

This at-a-glance summary (i.e., a visual summary) of the overall plan serves as a tool to describe gross level aspects of the plan by intervention strategy. It will emphasize how the intervention strategies work together and how the overall plan is a coordinated effort. Please complete the table below.

Intervention Strategy	Change in Scale	Resources Required	Current Funding	Planned Funding	Net Change in Funding	NHAS/DHAP Goal Addressed	Brief Justification
Name	Increase (I) No change (N) Decrease (D)	New (N) Existing (E) Existing but leveraged (EL)	List existing funding sources	List new sources or changes in current sources	Increase (I) No change (N) Decrease (D)	(1) Reduce New Infections (2) Reduce Health Disparities (3) Increase access to care/ Improve health outcomes for PLWHA	A brief justification for how the collection of activities in each intervention category will achieve the identified NHAS/DHAP goal and work in conjunction or coordination with other interventions/strategies in the plan

Key:

*Required Strategy

LAC – Los Angeles County

DPH GF – Department of Public Health General Fund

DHS- Department of Health Services

CDC ETP- Expanded Testing Program

CDC CoAg- CDC Cooperative Agreement

CDC DF- Directly Funded CBOs

CDC STD- STD Program Cooperative Agreement

RW- Ryan White Program Part A and Minority AIDS Initiative

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1* Routine, opt-out screening for HIV in clinical settings	Increase	Reprogrammed existing and new resources	CDC CoAg, CDC ETP, DPH GF, Gilead, DHS	ECHPP	Increase	1,2	Routine HIV screening in select high volume community health and urgent care settings must occur to reach case finding goals. Locally, this strategy will occur in high burden zip codes and will be an important complement to targeted testing efforts and allow us to identify individuals with no perceived risk of HIV infection. The re-programming of current resources will be based on our modeling activities

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								described in Appendix A that among things, compares the cost per diagnosis and reach for this testing strategy compared to others . The need for additional resources is clear.
2*	HIV testing in non-clinical settings to identify undiagnosed HIV infection	May increase, but scale dependent on modeling activities	Resource reprogramming likely.	CDC CoAg, CDC ETP, CDC DF, CA State, DPH GF	No change in sources	May increase, but level dependent on modeling activities	1,2	Testing in non-clinical settings targeted to high burden zip codes and disproportionately impacted groups has resulted in modest testing yields. Any re-programming of current resources will be based on our modeling activities described in Appendix A and our consideration of issues tied to cost per diagnosis, linkage to care patterns and overall intervention reach.
3*	Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection	Increase	Reprogrammed existing resources	CDC CoAg	Same sources	Increase	1,2,3	The extent of condom distribution scale-up will depend on modeling activities and will be influenced by the extent to which condom availability and access is a barrier currently, the cost to saturate the zip codes where transmission is highest and where condom access is a problem, the potential reach and effectiveness of the strategy and likelihood of success of this strategy given local community norms tied to condom use.
4*	Provision of Post-Exposure Prophylaxis (PEP) to populations at greatest risk	Increase	Existing and new	DPH GF, Pharma (in-kind)	DPH GF and CDC ECHPP	Increase	1,2	Recent PEP pilot efforts in LA suggest strong adoption of this biomedical intervention in select high risk areas. Given the geographic breadth of LA, several PEP disbursement hubs are necessary. In kind ART donations that supported the pilot effort will sunset resulting in a necessary increase in OAPP investment of nearly 100% to slightly increase the scale of the program.
5*	Efforts to change existing structures, policies, and regulations that are barriers to creating an	No change	Existing	DPH GF	Same sources	No change	1,2,3	In recent years, LAC has increased testing efficiency by eliminating many policy, procedural and regulatory barriers to testing at the local or state levels. LAC will now switch its focus to (1) building capacity and

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	environment for optimal HIV prevention, care, and treatment							maximizing the uptake of routine opt out HIV testing in medical settings throughout LAC; and (2) improving syringe access by increasing structural support for and removing barriers to implementation – without increasing the overall staff effort in structural change-related efforts.
6*	Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care	Increase	Existing	CDC CoAG, CDC ETP, NIDA, RW, DPH GF, CA State	Same sources	Will increase, but level dependent on modeling activities	1,2,3	LAC is improving its understanding of linkage to care patterns across several demographic and geographic areas. Linkage disparities persist and new strategies are needed to improve linkage rates. Several new linkage to care initiatives are underway. Any re-programming of current resources to further increase efforts will be based on our modeling activities described in Appendix A and our identification of the interventions that can best help improve linkage with the greatest reach and cost-effectiveness. The need for additional resources appears to be very likely.
7*	Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons	Increase	Existing	RW, CA State, DPH GF, SAMHSA	Same sources	Will increase, but level dependent on modeling activities	1,2,3	LAC is improving its understanding of retention and re-engagement needs across several demographic and geographic areas. Retention disparities persist and new retention approaches are necessary to meet NHAS goals. Any re-programming of current resources will be based on our modeling activities described in Appendix A and our understanding of the most cost-effective retention and re-engagement interventions. The need for additional resources appears to be very likely.
8*	Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment	Increase	Existing and new	RW, CA State	Current funding sources and Medicaid	Increase	1,2,3	LAC has achieved a strong ART coverage rate in the RW system and the level of coverage should increase with the rollout of Medicaid expansion efforts (MCE) locally. Overcoming drug financing hurdles associated with MCE will be crucial in California to meet this goal and addressing cultural and community norms that

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	guidelines for HIV-positive persons							challenge improved health access patterns require intervention.
9*	Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons	Increase	New	None	To be determined, RW likely	Increase	1,2,3	This intervention was defunded several years ago as part of a series of program adjustments resulting from a State deficit. Promoting ART adherence is necessary to ensure that all PLWHA on ART have fully suppressed HIV viral load, which would result in reduced community level viral load for LAC, an important strategy to reduce forward HIV transmission.
10*	Implement STD screening according to current guidelines for HIV-positive persons	May increase, but dependent on modeling activities	Resource reprogramming likely. Change in total investment is unclear	CDC CoAg, CDC STD, RW	Same sources	May increase, but dependent on modeling activities	1,2,3	STI screening is currently a performance measure among RW funded providers and compliance is strong. Ensuring ongoing STI screening according to guidelines for HIV-positive persons in LAC is necessary to improve treatment of STIs in this population, thereby reducing an important cofactor in forward HIV transmission. This does not require additional investment. Alternatively, any re-programming of current resources to further increase efforts will be based on our modeling activities described in Appendix A and our identification of new STI screening strategies based on reach and cost-effectiveness.
11*	Implement prevention of perinatal transmission for HIV-positive persons	No change	Existing	CDC CoAg, DPH GF, RW	Same sources	No change	1,2,3	There have been less than 5 documented cases of perinatal transmission of HIV in LAC in the last 5 years in a population of more than 10M. A level investment should keep this rate low.
12*	Implement ongoing partner services for HIV-positive persons	Increase	Existing	CDC CoAg	Same sources	Will increase, but level dependent on modeling activities	1,2,3	HD-based and community-based PHI's are critical to highly targeted case finding efforts locally. Starting shortly, the partner services PHIs will also work to facilitate linkage to HIV medical care for those newly diagnosed with HIV or out of care with concomitant STIs. Any re-programming of current resources will be based on our modeling activities described in Appendix

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								A and our understanding of the number of PHIs needed to provide partner elicitation and linkage to care for all new diagnoses. The need for additional resources appears to be very likely.
13*	Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV	Likely decreasing, but dependent on modeling activities	Resource reprogramming likely. Changes in total investment unclear/	CDC CoAg	No change in sources	Level of reduction dependent on modeling activities	1,2,3	It is likely that re-directing HE/RR program resources will occur. However, the extent of re-programming of current resources will be based on our modeling activities described in Appendix A and our understanding of the reach and effectiveness of these interventions to help meet NHAS goals
14*	Implement linkage to other medical and social services for HIV-positive persons	No change	Existing	CDC CoAg, RW, NIH	Same sources	No change	2,3	LAC currently manages a robust network of medical subspecialty and social services to improve health outcomes and quality of life for HIV+ individuals. Expansion of this system is not likely in a resource constrained and prevention starved environment.
15	Condom distribution for the general population	No change	No change	None	None	None	1	Given LACs population of more than 10M residents, and vast geographic area, it would be cost prohibitive and impractical to make condoms available to the entire population using public funds.
16	HIV and sexual health communication or social marketing campaigns targeted to relevant audiences	Increase	Reprogrammed existing resources	CDC CoAg, DPH GF	Same sources	Will increase, but level dependent on modeling activities	1,2,3	While increased visibility of HIV resources can lead to awareness of free testing and treatment services available throughout LAC, the local media market is extremely expensive. Any re-programming of current resources will be based on our modeling activities described in Appendix A and our understanding of the most cost-effective communication and marketing strategies that complement Act Against AIDS, Greater than AIDS, EraseDoubt and other social marketing efforts.
17	Clinic-wide or provider-delivered evidence-based HIV prevention	May increase, but dependent on modeling	Reprogrammed existing resources	RW	Same sources	May increase, but dependent on modeling	1,2,3	Integrating clinic-wide or provider-delivered evidence-based HIV prevention interventions locally will potentially reduce high risk behavior and reduce likelihood of

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	interventions for HIV-positive patients and patients at highest risk of acquiring HIV	activities				activities		transmitting or acquiring HIV infection. This requires the enforcement of the existing standards of care for prevention messaging delivered by clinicians during medical visits and may not require additional resources. However, any re-programming of current resources will be based on our modeling activities described in Appendix A and our understanding of the reach and effectiveness of these interventions to help meet NHAS goals.
18	Community interventions that reduce HIV risk	Increase	Existing	CDC CoAg, DPH GF	Same sources	Increase	1,2,3	Increased visibility of HIV resources can lead to awareness of free testing and treatment services available throughout LAC. See #16 above.
19	Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV; particularly those in an HIV-serodiscordant relationship	Likely will remain the same, but dependent on modeling activities	Resource reprogramming likely. Changes in total investment is unclear	CDC CoAg	No change in sources	Dependent on modeling activities	1,2	Behavioral risk screening followed by behavioral risk reduction interventions for high risk HIV-negative persons alone is unlikely to impact the transmission of HIV in Los Angeles County. Given the limited demonstrated long term effectiveness of the behavioral interventions and their relatively high cost, it is important for LAC to expand the prevention portfolio to include a range of evidence based interventions that target the individuals most at risk for acquiring HIV. Behavioral risk screening and interventions must be combined with substance use treatment, mental health treatment, STI treatment, partner services, homeless services, stigma and homophobia reduction efforts to effectively prevent forward transmission of HIV. Given the immense size and diversity of LAC, limited resources, and questionable/unknown efficacy over time, LAC needs to prioritize the availability of intensive behavioral risk reduction services to individuals most at

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								risk for HIV in LAC including HIV negative stimulant users and HIV negative individuals with STIs. OAPP’s modeling activities will help inform the scope and direction of all behavioral risk screening activities, including behavioral interventions directed towards HIV negative individuals, consistent with the NHAS goals (see Appendix A). Significant efforts are underway to assess the cost-effectiveness of various prevention strategies in order to prioritize activities and allocate resources commensurate with expected outcomes..
20	Integrated hepatitis, TB, and STD testing, partner services, vaccination, and treatment for HIV infected persons, HIV-negative persons at highest risk of acquiring HIV, and injection drug users according to existing guidelines	Increase	Existing	CDC CoAg	Same sources	Increase	1,2,3	Integrating HIV, STD, and viral hepatitis screening would potentially prevent new HIV infections and co-morbid infections. It is clear from local surveillance data that significant overlap exists among populations infected with HIV and syphilis, and also to a lesser extent with chlamydia and gonorrhea. Screening for multiple infections simultaneously is cost effective and increases likelihood of successful treatment and improved prevention messaging.
21	Targeted use of HIV and STD surveillance data to prioritize risk reduction counseling and partner services for persons with previously diagnosed HIV infection with a new STD diagnosis and persons with a previous STD diagnosis who receive a new STD diagnosis	Increase	Existing, but significant reprogramming is likely	CDC CoAg, DPH GF	Same sources	Increase	1,2,3	Access to real-time surveillance and laboratory data to inform programmatic activities including partner services and linkage to care follow-up would prevent forward HIV transmission to individuals at highest risk and improve health outcomes. Protocols for data sharing are in development and will be reviewed by legal counsel. Data can be used for the promotion of early intervention services which can identify new infections, help identify people who have fallen out of care,

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								and promote treatment adherence strategies to reduce viral load and the possibility of forward transmission.
22	For HIV-negative persons at highest risk of acquiring HIV, broadened linkages to and provision of services for social factors impacting HIV incidence such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and others	Increase	Existing	CDC CoAg, DPH GF	Same sources	Increase	1,2	Decreasing social factors impacting HIV risk among HIV-negative persons at highest risk of acquiring HIV through broadened linkages and by providing critical/targeted services (mental health and substance use Tx) could potentially reduce high risk behavior and decrease the likelihood of acquiring HIV infection. “Upstream” efforts will be identified to reduce stigma and increase awareness of the association of co-morbid mental health and substance issues with HIV infection; program collaboration and cross-screening will be encouraged through training and media efforts.
23	Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV	Increase unlikely, but dependent on modeling activities	Existing resources may be reprogrammed	RW, CDC CoAg, DPH GF	Same sources	Dependent on modeling activities, but increase in funding is unlikely	1,2,3	Alcohol use has shown to be associated with HIV risk behavior with HIV positive and negative individuals. Therefore, LAC will commission the development of a brief alcohol screening tool from our local Centers For AIDS Research (UCLA) for use in clinical settings that serve high risk negative and HIV positive patients. Given the immense size and diversity of LAC and limited resources available, LAC needs to prioritize the availability of brief alcohol screening to individuals most at risk of transmitting or acquiring HIV including men who have sex with men and transgender individuals.

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24	Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors	No change	Existing	RW, CDC CoAg, DPH GF	Same sources	No change	1,2,3	LAC is currently assessing the community mobilization expectations in reach and influence, and will determine how best to invest limited OAPP human and financial resources to impact HIV incidence through broad community mobilization efforts that challenge community norms, mores, stigma, homophobia, and transphobia.