CALIFORNIA
HIV / AIDS POLICY
RESEARCH CENTERS

Policy and Research Priorities to End the Epidemics of HIV, Viral Hepatitis, STIs, and Overdose: a California HIV/AIDS Policy Research Centers and End the Epidemics community convening

Introduction

Since 2020, the COVID-19 pandemic has led to significant disruptions in California's efforts to expand and improve services for HIV, viral hepatitis, sexually transmitted infections (STIs), and harm reduction. On November 10, 2021, the California HIV/AIDS Policy Research Centers (CHPRC) and the statewide End the Epidemics coalition (ETE) convened a community meeting to discuss these challenges and to identify policy and research priorities for improving HIV, viral hepatitis, STI, and harm reduction services. The event brought together over a hundred advocates, researchers, public health officials, and service providers from across California to discuss the many ways COVID-19 has affected their efforts to reach vulnerable communities and maintain progress in addressing these intersecting epidemics. The overall objectives of the meeting were to:

- Review policy developments during the 2021 legislative cycle;
- Present preliminary findings from a recent CHPRC Organizational Health Survey;
- Discuss successes and challenges to achieving health equity and improving HIV, viral hepatitis, STI, and harm reduction services in California; and
- Identify policy and research priorities to advance efforts to address HIV, viral hepatitis, STIs, and overdose.

Attendees participated in facilitated breakout groups to discuss key successes, challenges, and priorities for the coming year. This summary outlines primary findings and recommendations that emerged during the discussions. Findings are intended to help inform policy and research priorities.

Overview

Participants discussed broadly the need to identify specific goals to addressing syndemics, what funding is needed to achieve these targets, how public health professionals from different disciplines can play an active role in this work, and the need to unify a statewide movement to end the epidemics. Participants expressed that addressing stigma across the four areas is needed to break down barriers and begin fruitful conversations. Needs identified include flexible funding that covers not only clinical services, but also costs related to addressing social determinants of health (e.g. housing, food) to avoid medical costs in the future. Current funding mechanisms establish barriers that small organizations, including fledgling and grassroots organizations, cannot get past. Participants stressed the utility of "mini-grants," a grant-making vehicle common in prior decades, that delivers funding to cover start-up costs and account for delays in larger funding. Participants stressed that pushing for a similar funding mechanism would lower barriers to accessing funding, especially for smaller, less-resourced organizations.

In addition to funding, participants identified siloed systems of care as problematic as they are not set up to deliver holistic care. Participants discussed the need for greater communication between healthcare providers in primary care, behavioral health, and HIV/viral hepatitis specialty care. Systemic-level barriers include limitations on data sharing that make it difficult to treat the whole person rather than one symptom. Many recognized that the work of reducing silos and establishing an "any door is the right door" approach requires integration both in practice and in funding.

Decriminalization was discussed broadly as a strategy to address the public health consequences of criminal sanctions. Key populations facing disproportionate rates of infection and barriers to health access include criminalized individuals and those communities most targeted for criminalization. This includes Black, indigenous, and people of color (BIPOC), unhoused individuals, those engaged in sex work, and people who use drugs. Public health consequences discussed include the lack of screening and treatment for those in confinement and myriad unmet needs of re-entry populations (e.g. healthcare, housing, and other supports) with circumstances being especially critical during the transition from the carceral to community setting.

Finally, participants discussed the issue of health equity and the need for more diverse leadership especially within advocacy groups. Some noted the historical context where the majority of advocates addressing HIV in California were white individuals of greater economic means, which continues to overshadow opportunities to foster more diverse leadership. Participants discussed the need to carve out more space for community health workers with lived experience, training to ensure staff without lived experience are competent and empathetic to serve the community effectively and to address mistrust, and support to empower transgender and BIPOC-led efforts. A potential solution shared by several participants includes changing organizational policies around hiring by allowing programs to employ people who use drugs and other people from the community, paying people for their expertise and intellectual property rather than giving them incentives (e.g. gift cards), and expanding leadership opportunities at all levels of employment. Recent data from CHPRC indicate these opportunities have been largely limited to front line service positons.

Biggest Successes

During the convening, participants discussed successes in the prior year. They included improving and expanding on existing service delivery models. Chief among these was connecting COVID-19-related services to HIV services that helped to normalize testing across the board, including COVID-19, HIV and hepatitis C (HCV) testing. Participants noted that piggybacking specific services onto existing services is a concept that has worked especially well for services related to HCV. Doing so has helped to decrease stigma and expand outreach efforts to communities impacted by these intersecting epidemics.

Building provider capacity was also seen as success with the example of the eConsult phone line in San Francisco providing key technical assistance. Increasing the pool of providers delivering culturally appropriate HIV and STI services was made possible with telehealth options. Examples of successful telehealth projects include helping to address PrEP needs of rural communities and those seeking medication-assisted treatment (MAT). Participants discussed the importance of helping clients navigate around existing regulations and providers making warm handoffs to ensure linkages to care, including the use of peer navigators that make services more personal and individualized.

Because the digital divide continues to represent a systems-level barrier, making telephonic/audio-only visits was documented as a success. Participants shared how they brought technology into communities by conducting outreach using iPads and WiFi hotspots in rural spaces. This helped to bridge the digital divide especially among those facing specific barriers related to transportation. Organizations strived to expand existing services to individuals made particularly vulnerable as a result of the COVID-19 pandemic. For example, organizations offered unhoused clients the option to have medications delivered to their office where they can be safely stored and picked up. Participants spoke to curating

safe spaces during these challenging times by creating "judgement-free zones." Examples included diversity training for every employee within an agency or organization and creating data systems that capture pronouns, preferred names, and use of other accessible language.

Biggest Challenges

Participants were faced with addressing historical injustice, rooted in the denial and/or avoidance in addressing racism and various forms of stigma. PrEP-related stigma as well as prejudice and discrimination against unhoused populations was seen as a significant challenge. Current approaches to addressing homelessness (e.g. street sweeps, forced relocation) were critiqued, as they offer no permanent solution and further exacerbates risks among this population, including risk of overdose. Participants discussed how street sweeps disrupt existing networks of support, trauma-informed care, access to medications leading to increase in communicable diseases, and worsened mental health outcomes. Additionally, participants discussed how the needs of specific communities (e.g. Black women, transgender people) are often not prioritized and the failure to identify disparities starts with incomplete data collection.

Staffing challenges continue, including identifying leaders and hiring staff that reflect communities being served. Noted gaps in hiring were identified in the areas of mental health and substance use. Staff burnout was also a key challenge, resulting in compassion fatigue, secondary trauma, and high levels of stress. More broadly, training gaps continue to persist within the workforce, including the need to broaden the pool of providers (e.g. training primary care providers delivering HCV screening and treatment), expand the capacity of navigators to address a broader set of issues (e.g. insurance), and ensuring greater cultural sensitivity among providers serving already marginalized populations in resource-limited settings (e.g. BIPOC, transgender communities).

Research Opportunities

Participants identified research opportunities in the following areas:

- Identifying models of comprehensive care and to what degree existing resources and infrastructure are insufficient to addressing rising STI rates;
- Impact of telehealth on retention in care as well as shifting policies in the care setting (e.g. auto-refills) established during the COVID-19 pandemic, and the need make permanent regulations to support these alternative models of care;
- New PrEP modalities and issues related to equity in PrEP uptake and maintenance are still needed, including to what degree current law and policy protections for pill-based PrEP must extend to long-acting injectable formulations;
- Persistent payment-related barriers to accessing PrEP and PEP despite broad coverage options for those without insurance and limited income;
- Patients' perspectives on suboxone uptake and those diagnosed with HCV but remain untreated;
- Documenting the use of harm reduction data to demonstrate how harm reduction programs are making a 'dent' to influence local-level policy;
- The intersection of sexual minority status (e.g. gay and bisexual men) and injection drug use, including drug of choice.

Participants stressed how there remain opportunities to improve research approaches. Participants shared specific concerns around engaging unhoused populations that may feel dehumanized through the research process. Failure to compensate participants can lead to mistrust. Participants queried whether research projects could shelter chronically unsheltered individuals as part of the research process. Participants stressed the importance of community-based participatory research in which participants are paid in cash, not gift cards, and where community members have easy access to the data and results after findings are published.

Specific recommendations related to each individual epidemic were further discussed, as noted below.

HIV	Viral Hepatitis	STIs	Overdose
Increasing delivery of PrEP services means increased HIV testing. This leads to identifying more newly diagnosed individuals. More resources are needed to provide linkages to HIV services. Community education efforts are required to keep people aware of HIV prevention modalities in the pipeline and to disseminate accurate information about PrEP, including information from conferences, clinical trials, and scientific publications. Marketing for PrEP must center on disproportionately affected communities including gay and bisexual men of color, transgender persons and cisgender women. Given that non-profit organizations are delivering services during traditional working hours, more needs to be done to leverage PrEP and PEP delivery in emergency departments (ED). For individuals that use the ED as the main source of medical care, routinizing HIV screening in the ED may help identify new infections. Senate Bill 159 implementation requires attention. COVID-19 has disrupted the training of pharmacists for the disbursement of PrEP and PEP through local pharmacies.	Participants expressed that resources to address viral hepatitis are spread thin. The majority of funding seems to go to larger organizations located in heavily populated areas (e.g. downtown) leaving less populated areas and smaller organizations, including BIPOC-led organizations, underfunded. Rapid testing can give a same-day diagnosis, helping people with limited access. However, under-screening and under-testing for viral hepatitis remains an issue. Staff, which include primary care physicians, also need to be educated as the onus is on them to identify those who need to be screened and treated for viral hepatitis. Universal hepatitis B testing for pregnant women and an increase in hepatitis B and C testing in carceral settings, a place that the government both under-tests and underfunds, should be considered as future targets.	Allocating increased federal, state, and local funding to expand infrastructure and programming for routine STI screening, testing, diagnosis, and treatment are key to tackling the current STI epidemic. Efforts to reduce congenital syphilis continue to be impeded by fear of interaction with law enforcement while seeking prenatal care in the hospital. Women who are experiencing homelessness and/or engaging in substance use are afraid to present themselves for care for these reasons. Participants expressed that in other jurisdictions (e.g. New York) **destigmatizing** the names of clinics (e.g. "STI clinic") increased traffic and testing.	An increase in funding for collaboration and advocacy between government agencies (e.g. Department of Justice, Health and Human Services) and community organizations looking to create evidence-based overdose/ harm reduction policies is needed. This includes efforts to address barriers at the local level that threaten to shut down harm reduction services. Collective efforts could include creating centralized overdose databases, **decriminalizing** drug use at a national level, implementation of safe injection sites, and increasing Narcan distribution when patients are prescribed drugs. Participants expressed that people who use drugs need increased support that includes flexibility in types of supplies (e.g. including snorting/smoking paraphernalia) and services (e.g. drug checking/testing, safe injection sites) that are delivered. Program policies and treatment guidelines must shift, as they did as a result of the COVID-19 pandemic, to become more patient-centered. Harm reduction supplies delivery to street-based populations must employ flexible solutions (e.g. vending machines, partnerships with single room occupancy buildings).