AGN. NO.

MOTION BY SUPERVISORS HOLLY J. MITCHELL AND HILDA SOLIS 8/2/2022

RESPONDING TO LOS ANGELES COUNTY'S SEXUALLY TRANSMITTED DISEASE CRISIS

The rate and number of sexually transmitted diseases (STD) have been increasing in Los Angeles County (County) for over a decade. STDs are a type of disease or infection caused by a pathogen (bacterium, virus, or other microorganism) that can be transmitted or acquired via direct sexual contact from person to person. Congenital syphilis and syphilis, STDs that were nearly eradicated in the early 2000s, have increased at especially alarming rates. Syphilis, left untreated, can lead to serious health complications including heart disease, stroke, and infertility. Untreated syphilis amongst pregnant mothers can be passed on to the infant at birth. Known as congenital syphilis, the Centers for Disease Control and Prevention (CDC) estimates that up to 40% of babies born with congenital syphilis are stillborn or die at an early age. Infants can also experience short- and long-term complications including blindness, deafness, and liver and spleen complications.

In the County, congenital syphilis rates increased by 1300% and syphilis rates increased by 450% amongst women and 250% amongst men within the last 10 years. By 2018, in light of the sharp uptick in syphilis and congenital syphilis cases, the County Board of Supervisors (Board) allocated $5 million to the expansion of STD treatment and

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services and directed the Department of Public Health (DPH) to provide quarterly updates on the County's STD crisis. Since then, the ongoing COVID-19 pandemic has exacerbated challenges to the County's delivery of STD services. In 2020, the National Coalition of STD Directors reported that 78% of the STD/HIV health department workforce had redirected their priorities towards the pandemic. Therefore, on September 28, 2021, the Board directed DPH to provide an updated plan of action to address the STD crisis.

DPH's report back, submitted to the Board on April 1, 2022, recognizes that the decade-long increase in STD rates stems from systemic funding inequities predating the pandemic. Local public health departments and family planning clinics, which spearhead STD control efforts, are supported through a fragmented network of local, state, and federal funds. Unfortunately, federal funding sources for sexual health services have been cut or remained stagnant over the last decade. President Joseph Biden's budget proposal for Fiscal Year (FY) 2023 allocates a flat amount towards STD control, despite STDs like congenital syphilis increasing by 279% within 4 years nationally. The Title X Family Planning Program, a federal fund for clinics providing reproductive health services such as Planned Parenthood, has also received stagnant funding.

Inflation places an additional constraint on services. The CDC STD Prevention Budget decreased in purchasing power by 40% between FY 2003 and FY 2018 due to inflation. With consumer prices increasing by 8.6%, the fastest increase in 4 decades, the operational costs to provide sexual health services will increase, forcing providers to do more with less. DPH's existing STD programming prioritizes the most vulnerable populations needing sexual health services, including uninsured individuals, those without a regular primary care provider, and people experiencing homelessness or at-risk of becoming homeless. Given the growing rate of STDs, DPH and other local community health partners cannot address the STD crisis alone. As asserted in DPH's recommendations, a sustainable path forward requires participation and partnership across multiple sectors, agencies, providers, and advocates.

Private and public health insurance plans, in particular, are considered the largest payors for sexual health services including gynecological exams, birth control, and other services. An overwhelming majority of the County's residents are covered through their employer or a Medi-Cal managed care plan. Yet, despite being one of the largest payors

for sexual health services, current performance metrics for providers do not include comprehensive STD measures. The Healthcare Effectiveness Data and Information Set (HEDIS), managed by the National Committee for Quality Assurance, is the industry standard for evaluating the performance of insurance plans. HEDIS allows consumers to compare the performance of various health plans (Commercial, Medicare, and Medicaid) based on their ability to address significant public health issues such as cancer and heart disease. The data used to develop HEDIS measurements currently includes a limited range of STD measures. For example, chlamydia screening is included in HEDIS data, however, syphilis is not. Furthermore, HEDIS only collects STD rates among women. These gaps in data must be addressed, for providers and plans to adequately meet the needs of their members and improve the quality of their sexual health services.

Furthermore, as mandated through the California Healthy Youth Act (CHYA), school districts are also responsible for providing comprehensive sexual health education—including information on STDs—to middle and high school students. DPH reports that young people under the age of 25 have the highest risk for STDs. In 2016, youth represented the largest proportion of gonorrhea and chlamydia cases in the County. On a national level, young people ages 15 to 24 accounted for 22% of all reported syphilis cases, 42% of all gonorrhea cases, and 62% of all chlamydia cases despite making up only 13% of the population in 2018. Although considered an at-risk demographic for STDs, CYHA does not have a mechanism to ensure or assess whether school districts are disseminating up-to-date and accurate sexual health education in an effective and regulatorily compliant way.

A coordinated and collaborative response that engages partners in addition to local health departments is necessary to effectively address the STD crisis. California will pay a major cost if further action is not taken. One study, provided by the California Health Benefits Review Program (CHBRP), reports that each case of congenital syphilis costs an estimated $8,743 in direct costs and $78,396 in indirect costs for a total of $28.7 million for 329 cases in California (adjusted to 2021 dollars). The CHBRP also estimates that each case of syphilis would cost $742 per case in direct costs and $145 in indirect costs, translating to a total of $22.2 million in California for 25,344 cases in California (adjusted to 2021 dollars).

Moreover, untreated STDs can lead to serious short-term and long-term issues, and chronic health conditions that cause additional long-term costs, including costs of medical care, lost wages, and education. These long-term costs are disproportionately experienced by historically underrepresented and marginalized communities. This includes low-income persons, youth (ages 15-24), pregnant women and infants, transgender individuals, men who have sex with men, the prison population, individuals with substance use disorders, individuals in the child welfare system, and communities of color. In 2019, the National Association of County & City Health Officials (NACCHO) found that the rate of gonorrhea was 8.5 times higher in black men compared to white men and 6.9 times higher in black women than white women. Furthermore, NACCHO found that the rate of reported chlamydia cases is 5 times higher among black women relative to white women and 6.8 times higher amongst black men compared to white men. In the County, congenital syphilis and syphilis have disproportionately affected low-income communities of color. In 2020, Service Planning Areas (SPA) 4 and 6, which comprise Central and South Los Angeles, experienced the highest case of syphilis cases amongst females. Furthermore, a greater percentage of SPA 4 and 6 women diagnosed with syphilis did not receive treatment following their diagnosis. As we continue adapting to present health challenges, we must engage all partners in addressing an over decade long crisis.

I THEREFORE MOVE THAT THE BOARD OF SUPERVISORS:

1. Direct the Directors of the Department of Public Health (DPH), Department of Health Services (DHS), Department of Mental Health (DMH), and the Chief Executive Officer (CEO), to work with the Alliance for Health Integration, CEO's Anti-Racism, Diversity, and Inclusion Initiative, the CEO's Legislative Affairs and Intergovernmental Relations Branch, and relevant community stakeholders to:
    a. Appeal to the federal Department of Health and Human Services and to Congress to increase the federal investment for sexually transmitted disease (STD) Control efforts, including through, but not limited to services supported by the following agencies and funding streams, such as:

i. The Centers for Disease Control and Prevention and resources targeted for STD prevention and control that remain inadequate to address the high and growing level of STD morbidity;

ii. The Substance Abuse and Mental Health Services Administration and their State block grants given the strong nexus between substance use and STD risk and morbidity;

iii. The Health Resources and Services Administration through its grants to support Federally Qualified Health Centers (Bureau of Primary Health Care) and the Ryan White Program (HIV/AIDS Bureau) given the intersection of populations at risk for syphilis who are also at elevated risk for HIV.

b. Identify, with relevant stakeholder community-based advocacy organizations, additional opportunities to jointly advocate for more local, state, and federal funding, including STD policy proposals that prioritize communities or demographics that are disproportionately impacted by the STD epidemic.

c. Assess the impact workplace vacancies have on the delivery of STD-related programming, outreach, surveillance, and engagement administered through the County;

2. Direct the Director of DPH, the CEO, and the Executive Director of the Los Angeles County Youth Commission in coordination with the Superintendent of the Los Angeles County Office of Education, Superintendent of the Los Angeles Unified School District, and other relevant stakeholders to assess and report back in 60 days in writing on the implementation of the California Healthy Youth Act (CHYA).

a. This report should include, but not be limited to:

i. Available statistics on how often sexual health education is provided to middle school and high school students by school district;

ii. Available statistics on student attendance and participation including the number of students who opt-out of receiving sexual health education at the request of a parent or guardian;

iii. Strategies for ensuring curriculum is medically accurate, unbiased, up-to-date, inclusive, and adheres to all other requirements mandated by CHYA;
iv. Peer-led approaches which are promising or effective at delivering sexual health education; and
v. Input from family members, students, and instructors who have delivered sexual health education in compliance with CHYA.

b. Based on the findings in 2a above, this report should also specify any implementation challenges and recommendations for improvement related to CHYA including, but not limited to:
i. Funding needed, with cost estimates, to administer sexual health education in compliance with the CHYA;
ii. Feedback from educators, families, and students regarding CHYA and the effectiveness of sexual health education; and
iii. Limitations in the delivery or content of sexual health education being administered.

3. Instruct the Directors of DHS and DPH in partnership with managed care plans, and other relevant stakeholders to design a pilot program that implements antenatal syphilis point of care testing for pregnant mothers at-risk of syphilis and report back in writing in 60 days.
4. Instruct the Directors of DHS and DPH to identify the benefits and challenges of including STD testing (including oral, anal, and urine testing, blood tests, and bundled testing) within DHS-operated urgent care centers and emergency room settings, especially those located in high STD-incidence regions, and report back in writing in 60 days.
5. Direct the Directors of DPH and DHS to review their existing processes for sexual health screening and identify challenges and solutions to delivering screenings as it relates to asymptomatic people, young people, people with no pre-existing health conditions, and other target demographics who may not visit a provider or clinic frequently.

6. Direct the Directors of DPH, DHS and DMH in partnership with local managed care plans to improve messaging to increase Pre-Exposure Prophylaxis uptake.
7. Direct the Directors of DPH, DHS and DMH, in coordination with the Alliance for Health Integration, local managed care plans, and other relevant stakeholders to identify opportunities for improving Healthcare Effectiveness Data and Information Set measures or other related metrics tied to evaluating a health provider's provision of medically appropriate STD services, and report back in writing in 60 days.
8. Direct the Director of DPH to include reports on implementation progress in its quarterly STD updates.

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