry out the plan and bring the domestic STD response to scale.

Over the last three decades, a key ingredient in national initiatives to advance HIV progress has been a significant increase in revenue to finance expanded efforts with the intent of reaching newly established milestones. Since the inception of the Ryan White Program in 1990, investment levels in the domestic HIV response have kept pace with increases in the incidence and prevalence of HIV cases. The most recent national-level HIV initiative: Ending the HIV Epidemic, A Plan for America, was coupled with bold new investment of resources for forty-eight counties (including LA County), seven states, Washington, DC, and Puerto Rico). The initial increased investment has been coupled with additional resources for federally qualified health centers (in LA County a total of 11 FQHCs were funded in 2020 and an additional 19 were funded in 2021) and other EHE partner organizations. In the end, the flow of federal funds has kept pace with the increase in HIV incidence year to year for more than three decades.

In response to your Board's motion, Public Health has reviewed the Federal STI National Strategic Plan to inform the identification of key STD related metrics and milestones for adoption locally. Based on input from the Metrics and Milestones Workgroup and influenced by resource shortages, Public Health is recommending that we adopt a county-wide focus on the following four core indicators in the near term, with initial targets focused on stopping the decade long increase in STD rates:

1) Reduce rates of primary and secondary syphilis
2) Reduce rates of congenital syphilis
3) Reduce primary and secondary syphilis rate among men who have sex with men
4) Reduce gonorrhea rate among African-Americans/Blacks

Table 3: STD Performance Indicators and Targets1 for Adoption in LA County (LAC)

Core Indicator	2020 National Baseline	2025 National Target	2030 National Target	2019 LAC Baseline	2020 LAC Baseline
2. Reduce rates of Primary & Secondary (P&S) syphilis	13.6 per 100,000	13.2 per 100,000	12.2 per 100,000	25 per 100,000	TBD
3. Reduce rates of congenital syphilis[2]	67.7 per 100,000	57.6 per 100,000	33.9 per 100,000	86 per 100,000	114 per 100,000
8. Reduce P&S syphilis rate among MSM[3]	461.2 per 100,000	440.4 per 100,000	392.0 per 100,000	385 per 100,000	TBD
12. Reduce gonorrhea rate among African Americans/Blacks	632.9 per 100,000	604.5 per 100,000	538.0 per 100,000	644 per 100,000	TBD

[1] Rates (per 100,000 population) are provisional due to reporting delay and subject to change.
[2] Cases include probable congenital syphilis cases and syphilitic stillbirths. Case counts for 2020 congenital syphilis cases were made available after consultation with the cities of Long Beach and Pasadena. Data source: Long Beach Health and Human Services STD Surveillance (as of 10/29/2021), Pasadena Health Department STD Surveillance (as of 11/3/2021). Rate calculated per 100,000 live births. 2020 live births not yet available. 2020 rates calculated using 2019 live births as a proxy.
[3] MSM defined as men who have sex with men or both men and women. Data for the cities of Long Beach and Pasadena do not differentiate between sexual partners who identify as men and sexual partners who identify as transgender women (male-to-female transgender individuals), and therefore, both are included in the case counts. Rates for MSM were calculated with the assumption that 8% of men in LA County are estimated to be MSM. This was estimated utilizing data from the 2017 National HIV Behavioral Surveillance Survey conducted in LA County

Over the near term, Public Health will continue to convene its STD Workgroups, including the Metrics and Milestones sub-workgroup. As part of the next series of meetings Public Health will consider several factors to develop 2025 and 2030 LA County targets across the four indicators described in Table 3. We will share these targets with your Board as they are finalized. Reaching these performance metrics by 2025 and 2030 will be a remarkable public health

achievement—predicated on highly effective, coordinated multi-sector efforts that also consider the social, economic, racial, and structural factors that influence STD rates.

VI. Public-facing STD dashboard to track the County's progress towards reducing STD rates.

Public Health has developed the first iteration of a publicly facing dashboard to provide surveillance information related to syphilis, congenital syphilis, and gonorrhea. The dashboard, created in Power BI, will be embedded on the Public Health website and it will be updated each month to display the latest morbidity data in LA County. Because of reporting and data processing delays, cases reflected in the dashboard will be limited to those diagnosed three months prior to the reporting month.

In its initial iteration, the dashboard will compare cases diagnosed in 2021 with 2019 and 2020. As an overview, there are gauges displaying the percent change in case numbers from 2019 to 2021 for syphilis, congenital syphilis, and gonorrhea. The dashboard will include line charts which show cases by month of diagnosis for each calendar year. This will allow viewers to see changes over time as well as seasonal trends. For congenital syphilis, the number of stillbirths by month is shown as bars on the same chart. For gonorrhea, the number of disseminated gonococcal infections by month is also shown. All figures are interactive and have options to expand, sort, copy, and display underlying data.

In the second section of the dashboard, we will break out cases by demographic characteristics for 2019, 2020 and 2021 cases. The bar charts show distribution of syphilis and gonorrhea cases by age group, gender, and race/ethnicity for each year. Please note that Pacific Islanders and American Indians/Alaska Natives are grouped into the "Other Race" category given the number of cases for these sub-populations is too small to report out separately. The dashboard will also allow for data to be sorted by ascending or descending by value.

In the last section of the dashboard, we will present cases by geographic area. In the default view, the first table will show cases by service planning area (SPA) for congenital syphilis, syphilis among women, syphilis among men, and total syphilis cases in 2019 and 2021. It will also include percent change from 2019 to 2021 for each subpopulation. The percent change columns display visual data bars, with yellow highlighting an increase and green highlighting a decrease. All columns can be sorted through simple clicking of the header. To drill down to the health district (HD) level, viewers can click on the plus sign next to each SPA. Alternatively, there is an option to display all HDs. The table format allows dashboard users to easily compare metrics across and within SPAs and HDs. Alternatively, the bar chart allows viewers to focus on geographic patterns by gender. The buttons can be used to toggle between males and females. The chart can be sorted by case number or percent change to identify areas with high disease burden. Like the table, the chart can also drill down from SPAs to HDs. A second set of tables and charts provide data on gonorrhea cases by SPA/HD, gender, and year with the same features described above.

This is the first iteration of a dynamic, public-facing tool to visualize the STD epidemic in LA County. In the second and third phases of the evolution of this publicly facing STD dashboard, Public Health will explore introducing additional features and links to further consider, understand and personalize the toll of STDs in LA County. These additional attributes will

include links to Equity Explorer, a geographic information systems tool that will connect the social drivers and conditions that contribute to STD related disparities in our County, including redlining, poverty, health care access patterns and substance use. In the future, with additional resources, Public Health hopes to connect the dashboard Story Mapping Technology to reveal the personal and human toll that STDs play on our residents, including stigma, shame, infertility, fetal deformation, and stillbirths. Finally, Public Health will also add features to the dashboard that will review our progress toward shared metrics and milestones as well as a description of interventions and service delivery partners that are present in different areas of our County targeted to curbing the local STD crisis.

To view this dashboard, please use the following link:
http://publichealth.lacounty.gov/dhsp/dashboard.htm.

VII. Coordinate Federal and State Resources to Combat the STD Crisis

CEO's Legislative Affairs and Intergovernmental Relations Branch (CEO-LAIR) continues to advocate for STD funding and policy enhancements at the State and Federal levels, consistent with your existing Board-approved policy. Your Board's policy allows CEO-LAIR to support proposals and funding to increase access to STD prevention, screening, treatment, and surveillance activities for individuals who are at highest risk for these infections.

Over the last several years, in response to the year-to-year increases and now record levels of STDs across the United States, California and locally, there has been a significant increase in the number and diversity of budget and legislative proposals made to help support and expand STD control efforts to achieve a level of reach and impact that is commensurate with the scope and trajectory of the crisis. These appeals have not had the level of success as compared to advocacy tied to the HIV epidemic, the opiate epidemic, or the COVID pandemic.

Over the last three decades, a key ingredient in national initiatives to advance HIV progress has been a significant increase in revenue to finance expanded efforts with the intent of reaching newly established milestones. As stated earlier, since the inception of the Ryan White Program in 1990, investment levels in the domestic HIV response have kept pace with increases in the incidence and prevalence of HIV cases. The most recently announced national-level HIV initiative: Ending the HIV Epidemic, A Plan for America, was coupled with bold new investment of resources for forty-eight counties (including LA County), seven states in the Southern U.S., Washington, DC, and Puerto Rico. The initial increased investment has been coupled with additional resources for federally qualified health centers (in LA County a total of 11 FQHCs were funded in 2020 and an additional 19 were funded in 2021). Separately, private pharmaceutical industry partners have also made significant commitments in pharmaceuticals to enhance biomedical HIV prevention efforts.

Regrettably, the noteworthy investments made to tackle HIV over the last 30 years have not been applied to domestic STD control efforts. These resource challenges have persisted despite year-to-year increases in STD morbidity over the last 10 years and extremely sharp increases in syphilis and congenital syphilis over the last 5 years.

As a complement to focusing on four core indicators mentioned in Metrics section (Table 3), Public Health recommends that we also focus on improving the monitoring and compliance

related to other key STD program areas. Public Health maintains that a more robust reporting, compliance, and monitoring of performance items described below can further accelerate STD control efforts.

Table 4: Current Monitoring Mechanism and Consequences for Non-Compliance

Performance Item	Implementation Partner	Service Description	Oversight Body	Systematic Tracking Mechanism	Impact/ Consequence for Non-Compliance
California Healthy Youth Act	School Districts in California	2016 California law requiring school districts to provide comprehensive sexual education once each in middle school and high school	California Department of Education	None; please see Appendix F for more information	None
HEDIS Measure for Chlamydia intended to drive high quality patient centered care	Health Plans (Commercial HMO, Commercial PPO, Medicaid HMO)	Performance metric tied to annual CT screening of young women 16 to 24	National Committee for Quality Assurance		Influences Health Plan Ratings
National Health Center Program Uniform Data System (UDS)	Federally Qualified Health Centers		Health Resources and Services Administration	UDS System; Reporting compliance is high due to rate influence	Reimbursement Rates
1st and 3rd Trimester Screening for Syphilis Among Pregnant Persons	Ob/Gyns, Emergency Room Physicians,	Require syphilis screening during 1st and 3rd trimester of pregnancy	N/A	None	Unclear
Expedited Partner Therapy Utilization	Physicians/Health care providers diagnosing an STD	EPT allows diagnosing clinicians to prescribe or pharmacists to provide treatment for GC or CT for the partners of index patients with a medical visit or a partner name	N/A	None	N/A

Federal Advocacy

At the federal level, categorical STD resources are distributed through the Centers for Disease Control and Prevention (CDC) National Center for HIV, Hepatitis, STD, and TB Prevention (NCHHSTP) Division of STD Prevention and the domestic appropriation was $161.8 million annually in federal fiscal year 2021. As part of our annual PCHD grant, LA County receives $3,371,049 to enhance local STD control efforts, 90% of which is invested in personnel responsible for surveillance and epidemiology functions, case identification, contact tracing, education, compliance with disease reporting and applicable statutes, outbreak investigation,

condom distribution, training, program evaluation. In recent years, LA County has advocated unsuccessfully for additional resources from the CDC DSTDP to expand our STD control efforts.

LA County has concurred with increased funding requests advanced or endorsed by the National Coalition of STD Directors, Association of State and Territorial Health Officers, National Association of City and County Health Officials, National Association of State and Territorial AIDS Directors, National Minority AIDS Council, (SEICUS, APHA, Planned Parenthood of America). Despite these efforts, budget levels have remained largely stagnant and furthermore the domestic STD control investment has lost nearly half of its purchasing power of the last decade and a half.

While LA County applauds the release of the Federal STI Strategic Plan, the absence of a large infusion of resources to enlist multi-sectorial partners to bring to scale the interventions needed to meet the goals and objectives outlined in the plan will be a limiting factor.

In response to STD-related advocacy by NCSD, the Biden Administration approved a $1.13 billion investment to support Disease Intervention Specialist (DIS) infrastructure building across the United States through 2025. These resources will be used to support COVID-19, HIV, STD and TB DIS efforts in LA County and will help strengthen DIS training, coordination and evaluation efforts as well as expand the current DIS workforce.

Table 5: Federal Advocacy Recommendations

Recommendation 1	Appeal to Secretary of Health and Human Services Xavier Becerra to support an STD Control Pilot Program for LA County that helps accelerate progress towards meeting four of the fourteen indicators and targets identified in the Federal STI Strategic Plan.
Recommendation 2	Appeal to Secretary of Health and Human Services Xavier Becerra to launch the Ending the STD Epidemic Initiative: A Plan for America, modeled after the recently launched EHE Initiative and that enlists a renewed commitment from federal agencies, States, Counties and Cities, public and commercial health plans, the biotech sector and the vast network of Federally Qualified Health Centers and Community Health Centers to combat the STD crisis.
Recommendation 3	Appeal to the National Clinical Quality Association (NCQA) to adopt new incentives to improve compliance with the health plan HEDIS measure tied to annual chlamydia screening for young sexually women ages 16 to 24. Furthermore, given the growing rates of chlamydia among young men and gonorrhea among both men and women, appeal for NCQA's adoption of new HEDIS measures to enhance screening in these areas and among these disproportionately impacted sub-populations.

State Advocacy

In recent years, health advocates throughout California have recognized the interconnected nature of the HIV, Hepatitis C Virus (HCV), and STD epidemics. Often these are referred to as *syndemics* since these infections may be intertwined and one issue (e.g., syphilis) can fuel or lead to increased risk for another (e.g., HIV). As part of this platform, a statewide Ending the Epidemic Coalition was formed several years ago to develop, refine, and introduce several budget and legislative proposals that would have the greatest impact on the trajectory of these epidemics in our State.

In 2019, the ETE Coalition appealed to Governor Newsom to establish a statewide strategy to end the HIV, HCV, and STD epidemics. In response to concurrent appeals by STD advocates and from his administration, Governor Newsom approved a one-time allocation of $7 million ($2 million for CDPH and $5 million for counties) for STD treatment and prevention services for FY 19-20.

In 2020 and during the COVID-19 pandemic, the ETE Coalition continued to appeal to State leaders for the continuation of this investment in FY 20-21. Separately, there were three legislative proposals tied to STDs that were advanced during this time. The first was a proposal to expand the California Family Planning, Access, Care and Treatment (FPACT) authored by Assembly member Aguiar-Curry (AB 1965) that would have expanded access to human papilloma virus vaccination services. The second proposal introduced in 2020 was championed by Senator Weiner (SB 859) and proposed the creation of a California Master Plan for HIV, HCV, and STDs (the ETE Act of 2020) that would increase access to prevention services and address social determinants of health influencing the risk for these infections. The third proposal, authored by Senator Pan (SB 885) proposed an expansion of access to STD testing and treatment through Med-Cal, expansion of FPACT services to persons not necessarily seeking contraception services, and expanding access to EPT services. While the three legislative proposals failed to advance out of the legislature, the Governor's budget did include the continuation of $7 million for STD treatment and prevention services for FY 20-21 allowing this increased investment to continue for a total of two years through June 30, 2021.

Table 6: A Summary of New California STD Program Investments, including LA County's Allocation

	FY19/20	FY20/21	FY21/22	FY22/23	FY23/24
ETE Advocacy	$5M	$5M	$5M	$5M	TBD
CDPH Admin. Request	$2M	$2M	$2M	$2M	TBD
New Funds FY21/22			$4M	$4M	TBD
New Funds FY22/23				$5.5M	TBD
Total	$7M	$7M	$11M	$16.5M	TBD
Amount for Distribution to Counties	$4.5M	$4.5M	$4.5M + $3.6M	$4.5M + $3.6M + $5.5M	TBD
Total	**$4.5M**	**$4.5M**	**$8.1M**	**$13.6M**	**TBD**
LA County Allocation	**$497,400**	**$497,400**	**$497,400 + TBD**	**TBD**	**TBD**

In 2021, an appeal from community advocacy partners to expand FPACT with an additional investment of $7 million was denied. Conversely, the Governor approved the investment of an additional $4 million for STD treatment and prevention services effective FY 21-22 and an additional $5.5 million effective FY22-23. In 2021, the Governor also continued to approve the allocation of $7 million that was originally approved in FY19-20. The combined resources for the three STD funding streams have not yet been allocated to counties as CDPH is working to finalize the allocation strategy for these and future STD program funds. As part of this deliberation, on February 7, 2022, Public Health shared recommendations on the allocation of these funds with CDPH.

On October 4, 2021, Governor Newsom signed into law SB 306 (the STD Coverage and Care Act), a legislative proposal also championed by Senator Dr. Richard Pan. SB 306 allows for a more comprehensive approach to addressing California's rising STD crisis. The new law expands access to STI testing and treatment and is intended to create a more equitable sexual health system. The key provisions of the new law are:

- Requires health plans to cover at-home STI test kits ordered by in network primary care providers or via appropriate standing orders for HIV and STIs;
- Increases the number of providers who can provide HIV and STI testing in the community;
- Supports the delivery of EPT allowing more patients to obtain STI treatment for their partners;
- Require syphilis screening during both the first and third trimesters of pregnancy as stated in the CDPH Expanded Syphilis Screening Recommendations for the Prevention of Syphilis in Pregnancy.

As part of your Board's motion, you requested that we advance budget and legislative proposals to further advance STD control efforts, including those directed to Governor Newsom, California Secretary of Health and Human Services, and multiple California Departments. In that spirit, we offer the following recommendations for your review and consideration.

Table 7: State Advocacy Recommendations

Recommendation 1	Appeal to the Superintendent of Public Instruction to develop and implement a systematic tracking system to monitor compliance with the 2016 California Healthy Youth Act (CHYA) and implement strategies to address non-compliance with a focus on areas with the highest numbers and rates of chlamydia and gonorrhea.
Recommendation 2	Appeal to the Secretary of Health and Human Services to develop and implement a tracking system to monitor compliance with the recommendations outlined in the November 16, 2021 Dear Colleague letter related to the expansion of HIV and syphilis testing for pregnant patients and the newly enacted SB 306.
Recommendation 3	Appeal to Governor Newsom to appropriate funds to support the enhancement of California's STD Control Infrastructure to fully operationalize an STD Master Plan that includes congenital syphilis elimination, a reduction of syphilis morbidity to at least 2010 levels, enhanced STD surveillance, geo-mapping and cluster detection capacity, novel STD screening, diagnosis and treatment models and expansion of home testing modeled after the COVID response.

On March 15, 2022, your Board approved a motion calling for a five-signature letter from the Board in support of Governor Gavin Newsom's budget proposal for $300 million in ongoing State funding, including $200 million annually for local health jurisdictions to improve the local public health infrastructure. Moreover, the County will continue to advocate for ongoing State funding for health equity initiatives across California. CEO-LAIR Sacramento advocates will monitor the State budget and legislation for proposals moving forward that would increase funding for STD prevention in LA County. CEO-LAIR will work with affected departments to determine positions and advocacy strategies on such proposals. In collaboration with national public health organizations, CEO-LAIR Washington D.C. advocates will continue to request increased appropriations for STD prevention programs within the CDC. The CEO-LAIR Washington, D.C. advocates will also continue to support new Federal investments in Public

Health Infrastructure that would undergird STD prevention and control within the County. In the recently enacted H.R. 2471, the Consolidated Appropriations Act of 2022, which sets appropriations levels and allocations for the remainder of the 2022 federal fiscal year, there was a small increase of $2.5 million for CDC STD prevention efforts above the prior FY level. There was also a new line item of $200 million for a new, flexible funding stream for public health infrastructure and capacity nationwide.

Conclusion

Public Health looks forward to working with your Board, CEO, DHS, DMH, AHI, the Commission on HIV, health plans, health care providers, community-based organizations, policy advocates, residents affected by STDs, and other stakeholders to further advance and improve the impact of local STD control efforts. Our charge will require a multi-sector effort that brings a renewed and more focused effort on syphilis and congenital syphilis in the immediate term. The level and reach of the interventions must be at a scale that is much more in line with both the current level of disease and the anticipated year-to-year spread of these preventable, treatable, and curable bacterial infections that have outpaced available resources.

We look forward to working with your Board to engage and partner with leaders in Sacramento and Washington, DC to endorse and support bold and long-term budget and legislative proposals that offer us the opportunity to tackle this crisis much more upstream through efforts advanced by the ARDI and CHE or through comprehensive sexual health education (CHYA), and downstream (intensive interventions with pregnant persons diagnosed with syphilis, experiencing homelessness and using methamphetamine) and along the continuum of intervention opportunities.

We will continue to convene the newly formed Internal County STD Workgroup (and sub-workgroups) to inform, prioritize, implement and refine our STD control efforts; and we will continue to convene the Internal/External County STD Policy Workgroup to shape and advance our advocacy strategy, ensure that funding formulas are closely aligned with the levels of morbidity across jurisdictions in California and the United States, and have the longevity needed to meet disease reduction goals over the next decade.

As we continue to confront the ravages and impact of the COVID-19 pandemic, we recognize that other disease control efforts have been adversely impacted, including those tied to syphilis, congenital syphilis, gonorrhea, and chlamydia. We look forward to expanding the reach and impact of more sexual health and STD control partners that reverses the impact of these difficult decisions.

Our trends in STD rates should remind us of the importance of core public health functions and disease control infrastructure at levels that match the scope and urgency of the problem. The use of surveillance, epidemiology, laboratory, disease reporting, testing technology, social marketing, community engagement and mobilization and other tools have been instrumental to our COVID-19 response and historically with our HIV response. These experiences offer a blueprint for expanded STD control efforts in LA County and as we consider the metrics and milestones we commit to reaching by 2025 and 2030.

As always, Public Health will continue to keep your Board updated on developments related to our local STD control efforts. If you have any questions or need additional information, please let me know.

BF:RS:MJP

c: Chief Executive Officer
Executive Officer, Board of Supervisors
County Counsel
Alliance for Health Integration
Health Services
Mental Health

APPENDIX A: A SUMMARY OF STD MORBIDITY OVER THE LAST DECADE

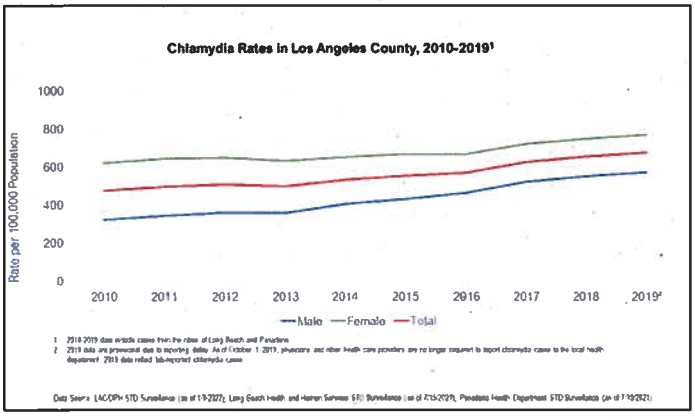
Since 2010, Los Angeles County (LAC) has observed a steady increase in both the number and rate of STDs among both males and females, across multiple age groups and among a sub-set of racial/ethnic groups. These increases mirrored patterns observed across the United States and across California over the same time frame. The sharpest increases were observed with the syphilis and congenital syphilis epidemics – two scourges that were near elimination just a decade and a half ago.

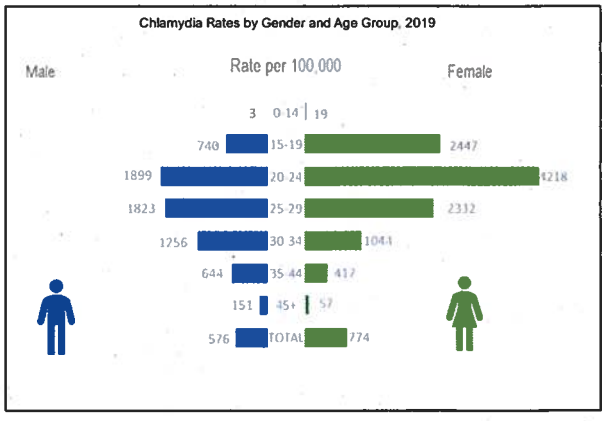
Chlamydia

We continue to observe a steady increase in chlamydia, the most commonly reported, but curable bacterial STD. Chlamydia cases increased from 46,762 (476 per 100,000 residents) in 2010 to 69,353 (676/100,000) in 2019. While the largest proportion of these cases were diagnosed among women (particularly women under 25 years of age), 66% of all cases in 2010 and 58% of all cases in 2019, the rate of chlamydia among males increased considerably (323 per 100,000 to 573 per 100,000, respectively) compared to females (621 per 100,000 to 771 per 100,000, respectively) over that same time span. In 2019, transgender women represented 0.2% of reported chlamydia cases. Beginning October 1, 2019, physicians and other health care providers were no longer required to report chlamydia cases to the local health department. The data for 2019 are therefore based on laboratory-based reporting.

Chlamydia continues to disproportionately impact young women (25 years and younger) and young men (29 years and younger). Provisional data for 2019 suggests that 59% of all female cases were between 15 and 24 years, while 57% of all male cases were between 15 and 29 years. Among the Health Districts in LAC with the highest rates of reported chlamydia cases were South, Southwest, Hollywood-Wilshire, Central, Southeast, Compton, Inglewood, and Long Beach. The changes in chlamydia reporting in the State of California mentioned above has impacted data completeness. As such, race/ethnicity data are more incomplete, and case rates and percentages cannot be reported for race/ethnicity with reliability. In 2019, 43% of all reported chlamydia cases were missing race/ethnicity data.

Table 8: Chlamydia Rates in Los Angeles County



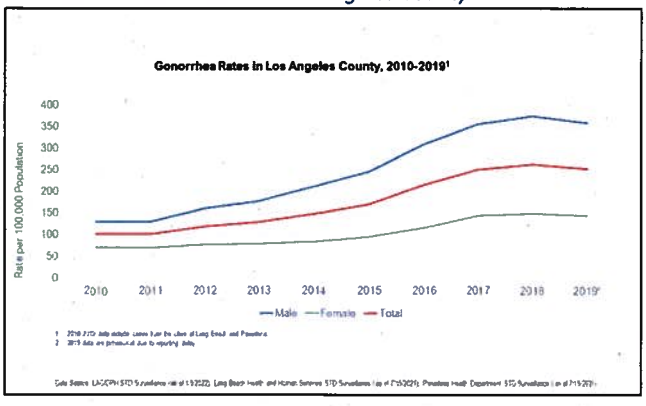


Gonorrhea

From 2010 to 2019, the number of reported gonorrhea cases increased from 9,834 to 25,904, a 163% increase. Gonorrhea most commonly impacts males (70% of all cases diagnosed in 2019), and most disproportionately African-American males. African-American males have a case rate of 928 per 100,000 based on provisional 2019 data and accounted for 21% of reported cases among males despite making up 8% of the male population in LAC. From 2010 to 2019, the rate of gonorrhea among males increased by 179% (129/100,00 in 2010 to 360/100,000 in 2019) while the rate of gonorrhea among females increased by 103% (71/100,00 in 2010 to 144/100,000 in 2019). Gonorrhea-related disease control efforts benefit from screening the genital area, rectum, and pharynx (3-site testing) for this treatable and curable bacterial infection. Across racial/ethnic groups over the same ten-year span, African-Americans had the highest rate of gonorrhea (666 per 100,000), followed by Pacific Islanders (417/100,00), American Indians/Alaska Natives (323/100,000), Whites (171/100,000), Latinx (168/100,00) and Asians (62/100,00). Among the geographic areas with the highest rates of reported gonorrhea cases are the Hollywood-Wilshire, Central, Southwest, South, Southeast, Compton, Inglewood, and Long Beach health districts. Over the last decade, there has been increased focus on ensuring that STD service delivery partners increase the frequency of 3-site gonorrhea testing, particularly among men who have sex with men. Improved screening practices among men may contribute to increases in reported cases. Transgender individuals represented 0.7% of the reported gonorrhea cases in 2019, with transgender women representing 0.6% of all cases.

A review of preliminary data from January through October 2021 reveals that the highest number of new gonorrhea cases were reported in the Hollywood-Wilshire Health District. By comparison, between January and October 2019, the largest percent increase in cases was observed in the Harbor Health District. Among women, between January and October 2019, an increase of over 30% in cases was observed in the Harbor, Central, Bellflower, East Los Angeles, and Inglewood Health Districts. Among men, during the same time frame, an increase of over 30% in cases was observed in the Harbor, Whittier, Antelope Valley, and Bellflower Health Districts.

Table 9: Gonorrhea Rates in Los Angeles County



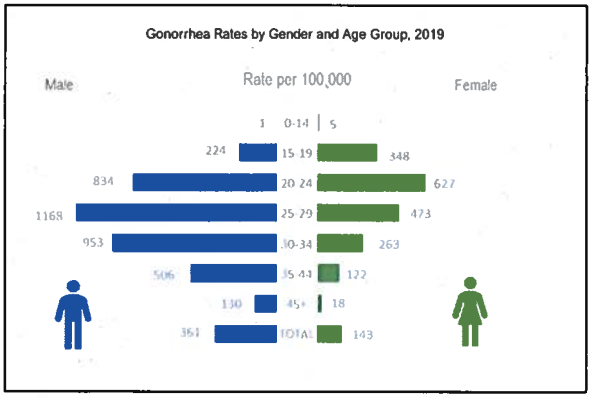
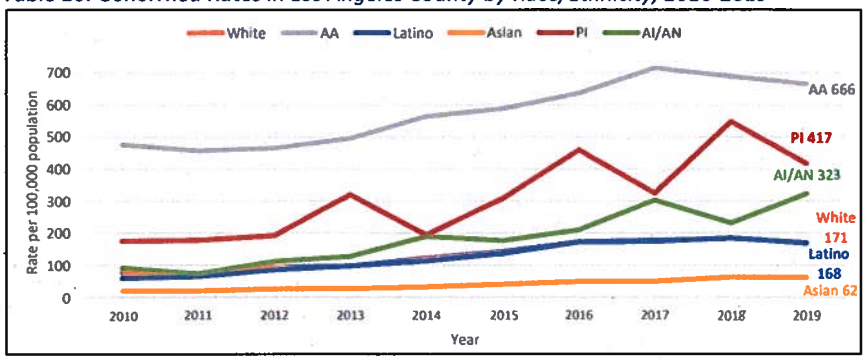


Table 10: Gonorrhea Rates in Los Angeles County by Race/Ethnicity, 2010-2019



Syphilis (Early Syphilis)

Syphilis is a complex bacterial STD that can lead to very serious complications if left untreated and can lead to significant deformity or death when passed from a pregnant person to their newborn (these cases are referred to as congenital syphilis.) When left untreated, syphilis can progressively worsen over several stages (primary, secondary, early latent, and late latent). Persons with syphilis are most infectious during the primary and secondary stages of the infection. For disease reporting purposes, the first three stages of the infection (primary, secondary and early latent) are referred to as Early Syphilis.

Over the last decade, there has been a 1,000% increase in the rate of early syphilis among females (1 per 100,000 in 2010 to 11 per 100,000 in 2019) and a 184% increase in the rate among males (37 per 100,000 in 2010 to 105 per 100,000 in 2019.) Among men, syphilis has disproportionately impacted MSM. In 2019, MSM accounted for 66% of cases among males while men who have sex with men and women (MSMW) accounted for 20% of cases among males. Transgender individuals represented 2.5% of early syphilis cases in 2019 with 2.3% reported among transgender women. Among both males and females, a significant fraction (72%) of early syphilis cases were reported among persons 20 to 44 years. Among both males and females, rates were highest among persons aged 25-29 years (157 per 100,000).

Between 2010 and 2019, across racial/ethnic groups, Pacific Islanders had the highest early syphilis rate (141 per 100,000) followed by African-Americans (135/100,000), American Indian/Alaskan Natives (82/100,000), Latinx (54/100,000), Whites (51/100,000) and Asians (21/100,000). Among the geographic areas with the highest rates of reported early syphilis cases are the Hollywood-Wilshire, Central, Southwest, South, Southeast, Long Beach, Northeast and Inglewood health districts.

A review of preliminary data from January through October 2021 revealed that the highest number of new syphilis cases was observed in the Hollywood-Wilshire Health District. By comparison, between January and October 2019, the largest percent increase in cases was observed in the San Fernando Health District, while the Torrance Health District experienced the largest percent decrease. Among women, between January and October 2019, an increase of over 50% in cases was observed in the Central, East Los Angeles, Foothill, and Whittier Health Districts. Among men during the same time frame, an increase of over 30% was observed in the San Fernando, Harbor, and Antelope Valley Health Districts.

Table 11: Early Syphilis Rates in Los Angeles County

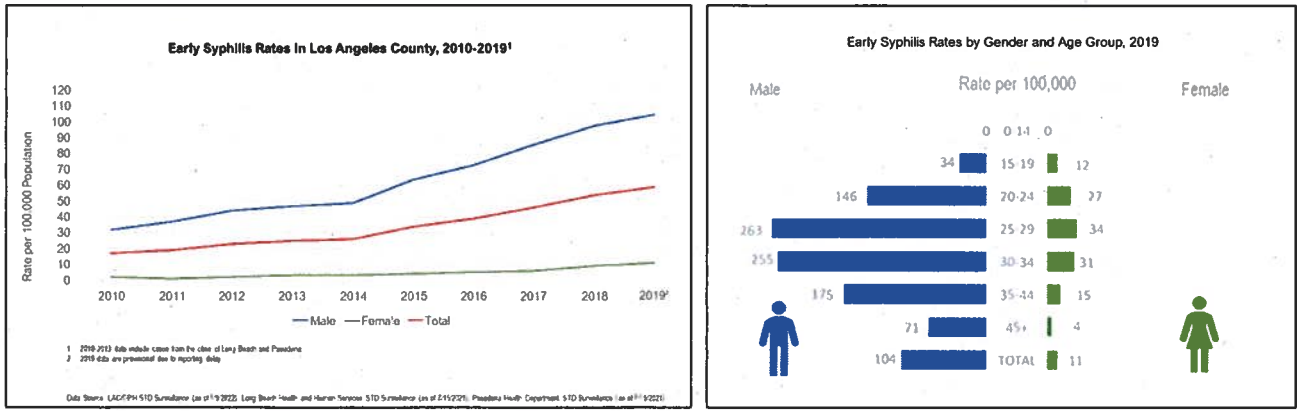
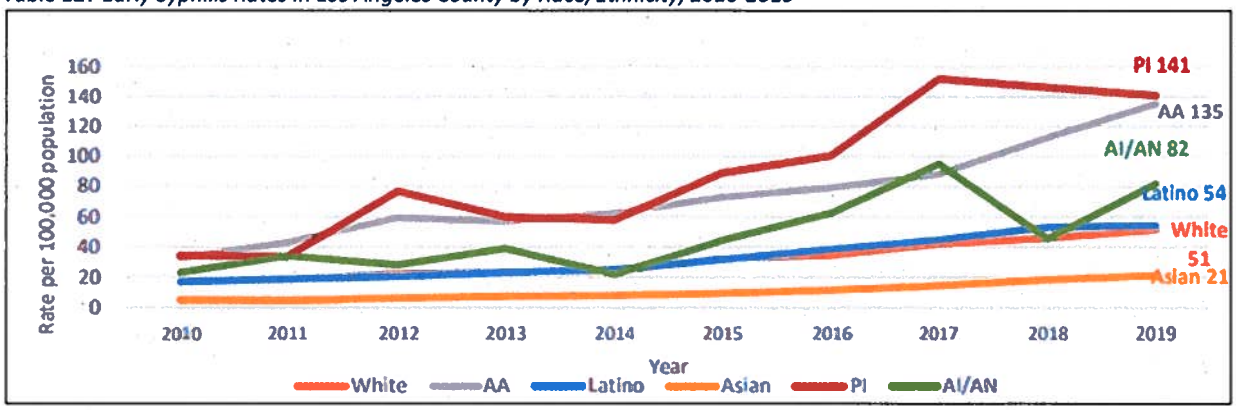


Table 12: Early Syphilis Rates in Los Angeles County by Race/Ethnicity, 2010-2019

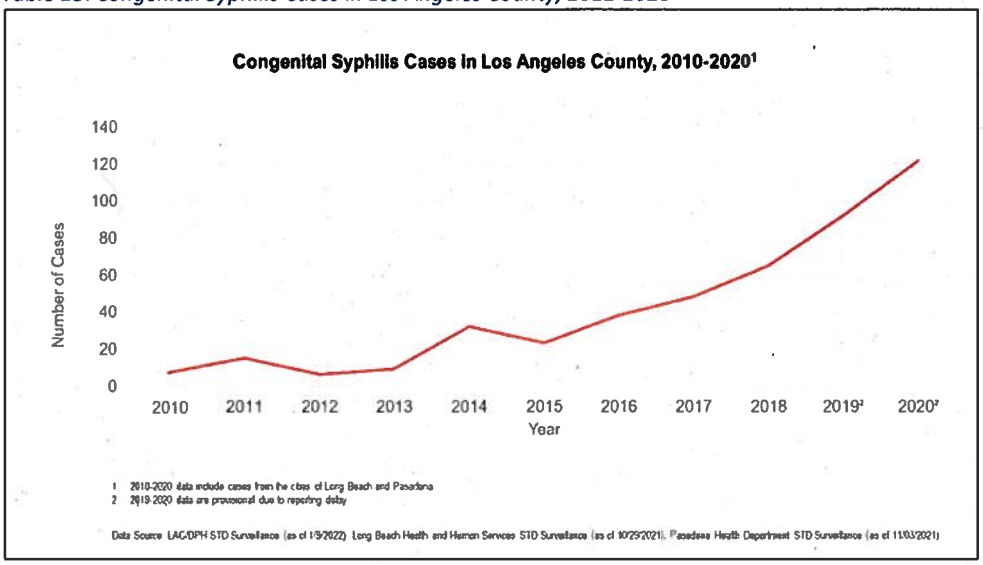


Congenital Syphilis

Among the most troubling STD-related increases over the last decade has been those tied to congenital syphilis. From 2010 through 2020, the number of congenital syphilis cases increased from 7 to 122 cases, largely among newborns born to Latinx (48%) and African-American (32%) pregnant persons. The rise in congenital syphilis continues to be tied to an overall increase in cases among males and associated increases among females of childbearing age. Among both males and females diagnosed with syphilis, the use of methamphetamines plays a prominent factor. More specifically, a review of the maternal characteristics tied to 88 congenital syphilis cases reported in 2019, revealed that 36% of mothers had a history of incarceration, 40% were unstably housed, 49% were using methamphetamine or some drug combination with methamphetamine and 68% had a substance use disorder. A review of prenatal care patterns among the same group of pregnant persons revealed that 18% entered prenatal care in the first trimester, 18% in the second trimester, 22% in the third trimester, and 35% received no prenatal care (prenatal care access could not be confirmed for 7% of the 88 cases.) These data highlight the importance of syphilis awareness and client engagement across all sectors of providers serving pregnant persons, and syphilis screening compliance across multiple trimesters of pregnancy. Furthermore, continued expansion of interventions designed to link pregnant persons to pre-natal care (including persons with substance use disorder, mental illness, experiencing homelessness) remain critical.

Preliminary data show that from January through October 2021, the highest increase in the number of new congenital syphilis cases was observed in the Antelope Valley Health District. In addition, between January and October 2019, a two-fold or more increase in cases was observed in the Antelope Valley, East Los Angeles, Southwest, and West Health Districts. When reviewing by Health District for January through October 2021, Antelope Valley (11) yielded the highest total number of congenital syphilis cases, followed by West Valley (10), Southwest (8) and South (7). When analyzed by SPA in the same time period, SPA 6 (South) accounted for 23% of congenital syphilis cases (21 of 91 cases). Additionally, Glendale and San Fernando Health Districts did not have any reported congenital syphilis cases between January and October 2019 but reported between 1 and 3 cases between January and October 2021.

Table 13: Congenital Syphilis Cases in Los Angeles County, 2011-2020[1]



APPENDIX B: WORKGROUPS AND KEY CONVERSATIONS

Appendix B1: Internal Los Angeles County Workgroup

Purpose: This workgroup of internal Los Angeles County partners was formed to inform the response to the September 2021 Board motion aimed at addressing the local STD crisis. Meeting activities included eliciting input on the proposed response, eliciting input on strategies to enhance cross-departmental collaboration, providing updates on key conversations and workgroups, and reviewing the draft STD Dashboard.

Meeting Dates: December 9, 2021; January 20, 2022

Attendees:
D'Artagnan Scorza, ARDI
Heather Jue Northover, ARDI
Sarkis Semerdjyan, CEO Leg Affairs
Paul Beddoe, CEO Leg Affairs
Faith Conley, CEO Leg Affairs
Jaclyn Baucum, AHI
Gayle Haberman, AHI
Erin Saleeby, DHS
Paul Giboney, DHS
Sulma Herrera, DHS
Theion Perkins, DMH
Muntu Davis, DPH
Rita Singhal, DPH
Deborah Allen, DPH
Joshua Bobrowsky, DPH
Gema Morales-Meyer, DPH
Jan King, DPH
Leo Moore, DPH
Linda Aragon, DPH MCAH
Gary Tsai, DPH SAPC
Susie Baldwin, DPH OWH
Sonya Vasquez, DPH CHE
Scott Chan, DHP CHE
Jacqueline Valenzuela, DPH
Rebecca Cohen, DPH DHSP
Shobita Rajagopalan, DPH DHSP
Andrea Kim, DPH DHSP
Sherry Yin, DPH DHSP
Juli Carlos Henderson, DPH DHSP

Facilitator: Mario J. Pérez, DPH
Notetakers: Julia Heinzerling, DPH; Marisa Cohen, DPH

Appendix B2: Internal/External Los Angeles County Policy Workgroup

Purpose: This workgroup was formed to focus on the third directive of the Board of Supervisors STD motion tied to STD-related policy and budget proposals for consideration at the state and federal level. Workgroup meetings focused on gathering feedback and recommendations on STD related legislative and budget proposals.

Meeting Dates: December 16, 2021; December 23, 2021; January 6, 2022

Attendees:
Candace Gragnani, Academy of Pediatrics (AAP)
Katja Nelson APLA Health/COH Public Policy
Craig Pulsipher, California End the Epidemics
Lisa Fisher, CCALAC
Everardo Alvizo, City of Long Beach
Cheryl Barrit, Commission on HIV
Nomsa Khalfani, Comm Prev & Pop Health TF
Sylvia Castillo, Essential Access Health
Paul Young, HASC
Ward Carpenter, LA LGBT Center
Maryjane Puffer, LA Trust for Children's Health
Gabrielle Tilley, LA Trust for Children's Health
Rebecca Trotzky-Sirr, LACUSC Urgent Care/ED
Maricela Ramirez, LACOE
Susan Chaides, LACOE
Tonya Ross, LACOE
Ayako Miyashita, UCLA Luskin School of Public Policy
Hannah Kwak, UCLA Preventive Medicine Fellow
Caitlin Newhouse, UCLA Preventive Medicine Fellow
Valerie Coachman-Moore, WeCanStopSTDsLA
Jaclyn Baucum, Alliance for Health Integration
Lauren Nakano, Alliance for Health Integration
Faith Conley, CEO Leg Affairs
Paul Beddoe, CEO Leg Affairs
Sarkis Semerdjyan, CEO Leg Affairs
Prabhu Gounder, DPH ACDC
Joshua Bobrowsky, DPH
Sonya Vasquez, DPH CHE

Facilitator: Mario J. Pérez, DPH
Notetakers: Julia Heinzerling, DPH; Marisa Cohen, DPH

Appendix B3: Metrics and Milestone Sub-Workgroup

Workgroup Purpose: This sub-workgroup of internal Los Angeles County partners was formed to focus on outlining metrics and milestones for STD related progress. Meeting activities included identifying shared metrics that can be used to measure progress effectively, and discussing milestones, metrics, and goals that are specific and tailored to highly impacted populations.

Meeting Date: January 6, 2022

Attendees:
Heather Jue Northover, CEO-ARDI
Jaclyn Baucum, AHI
Lauren Nakano, AHI
Paul Giboney, DHS
Theion Perkins, DMH
Deborah Allen, DPH
Leo Moore, DPH
Rashmi Shetgiri, DPH
Karen Swanson, DPH
Scott Chan, DPH CHE
Sonya Vasquez, DPH CHE
Angel Perdomo, DPH MCAH
Maria Mejia, DPH MCAH
Marian Eldahaby, DPH MCAH
Noribel Taguba, DPH MCAH
Tina Kim, DPH SAPC

Facilitator: Mario J. Pérez, DPH
Notetakers: Julia Heinzerling, DPH; Marisa Cohen, DPH

Appendix B4: Additional Conversations

STDs through an Equity Lens
Purpose: This meeting was held to discuss STD related efforts through the Center for Health Equity.

Meeting Date: January 4, 2022

Attendees:
Heather Jue Northover
Sonya Vasquez
Scott Chan

Facilitator: Mario J. Pérez, DPH
Notetaker: Marisa Cohen, DPH

The Role of Pharmacists in Expanded STD Control Efforts
Purpose: This meeting was held to discuss the role of pharmacists in STD control in Los Angeles County. The meeting focused on pharmacist's role in PrEP and EPT.

Meeting Date: January 19, 2022

Attendees:
Jerika Lam, Chapman
Carla Blieden, USC
Tam Phan, USC
Shobita Rajagopalan, DPH DHSP

Facilitator: Mario J. Pérez, DPH
Notetakers: Julia Heinzerling, DPH; Marisa Cohen, DPH

APPENDIX C: CDPH DEAR COLLEAGUE LETTER

State of California—Health and Human Services Agency
California Department of Public Health

Tomás J. Aragón, M.D., Dr.P.H.
Director and State Public Health Officer*Acting Director*

GAVIN NEWSOM
Governor

November 16, 2021

Subject: Call to expand HIV and syphilis testing for pregnant women

Dear Colleague,

The California Department of Public Health (CDPH) requests your assistance in responding to alarming increases in congenital syphilis and perinatal HIV transmissions in California. In 2019, 446 congenital syphilis cases were reported in California, the highest number of cases since 1993. In 2020 there were also six perinatal HIV transmissions in California, compared to four in 2019 and three in 2018. Most of the birthing parents of children with perinatal HIV were co-infected with or had a recent history of syphilis, one of the indicators for offering HIV prevention medication (i.e., Pre-Exposure Prophylaxis or PrEP), highlighting the need for an integrated approach to these devastating and preventable infections. In addition, significant racial disparities have been observed, as rates of congenital syphilis are significantly higher among Black/African American and American Indian/Alaska Native infants than the statewide rate.

Perinatal HIV transmission and congenital syphilis can be prevented with timely testing and treatment. A common risk factor, however, is receiving late or no prenatal care. HIV and syphilis testing and treatment must expand beyond prenatal care clinics to other settings serving women at elevated risk for HIV and syphilis. CDPH requests your assistance to implement the following policies and best practices to Screen, Treat and Prevent, and Prepare for perinatal transmissions including, but are not limited to, the following:

Screen

- **Confirm HIV and syphilis status of all pregnant patients receiving care or services at emergency departments; urgent care clinics; jails; mental health, drug treatment, and syringe services programs; and street medicine or homeless outreach programs** with documented lab results or by providing opt-out HIV and syphilis testing.

- Screen all pregnant patients for HIV at least once[1] and for syphilis three times during pregnancy: the first test should be as early as possible (during the first trimester), the second test should be during the third trimester (ideally between 28–32 weeks' gestation), and the third test should be at delivery[2,3]. Pregnant women who initially test negative for HIV but are at higher risk should have repeat HIV testing during third trimester or at delivery if not tested during 3rd trimester.

Treat and Prevent Syphilis and HIV

- **Pregnant women with syphilis should be treated with the recommended penicillin regimen for their stage of infection as soon as possible.**
- **Infants born to mothers with syphilis during pregnancy should be evaluated and treated for congenital syphilis** per recommendations in CDC's Sexually Transmitted Infection Treatment Guidelines (link here).
- **Pregnant women newly diagnosed with HIV or previously diagnosed with HIV but not on antiretroviral therapy should start treatment as soon as possible.** Pregnant women with HIV should receive antiretroviral therapy throughout pregnancy (including the intrapartum period). Pregnant women on antiretroviral therapy but not virally suppressed should have their therapy urgently optimized to achieve viral suppression.
- **Infants born to mothers with HIV should immediately receive appropriate antiretroviral medications to prevent perinatal HIV transmission[4].** Local health departments, Ryan White clinics, and CDPH can help facilitate rapid consultations for HIV care. The National Perinatal HIV Hotline (1-888-448-8765) provides free clinical consultation on all aspects of perinatal HIV care.

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[1] Repeat HIV testing in the third trimester is recommended for pregnant women who are at increased risk of acquiring HIV, including those receiving care in facilities that have an HIV incidence of ≥1 case per 1,000 pregnant women per year. Repeat HIV testing is also recommended for pregnant women with a sexually transmitted infection (STI) or with signs and symptoms of acute HIV infection.

[2] All infants and mothers should be tested for syphilis at delivery unless there is low risk for infection and third trimester testing is negative.

[3] Expanded Syphilis Screening Recommendations for the Prevention of Congenital Syphilis: Guidelines for California Medical Providers 2020. Available at: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Expanded-Syphilis-Screening-Recommendations.pdf

[4] Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission. Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States. Available at https://clinicalinfo.hiv.gov/sites/default/files/guidelines/documents/Perinatal_GL.pdf.

Prepare

- **Refer and navigate all women diagnosed with bacterial STIs (syphilis or gonorrhea) for HIV Pre-Exposure Prophylaxis (PrEP) which can safely be provided during pregnancy.**
- **Birthing hospitals should have expedited HIV and syphilis testing available 24 hours a day with results available within 1 hour** during labor or delivery for women with undocumented HIV or syphilis status, including women who were not retested in the third trimester.
- If HIV or syphilis results are positive, a protocol should be in place to provide immediate intrapartum antiretroviral prophylaxis (HIV) or penicillin G treatment (syphilis) to the mother.
- Pregnant patients with HIV or syphilis may require intensive case management to ensure that they have access to treatment and care. Contact your local health department (and Ryan White clinic if HIV) to assist with navigation and support services. Preventing perinatal HIV and congenital syphilis are critical priorities for public health in California.

Early diagnosis and treatment can prevent perinatal HIV transmission and congenital syphilis but can only be achieved if testing and treatment are expanded beyond traditional settings. Thank you for your work to improve the sexual health of all Californians. Together, we can end these epidemics and eliminate perinatal HIV transmission and congenital syphilis. Additional information and resources are appended below.

Sincerely,

Philip Peters, MD
Office of AIDS Medical Officer
Center for Infectious Diseases
California Department of Public Health

Kathleen Jacobson, MD
Chief, STD Control Branch
Center for Infectious Diseases
California Department of Public Health

APPENDIX D: STD INDICATORS

Appendix D1: STI National Strategic Plan: Key STD Indicators

For each indicator, the STI Plan records baseline measurements and establishes 5- and 10-year targets, as well as annual targets to monitor efforts to meet targets. Data sources are based on nationally representative samples. Data sources provide regular and consistent estimated data to enable cross-year comparisons and stratification by age, geographic region, race/ethnicity, and sex, and, when available, sex of sex partners. The data sources are described following the tables of core indicators and disparities indicators and their targets.

CORE INDICATORS

Table B.1 presents the baseline measurements, annual targets, and data sources for each core indicator. Five- and 10-year targets are bolded and underlined.

Table B.1. STI Plan Core Indicators

Core Indicator	Baseline[a]	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Data Source[b]
1. Increase the percentage of adolescents aged 13–17 years who receive the routinely recommended doses of HPV vaccine												
Percent	51	57	63	69	75	**80**	81	82	83	84	**85**	NIS-Teen
2. Reduce rates of P&S syphilis[c]												
Rate per 100,000	13.6	13.5	13.4	13.3	13.3	**13.2**	13.0	12.8	12.6	12.4	**12.2**	NNDSS
3. Reduce rates of congenital syphilis[c]												
Rate per 100,000	67.7	66.0	64.3	62.3	60.3	**57.6**	54.2	50.1	45.4	40.0	**33.9**	NNDSS
4. Reduce gonorrhea rates[c]												
Rate per 100,000	221.9	220.8	219.7	218.4	217.1	**215.3**	213.1	210.4	207.3	203.7	**199.7**	NNDSS
5. Increase chlamydia screening in sexually active females aged 16–24 years												
Percent	58.8	59.7	60.6	62.2	64.1	**66.4**	68.0	71.1	73.3	75.0	**76.5**	HEDIS
6. Reduce PID in females aged 15–24 years[c]												
Rate per 100,000	171.6	169.9	168.2	166.1	164.0	**161.3**	157.9	153.8	149.0	143.5	**137.3**	HCUP NEDS
7. Increase condom use at last sex among sexually active high school students[c]												
Percent	51.3	51.6	51.8	52.3	52.9	**53.5**	54.2	54.9	55.5	56.0	**56.5**	YRBSS

[a] Baseline is 2020, except for Indicator 1, which uses a 2018 baseline. 2020 data points are projected based on trajectory in recent years.
[b] HCUP NEDS = Healthcare Cost and Utilization Project Nationwide Emergency Department Sample; HEDIS = Healthcare Effectiveness Data and Information Set; NIS-Teen = National Immunization Survey-Teen; NNDSS = National Notifiable Diseases Surveillance System; YRBSS = Youth Risk Behavior Surveillance System. See Data Sources section below for a description of each data source.
[c] This core indicator has a corresponding disparities indicator(s).

Appendix D1: STI National Strategic Plan: Key STD Indicators (continued)

DISPARITIES INDICATORS

Disparities indicators were identified by evaluating current STI data trends and selecting priority populations and subgroups most vulnerable. Table B.2 presents the baseline measurements and annual targets for each disparities indicator. Five- and 10-year targets are bolded. Each disparities indicator uses the same data source as its corresponding core indicator.

Table B.2. STI Plan Disparities Indicators

Disparities Indicator	Baseline[a]	2021	2022	2023	2024	**2025**	2026	2027	2028	2029	**2030**
8. Reduce P&S syphilis rate among MSM											
Cases/100,000	461.2	457.7	454.3	450.1	446.0	**440.4**	433.5	425.2	415.5	404.5	**392.0**
9. Reduce congenital syphilis rate among African Americans/Blacks											
Rate/100,000	167.5	162.9	158.3	152.8	147.3	**139.9**	130.7	199.6	106.7	92.0	**75.4**
10. Reduce congenital syphilis rate among AI/ANs											
Rate/100,000	207.6	201.9	196.2	189.3	182.5	**173.3**	161.9	148.2	132.2	113.9	**93.4**
11. Reduce congenital syphilis rate in the West											
Rate/100,000	89.7	87.2	84.7	81.8	78.8	**74.9**	69.9	64.0	57.1	49.2	**40.3**
12. Reduce gonorrhea rate among African Americans/Blacks											
Rate/100,000	632.9	628.2	623.5	617.8	612.1	**604.5**	595.0	583.6	570.3	555.1	**538.0**
13. Reduce gonorrhea rate in the South											
Rate/100,000	211.3	209.6	207.9	205.8	203.7	**201.0**	197.5	193.4	188.5	183.0	**179.6**
14. Increase condom use at last sexual intercourse among sexually active MSM high school students											
Percentage	53.8	53.8	54.2	54.9	55.8	**56.9**	58.0	59.1	60.0	60.8	**61.9**

[a] Baseline is 2020 for all of the disparities indicators. 2020 data points are projected based on trajectory in recent years.

DATA SOURCES

The Healthcare Cost and Utilization Project Nationwide Emergency Department Sample (HCUP NEDS) is the nation's most comprehensive source of hospital care data, including information on in-patient stays, ambulatory surgery and services visits, and emergency department (ED) encounters. HCUP is a family of databases, software tools, and related products developed through a federal-state-industry partnership and sponsored by the HHS Agency for Health Research and Quality. The database consists of administrative claims data from roughly 30 million ED visits at 950 hospitals that approximate a 20% stratified sample of U.S. hospital-based EDs with records at the ED visit level. HCUP NEDS data are collected annually, but usually with a 3-year delay in reporting.

Appendix D2: STI National Strategic Plan, Indicators and Targets

Core Indicator	Jurisdiction	Measure	2020 National Baseline	2019 LAC Baseline	2020 LAC Baseline[2,3]	2025 LAC Target	2030 LAC Target
2. Reduce rates of Primary & Secondary (P&S) syphilis	LA County, Long Beach and Pasadena	Rate	13.6	25	TBD	TBD	TBD
		N		2,538	TBD		
	LA County Only[4]	Rate		24	21		
		N		2,356	2,029		
3. Reduce rates of congenital syphilis[5]	LA County, Long Beach and Pasadena	Rate[6]	67.7	86	114	TBD	TBD
		N[7]		92	122		
	LA County Only[4]	Rate[6]		-	TBD		
		N		88	113		
8. Reduce P&S syphilis rate among MSM[8]	LA County, Long Beach and Pasadena	Rate	461.2	385	TBD	TBD	TBD
		N		1,558	TBD		
	LA County Only[4]	Rate		378	325		
		N		1,438	1,228		
12. Reduce gonorrhea rate among African Americans/Blacks	LA County, Long Beach and Pasadena	Rate	632.9	644	TBD	TBD	TBD
		N		5,607	TBD		
	LA County Only[4]	Rate		670	734		
		N		5,288	5,640		

[1] Cases and rates (per 100,000 population) are preliminary due to reporting delays and pending data review from the California STD Control Branch and the Centers for Disease Control and Prevention. In addition, 2020 data from the cities of Long Beach and Pasadena are not yet available from CDPH for use by LAC/DPH; thus, case counts and rates have been provided with and without the cities of Long Beach and Pasadena. Case counts and rates are subject to change. Rates for groups with fewer than 5 cases are not shown; rates based on <12 observations are considered to be unstable.
[2] Note that due to Los Angeles County safer-at-home orders, decreased screening services and increased use of telemedicine contributed to noticeable decreases in reported STDs during the months of March-May 2020. This has impacted LAC's ability to fully understand the STD epidemic for 2020. Caution is advised when interpreting 2020 case counts and rates for long term planning.
[3] Rates are calculated using provisional 2020 population estimates prepared by Henderson Demographic Services for the Los Angeles County Internal Services Department. Revised 2020 population estimates will not be available until at least May 2022. Rates are subject to change.
[4] Data from the cities of Long Beach and Pasadena are not included.
[5] Cases include probable congenital syphilis cases and syphilitic stillbirths.
[6] Rate calculated per 100,000 live births. 2020 live births not yet available. 2020 rates calculated using 2019 live births as a proxy. Rates could not be calculated for LAC only as the live birth denominator data includes all jurisdictions.
[7] Case counts for 2020 congenital syphilis cases were made available after consultation with the cities of Long Beach and Pasadena. Data source: Long Beach Health and Human Services STD Surveillance (as of 10/29/2021), Pasadena Health Department STD Surveillance (as of 11/3/2021).
[8] MSM defined as men who have sex with men or both men and women. Data for the cities of Long Beach and Pasadena do not differentiate between sexual partners who identify as men and sexual partners who identify as transgender women (male-to-female transgender individuals), and therefore, both are included in the case counts. Rates for MSM were calculated with the assumption that 8% of men in Los Angeles County are estimated to be MSM. This was estimated utilizing data from the 2017 National HIV Behavioral Surveillance Survey conducted in Los Angeles County.
Data Source: LAC/DPH STD Surveillance (as of 1/9/2022), Long Beach Health and Human Services STD Surveillance (as of 7/15/2021), Pasadena Health Department STD Surveillance (as of 7/15/2021)