

## Los Angeles County ECHPP Project

### Workbook #1: SITUATIONAL ANALYSIS & GOAL SETTING

**This workbook is to document:**

- **The results of a current situational analysis for all interventions and public health strategies currently conducted in the jurisdiction; goals and rationale for selecting each intervention or public health strategy included in the enhanced plan**

*(Please see pp. 9-11 in the published FOA for a complete list of the 14 “required” interventions or strategies. Please see pp. 11-13 of the FOA for an additional list of 10 “recommended to consider” or optional interventions.)*

This Workbook documents the results of Step 1 ‘Situational Analysis’ and Step 2 ‘Goal Setting’. It is organized by intervention/public health strategy and lists the 14 required by the FOA, with additional space to include information for other relevant interventions/public health strategies. Grantees must complete the **entire** Situational Analysis in Step 1 before moving onto Goal Setting in Step 2. The Situational Analysis should consider the current state of their jurisdiction as a whole (not just within each intervention/strategy).

## Workbook #1: INSTRUCTIONS

### **STEP 1: 'Situational Analysis' (Box A)**

**In box A, please write a complete and clear description of this intervention or public health strategy. Describe key features on how this intervention or public health strategy currently is being used or delivered in your jurisdiction. See Appendix 1 for points to cover in your description.**

- 1) At a minimum, please address each of the considerations listed in Appendix 1 at the end of the Workbook. This list of considerations is intended to provide some guidance on what to document in your situational analysis. Feel free to address additional considerations, but be certain to address those listed in Appendix 1.
- 2) Whenever possible, please cite sources that support statements about your local situation. (For example, if you cite epidemiologic or other data, did you get it from a specific location in your local Epi Profile or some other source?)

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Upon completing the situational analysis and preparing to consider goals, it is important to identify potential opportunities for maximizing the impact on reducing HIV infections. Also consider how HIV-related health disparities are being addressed by each intervention or public health strategy before moving on to goal setting (Step 2).

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### **STEP2 'Goal Setting' (Box B)**

**In box B, please do the following:**

- 1) *Description*: State clearly and with detail the primary HIV prevention goals for this intervention strategy
- 2) *Rationale*: Describe the rationale for how each goal will support maximizing the plan's impact on reducing new HIV infections and HIV-related health disparities.
- 3) Describe the extent to which the goal(s) of this intervention or public health strategy is part of an optimal combination of efforts described in the plan.

Goals are defined as broad aims that define the intended results of each intervention or public health strategy included in the Enhanced Plan. Collectively, these goals should optimize the provision of HIV prevention, care and treatment in your jurisdiction.

**In addition to the results of your situational analysis, please consider the following sources of information (as available) when developing these goals:**

- 1) Local epidemiologic data
- 2) Current available resources
- 3) Opportunities for leveraging resources across partners and/or funding streams
- 4) The results of gap analysis
- 5) Priority areas from existing comprehensive plan
- 6) Efficacy data
- 7) Cost information
- 8) Cost-effectiveness data

**Required Intervention #1: “Routine, opt-out screening for HIV in clinical settings”****A: Situational Analysis**

The County of Los Angeles, Department of Public Health (DPH), Office of AIDS Programs and Policy (OAPP) has adopted CDC’s revised recommendations to support and implement HIV screening for all health care providers working in clinic settings that include but are not limited to inpatient services, substance abuse treatment clinics, community clinics, correctional health care facilities, prenatal care clinics and other primary care settings. Since 2008, OAPP has partnered with hospitals, community clinics and other medical providers to scale up routine HIV screening in high prevalence areas, and greatly expanded routine testing within health care settings by working with six hospitals and clinics in Los Angeles County.

In 2009, 18 facilities were funded or supported by OAPP to provide routine HIV testing.

- Twelve Department of Public Health STD clinics
- Four community based clinics were supported through CDC funding (the cooperative agreement and the Expanded Testing Initiative)
- Two clinics (one community base clinic and one County clinic) were supported through funding by Gilead as demonstration projects. OAPP provided implementation technical assistance, and overall oversight and additional technical assistance for the program
- OAPP also provided technical assistance to four other clinics interested in implementing routine testing
- Additional routine testing supported by Gilead through their FOCUS Initiative in LAC at the following sites with data not yet available: AltaMed, Planned Parenthood, Watts Healthcare Corporation, and JWCH Institute

Table 1 shows the number of tests conducted and HIV positivity rates at OAPP-funded routine testing programs and supported sites in 2009.

**Table1. OAPP-funded Routine Testing Programs HIV Positivity & New Positivity Rates, 2009**

| Type of Testing Program          | Number of HIV Tests | HIV Positivity Rate |       | HIV New Positivity Rate |       |
|----------------------------------|---------------------|---------------------|-------|-------------------------|-------|
|                                  |                     | N                   | %     | N                       | %     |
| <b>Routine Testing</b>           | 7,643               | 86                  | 1.13% | 81                      | 1.06% |
| <b>Public Health STD Clinics</b> | 25,171              | 203                 | 0.81% | 164                     | 0.65% |

**Data Source:** Office of AIDS Programs and Policy, Los Angeles County Department of Public Health, HIV Testing Annual Report, January through December 2009, November 2010, 1- 53. Available online:

<http://publichealth.lacounty.gov/aids/reports/HCT2009Report.pdf>

OAPP currently invests CDC Cooperative Agreement and Expanded Testing Program (ETP) funds to support routine testing programs at a level of \$1,033,000 (\$600,000 is for routine testing at STD clinics). This investment is complemented by small targeted investments made by Gilead to further enhance and optimize routine HIV testing in clinical settings in LAC. A significant increase in financial and human resources is needed to scale up routine testing locally to levels that would allow us to meet our NHAS goals. This amount will be informed by our ongoing modeling activities (see Appendix A).

OAPP will continue to assist health care settings to maximize alternate payer sources to support routine

testing through development and distribution of collateral materials that include billing codes (ICD9/CPT codes). The codes are used for Medicaid, Medicare and private insurance. In addition, information is provided on other potential public sources of support for reimbursement such as Family Pact (California's family planning initiative).

## B: Goal Setting

Primary HIV prevention goals:

1. Implement routine opt-out HIV screening in urgent care and emergency departments located in areas with the highest burden of HIV.
2. Increase the number of individuals who know their HIV status and normalize testing.

**Rationale:** {LAC has over 10 million residents covering more than 4000 square miles, making it 88 times larger than San Francisco. Of the estimated 62,000 people living with HIV in LAC, an estimated 12,000-15,000 are undiagnosed. Targeting resources for proven interventions to high-risk populations in areas of known disease burden is one way of reducing the gap between known and unknown infection. Toward that end, LAC has embarked on a strategic partnership with RAND Corporation to produce mathematical models that will assist local planners in determining which interventions are most likely to prevent infection, identify people with undiagnosed infection, link them to care and treatment, and prevent forward transmission. These modeling activities are done in combination with analysis of existing data from HIV/STD surveillance, program evaluation, care and treatment providers, local research studies, and best-practices literature.}

Local data tell us that the epidemic in LAC continues to be sexually driven, most often by men who have sex with men, and especially men of color who have sex with men. Sophisticated mapping activities have shown us where the burden of HIV is highest.

Routine opt-out screening will assist us with reaching high risk individuals as well as individuals with no perceived risk, and individuals with inconsistent health access patterns (e.g. homeless persons, persons with an incarceration history, substance abuse issues, and no health insurance). Routine screening will also identify HIV positive individuals at an earlier disease stage which, through linkage to care and ART, will help prevent disease progression and reduce forward HIV transmission. We will scale up routine opt-out HIV screening in clinics that are located within high burden areas, specifically in the central and southern portions of the county that encompass Hollywood, West Hollywood, Silverlake, downtown, south and east LA City, and Long Beach...all discrete geographic areas within LAC where people at elevated risk are known to reside and are likely to seek medical care. Target zip codes for routine screening and many other interventions have been determined based on the cluster analysis that is currently in progress (see Appendix A). These target zip codes will be referenced throughout this document. Continuation of the modeling activities will help determine the amount of investment in routine screening necessary to achieve the NHAS goal of reducing the percentage of undiagnosed infections to as little as 10%.

## Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"

### A: Situational Analysis

In July 2009, OAPP implemented new HIV testing programs that followed the recommendations made in

the Los Angeles County HIV Prevention Plan 2009-2013. The plan not only identified the geographic areas and the target populations to be prioritized in 2009-2013, but also increased the allocation amount for HIV Counseling and Testing (HCT) services. For 2010, OAPP increased the number of HCT providers from 18 to 22 and the number of HCT programs from 26 to 32 (increases of 22% and 23%, respectively). The non-clinical testing modalities include 1) storefront testing; 2) mobile testing; 3) multiple morbidity mobile testing units that test for HIV, STD, and Hepatitis A, B and C; and 4) commercial sex venue (bath houses and sex clubs) testing. In addition to these models, OAPP continues to provide direct HIV counseling and testing services in LAC courts, shelters, and drug rehabilitation sites.

Table 2 shows the number of tests and positivity rates obtained in 2009 through testing at non-clinical sites in Los Angeles County.

**Table 2. DPH Testing In Non-clinical Settings HIV Positivity & New Positivity Rates, 2009**

| Type of Testing Program                                 | N of HIV Tests | HIV Positivity Rate |              | HIV New Positivity Rate |              |
|---|----------------|---------------------|--------------|-------------------------|--------------|
|   |                | n                   | (%)          | n                       | (%)          |
| <b>Total Tests</b>                                      | <b>66,611</b>  | <b>699</b>          | <b>1.05%</b> | <b>564</b>              | <b>0.85%</b> |
| <b>Testing within Jail Settings</b>                     | <b>9,631</b>   | <b>7</b>            | <b>0.07%</b> | <b>4</b>                | <b>0.04%</b> |
| <b>Targeted Testing</b>                                 | <b>31,162</b>  | <b>450</b>          | <b>1.44%</b> | <b>362</b>              | <b>1.16%</b> |
| <b>OAPP Subcontracted Agencies</b>                      |                |                     |              |                         |              |
| <i>Storefront</i>                                       | 18,471         | 280                 | 1.52%        | 227                     | 1.23%        |
| <i>Mobile Testing Unit Program</i>                      | 6,419          | 73                  | 1.14%        | 64                      | 1.00%        |
| <i>Multiple Morbidity Mobile Testing Units Programs</i> | 2,709          | 35                  | 1.29%        | 22                      | 0.81%        |
| Bath Houses and Sex Clubs                               | 1,766          | 28                  | 1.59%        | 27                      | 1.53%        |
| Court Ordered & Drug Expansion Testing Programs         | 1,797          | 34                  | 1.89%        | 22                      | 1.22%        |

**Data Source:** Office of AIDS Programs and Policy, Los Angeles County Department of Public Health, HIV Testing Annual Report, January through December 2009, November 2010, 1- 53. Available online:

<http://publichealth.lacounty.gov/aids/reports/HCT2009Report.pdf>

Among the OAPP subcontracted agencies, table 3 presents the number of tests and HIV positivity rates by priority and critical target populations defined in the Los Angeles County Department of Public Health HIV Prevention Plan 2009-2013.

**Table 3. Priority & Critical Target Population HCT Summary Data from Targeted Testing Sites, 2009**

| Characteristic   | N             | New Positives(n) | New Positivity Rate (%) |
|--|---------------|------------------|-------------------------|
| <b>Number of HIV Tests<sup>1</sup></b>                           | <b>28,362</b> | <b>327</b>       | <b>1.15%</b>            |
| <b>Target Populations<sup>2</sup></b>                            |               |                  |                         |
| <b>HIV Positive Individuals<sup>3</sup></b>                      | <b>412</b>    | <b>327</b>       |                         |
| <i>Gay men</i>   | 303           | 251              |                         |
| <i>Non- gay identified men who have sex with men<sup>4</sup></i> | 7             | 6                |                         |
| <i>Transgender Individuals</i>                                   | 28            | 21               |                         |
| <i>Women</i>   | 33            | 21               |                         |

|  |               |            |              |
|--|---------------|------------|--------------|
| <b>Youth (12-24 years)</b>                                 | <b>7,582</b>  | <b>57</b>  | <b>0.75%</b> |
| Gay men  | 2,569         | 48         | 1.87%        |
| Non- gay identified men who have sex with men <sup>4</sup> | 265           | <5         | -            |
| Transgender Individuals                                    | 76            | 5          | 6.58%        |
| Sex Workers  | 808           | 15         | 1.86%        |
| Women who have sex partners of unknown HIV status          | 2,629         | <5         | -            |
| <b>Male</b>  | <b>19,685</b> | <b>285</b> | <b>1.45%</b> |
| Gay men  | 10,417        | 251        | 2.41%        |
| Non- gay identified men who have sex with men <sup>4</sup> | 913           | 6          | 0.66%        |
| <b>Female</b>  | <b>8,447</b>  | <b>21</b>  | <b>0.25%</b> |
| Women who have sex partners of unknown HIV status          | 8,176         | 18         | 0.22%        |
| <b>Transgender Individuals</b>                             | <b>230</b>    | <b>21</b>  | <b>9.13%</b> |
| <b>People who Share Needles/Works</b>                      | <b>1,849</b>  | <b>22</b>  | <b>1.19%</b> |

**Data Source:** Office of AIDS Programs and Policy, Los Angeles County Department of Public Health, HIV Testing Annual Report, January through December 2009, November 2010, 1- 53. Available online:

<http://publichealth.lacounty.gov/aids/reports/HCT2009Report.pdf>

\*Indentation shows that the characteristic is a subset (sample) of the characteristic above it.

<sup>1</sup>3,447 of targeted tests excluded due to limitations in data reporting system.

<sup>2</sup> Priority and critical target populations as identified in Table 4.6 in the Los Angeles County Department of Public Health HIV Prevention Plan 2009-2013 <http://publichealth.lacounty.gov/aids/PreventionPlan.htm>

<sup>3</sup> Includes newly identified positive individual and individuals who previously tested positive.

<sup>4</sup> Includes males who did not self-identify as homosexual or bisexual and reported having sex with men.

Table 4 below presents OAPP’s investment in HIV testing in non-clinical settings.

**Table 4. OAPP’s Funding Sources for HIV Testing in Non-clinical Settings**

| <b>Funding Source</b>             | <b>\$</b>        |
|-----------------------------------|------------------|
| CDC- Cooperative Agreement        | \$3,958,667      |
| CDC – Expanded Testing Initiative | \$100,000        |
| California State                  | \$1,035,354      |
| <b>TOTAL</b>                      | <b>5,094,021</b> |

**B: Goal Setting**

Primary HIV prevention goals:

1. Re-assess provision of non-clinical HIV testing services to better target the epicenters of disease burden.
2. Identify new/innovative targeted testing strategies to identify new infections.

**Rationale:** LAC has an estimated 12,000-15,000 undiagnosed individuals living with HIV/AIDS. While routine opt-out screening will be scaled up to assist in the identification of undiagnosed infection among people who may not think of getting screened (#1 above), increasing targeted HIV testing in non-clinical settings provides HIV screening in the communities where disease prevalence is highest, and screening activities are actively promoted among target populations. Given the immense size and diversity of LAC, LAC can only support testing in a limited number of venues that optimally engage and serve the highest-risk populations that are not likely to routinely access health care services. HIV testing in non-clinical settings will target the sub-populations with the highest HIV prevalence: men who have sex with men, men who have sex with men and women, transgender individuals, and substance users, as well as the social and sexual networks of HIV positive individuals within target zip codes. HIV testing in non-clinical settings will also identify HIV positive individuals at an earlier disease stage which, through linkage to care and ART, will help prevent disease progression and reduce forward HIV transmission. OAPP is in the final stages of its HIV testing modeling exercise to determine the investment necessary in non-clinical settings needed to meet the NHAS goal of 10% or less of undiagnosed HIV infection (see Appendix A).

**Required Intervention #3: “Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection”**

**A: Situational Analysis**

Fifty-three (53) OAPP-contracted Health Education/Risk Reduction (HE/RR) programs have a line item in their budgets to purchase condoms and distribute to the prioritized target populations targeted through HE/RR including HIV-positive persons and persons at highest risk of acquiring HIV infection. Currently OAPP spends approximately \$74,401 on purchasing condoms for HE/RR programs. Since HCT programs are fee-for-service, no direct funding is provided for condom purchase; however, all funded HCT providers (22 agencies) have condoms available for people who test at their sites. Public Health Department STD clinics (12 clinics) also distribute condoms on-site. OAPP is working with the County of Los Angeles, Department of Public Health, Sexually Transmitted Diseases Program (STDP) to leverage resources in order to purchase more condoms in bulk for distribution across clinics, funded agencies, and selected venues throughout the County where both HIV-positive and high-risk HIV-negative persons can access condoms. Development of an “LA condom” and associated marketing program are underway.

**Gaps to address:**

Condom distribution is not at the level needed to adequately target HIV-positive persons and persons at highest risk of acquiring HIV infection. OAPP’s goal is to scale up this intervention.

**B: Goal Setting**

Primary HIV prevention goal:

1. Increase condom distribution to target priority populations.
2. To design, market, and distribute an “LA Condom” to brand condom use as a part of the Erase

Doubt social marketing campaign.

**Rationale:** There are an estimated 62,800 Persons Living with HIV/AIDS (PLWHA) in LAC, with 2,000-3,000 new infections in LAC each year and over 55,000 STDs reported in 2009 (74% Chlamydia, 14 % gonorrhea, 5% syphilis). Most new HIV infections are attributed to sexual contact (94%). Safer sex practices are critical to reducing HIV infection and transmission, and visibility of and access to condoms are both crucial.

However, given the immense size and diversity of LAC, LAC can only support increased condom availability in a limited number of venues that optimally engage and serve the highest-risk populations (listed above in #2) who confront condom access barriers (e.g. financial, community norms, behind the counter condom sales, and/or other availability issues). While condoms are routinely made available free of charge to current prevention program clients, the current condom availability, saturation, and consistency of access is unknown. Re-engagement of social forums like gay bars and clubs, bath houses, sex clubs, and “condom patrol” distribution in high burden areas is the first step in increasing both condom visibility and access. OAPP will begin condom distribution programming, including the introduction and promotion of the LA condom (currently in development) in very high burden areas of the county like Hollywood, West Hollywood, Long Beach, Silverlake, Skid Row, and south LA. While it is clear from existing data that condom availability must increase, the total investment will be guided by the modeling activities currently underway.

#### Required Intervention #4: “Provision of Post-Exposure Prophylaxis to populations at greatest risk”

##### A: Situational Analysis

OAPP, in collaboration with the University of California, Los Angeles (UCLA), Friends Research Institute Inc., and two community based clinics (LA Gay and Lesbian Center Sexual Health Program in Hollywood and OASIS clinic in South Los Angeles) are currently conducting two non-occupational Post Exposure Prophylaxis (nPEP) pilot programs. The rationale for the pilot programs is to introduce biomedical/bio-behavioral intervention strategies as part of LAC’s overall prevention portfolio with the goal that the combination of available prevention strategies will reduce further HIV transmission. Funding for these pilot programs are supported through the County of Los Angeles Department of Public General Fund with PEP medications donated by pharmaceutical companies.

1). P-QUAD – This pilot program was developed in 2009 and was implemented on March 2, 2010 at two HIV care clinics, which also provide HIV prevention and testing. The program targets HIV-negative individuals at highest risk for sexual and intravenous exposure to HIV. The pilot’s nPEP services provide a 28-day course of highly active antiretroviral therapy initiated within 72 hours after HIV exposure in combination with STD screening, education, and intensive behavioral risk reduction counseling. At the demonstration sites, after eligibility, screening is performed, a baseline evaluation is conducted and an initial 14-day supply of PEP medications is provided. All subjects who receive an initial medication supply are required to return to the site for -up evaluation, adherence counseling, and risk-reduction programming. Then PEP services are designed to be easily accessible, non-judgmental, culturally, ethnically, and linguistically appropriate to the relevant populations, community-based, and independent of ability to pay. They also provide vital linkages to substance use and sexual risk reduction services, HIV testing at four time-points during service delivery, and primary health care in the event of seroconversion. Currently, the P-QUAD program is supported by the County of Los Angeles Department



of Public General Fund (\$198,507). Antiretroviral medication for the P-QUAD was donated by Pharmaceutical companies. Providers were given criteria in which they may initiate a 2 drug (Truvada or Combivir) regimen, and criteria for which they may add a third drug (Kaletra or Raltegravir) in the setting of exposure to known HIV-positive with suspected drug resistance. However, given the successful implementation demonstrated in this pilot program, OAPP will be investing in moving forward into an expanded nPEP service delivery program. OAPP estimates the cost of a nPEP service delivery program to be approximately \$2,200/person (in LAC this would be \$880,000 for 400 individuals enrolled over 12 months) if a 2 drug regimen is used in all but exceptional cases of document drug resistant source. OAPP plans to use ECHPP funding to address this gap in nPEP service delivery.

As of December 1, 2010:

- 155 individuals were screened of whom 141 were enrolled
- 2 significant adverse events: both continued treatment
- Self-reported adherence rates: 97%
- 2 sero-conversions

2). Combined Bio-behavioral Intervention for HIV-negative Methamphetamine-using Men who have Sex with Men (CM-PEP program). This was a pilot project with a planned enrollment of 55 participants. It was supported for 12 months with \$200,000 of the County of Los Angeles Department of Public General Funds, which included covering a 2-drug regimen of Truvada, with Combivir as an alternative.

Eligible participants include:

- Men who have sex with men
- 18 years and older
- HIV negative (self report and rapid test)
- Self-reported meth use in the previous 30 days
- Self-reported unprotected anal intercourse with HIV-positive/unknown partner in the previous 90 days

The pilot protocol consists of:

- Contingency Management, three times a week for 8 weeks. Participants may “cash in” accumulated voucher points for goods or services at any time
- Participants enrolling in the absence of an eligible high-risk exposure to HIV are provided a 4-dose starter pack of Truvada. In the event of high-risk exposure to HIV, starter pack use is initiated. Attempt to reduce exposure-to-dose time
- Participants reporting at baseline a high-risk HIV exposure within the previous 72 hours will

initiate PEP concomitantly with enrollment and Contingency Management

Findings to date show that the combined contingency management behavioral intervention and nPEP among meth using MSM appears to be safe and feasible for HIV prevention. Time to PEP initiation and adherence rates appear comparable to non-meth using populations. Meth-using men who have sex with men demonstrated high rates of sexual risk behavior as evidenced by high prevalent STI rates. Although a small sample size, there was only one incident sero-conversion.

### **B: Goal Setting**

Primary HIV prevention goal:

1. Implement a nPEP service delivery program within Los Angeles County.

**Rationale:** There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new infections in LAC each year. Most new HIV infections are attributed to sexual contact (94%) among high-risk populations. Biomedical interventions like nPEP are necessary for high risk groups who have been failed by traditional HIV prevention activities and programming. LAC will expand the prevention portfolio to include evidence based biomedical interventions that target the highest risk individuals with a recent known exposure from a known or unknown positive individual (as defined in the situational analysis above). Given the immense size and diversity of LAC, LAC can only support targeted nPEP availability in a limited number of venues that optimally engage and serve the highest-risk persons. Given the success of the pilot nPEP program, LAC will increase the availability of nPEP in target zip codes in central and south LAC. The extent of the scale-up will be finalized by the modeling activities currently underway.

### **Required Intervention #5: “Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment”**

#### **A: Situational Analysis**

Los Angeles County’s efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment include activities listed below.

- Meetings and conversations with local, state, and federal legislators and policy makers; participation in UCHAPS and other bodies that influence policy
- Supported and pursued successfully statewide legislation that removes barriers to HIV testing/screening. These include:
  - A bill requiring health care service plans and health insurers to provide reimbursement for HIV testing when conducted as a routine screening for all patients, and not limited to risk based screening only
  - A bill that reduces barriers to implementing HIV screening a routine part of healthcare delivery by authorizing testing as part of the general consent for medical care and deleting provisions from existing law that required written informed consent and counseling to be provided with HIV testing in medical settings

- Supported and pursued successfully legislation that mandates the reporting of new HIV cases by name in order to better map the statewide HIV burden and bring the County and state into compliance with CDC and HRSA guidelines for eligibility and funding
- Supported and pursued successfully legislation that requires labs to report all CD4 count test results to the local health officer within seven days of the completion of a CD4 count test. Persons identified through this process as living with HIV/AIDS are added to the existing State HIV case registry to provide a more accurate picture of the HIV epidemic in California, including easier identification of unmet need
- Currently working internally and with local and state partners and stakeholders to effectively implement the above state laws to propagate the most optimal HIV prevention, care and treatment environment possible
- In recognition of the public health crisis related to needle sharing and its relation to the transmission of infectious diseases, including HIV and hepatitis B and C, the County of Los Angeles implemented, in collaboration with the City of Los Angeles, a syringe exchange program in 2007 that is administered by five agencies at multiple sites. OAPP also played a large role in traversing the local bureaucratic barriers that existed leading up to implementation
- Continue to pursue both legislative and regulatory solutions that would mandate the use of condoms among performers in the adult film industry in order to reduce HIV transmission amongst a high risk population that is, in many ways, unique given the significant proportion of adult films that are produced in Los Angeles County
- OAPP is in the process of investigating the possibility of changing HIV testing reimbursement structures due to existing challenges at the agency level

OAPP in collaboration with other County of Los Angeles Department of Public Health Programs, as part of the ECHPP process, are working together to address other structural barriers that can be addressed in order to better provide HIV prevention services. OAPP uses the County of Los Angeles, Department of Public Health General Funds to support these activities.

### **B: Goal Setting**

Primary HIV prevention goals:

1. Implement effective syringe access program county-wide to be administered out of OAPP.
2. Improve data collection and tracking for HIV testing in medical settings to facilitate measurement of HIV screening rates.

**Rationale:** In general, Los Angeles and California have policies and laws that support and facilitate effective HIV prevention; however, several structural barriers to optimal prevention remain. The first goal is to work toward removing existing barriers to accessing syringes by educating LAC policy makers

and law enforcement on the value and importance of providing sterile syringes, sterile injection equipment, and education to people who inject drugs, steroids, and hormones in order to prevent acquiring or transmitting HIV transmission and other co-morbidities (e.g. hepatitis C). With regard to the second goal, current data systems do not allow us to accurately track the level of routine HIV screening within health care centers in LAC, making it difficult to assess where to prioritize scale up (see intervention #1). Therefore our second goal will address barriers to measuring our success at scaling up routine opt-out HIV screening in medical settings, and also help us know where we can improve so we can achieve optimal testing rates. Current resources will be redirected in order to focus on increasing access to sterile syringes.

**Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV positive and not currently in care”**

**A: Situational Analysis**

The HIV Epidemiology Department Surveillance Team reported that as of December 31, 2009<sup>1</sup>, Los Angeles County has an estimated 62,800 people living with HIV/AIDS (PLWHA). California implemented code-based HIV reporting in July 2002, and name-based HIV reporting in April 2006. Thus, HIV data are still preliminary and underestimate true HIV prevalence in the County.

Aggressive case finding is a key component in all of OAPP’s program planning. OAPP ensures a smooth transition from diagnosis to care through the coordination of HIV Counseling and Testing (HCT), early intervention and wrap-around services with primary medical care. To ensure referrals and linkage to services for individuals informed of their status, LAC applies the below strategies:

1) A significant proportion of Ryan White Minority AIDS Initiative funding is devoted to early intervention in an effort to locate PLWHA of color who have not accessed or have fallen out of care. Early intervention programs that were previously funded through the state will maintain their outreach and social work components to help vulnerable PLWHA with access and retention.

The Early Intervention Programs (EIP) to identify unaware PLWHA and support them in their entry in and adherence to HIV treatment. EIP is supported through Ryan White Part A, Minority AIDS Initiative and County funds play a pivotal role in connecting newly diagnosed PLWHA to medical care in LAC, especially populations with special needs, such as African-Americans, Latinos and women. EIPs aim to ensure early entry to necessary HIV care for newly diagnosed PLWHA, delay progression of HIV disease, promote optimal health, interrupt further HIV transmission through behavioral change, and to promote patient self-management of their HIV disease. The EIP services require frequent outreach activities at places such as community clinics, STD clinics, emergency rooms, detention centers, residential substance abuse treatment sites, homeless shelters, and on the street, to actively locate unaware individuals and PLWHA who are aware of their HIV infection but have not yet accessed medical care. With an interdisciplinary team approach, the EIPs combine outreach, mental health, health education, case management, medical care and risk reduction services to provide comprehensive support for PLWHA to access and remain in treatment. These efforts include building relationships with local clinics that do not provide

<sup>1</sup> HIV Epidemiology Program, Los Angeles County Department of Public Health. HIV/AIDS Surveillance Summary, January 2010: 1-33.

HIV services; HIV medical providers collaborating with non-medical HIV organizations; participation in health fairs, festivals and school events; working with medical providers to jointly develop care plans; and targeted interventions and partner services.

2) All of OAPP-funded HIV Counseling and Testing providers are required to refer HIV-positive clients to HIV care and track their linkage to care whenever possible. Performance-based HCT Fee-for-Service Reimbursement to Increase Provider Incentives for Disclosure and Linkage to Care. OAPP incorporates explicit contract language and a modified HCT fee-for-service structure to improve delivery of test results and linkage to medical care. Fee-for-service reimbursement offers providers financial incentives for disclosure, particularly to HIV-positive testers. OAPP increased the HCT reimbursement for linkage to medical care significantly from \$185 to a range of \$375-\$395 per client using the California Office of AIDS Program's HCT fee-for-service structure. This provides HCT agencies a considerable financial incentive to complete linkages to medical care for newly diagnosed individuals. OAPP will continue this practice for FY 2011. Agencies will document the referral and linkage using standardized forms and procedures. As a standard, referring and linking clients diagnosed with HIV to care and treatment is the responsibility of the HCT counselors, and the agency can receive highest reimbursement for successful linkages.

3) Provider Activities. Efforts to engage individuals into and keep them in care primarily involve calling clients who miss appointments and sending them correspondence by mail. Fifty percent (50%) of providers follow up with lapsed clients by phone, postcards, and letters. Approximately one-third of that group also focuses their retention/adherence efforts by using home visits, support groups, outreach in "former hangouts" and non-traditional settings, and incarceration settings. A number of agencies also have designated staff who conduct home visits and street outreach to contact clients. A quarter of the provider respondents use community outreach to target people who have never been in care in order to enroll them into care.

4) Collaboration with Children's Hospital Los Angeles (CHLA) – OAPP's current collaboration with CHLA is assisting an Adolescent Medicine Trials Unit Linkage Care Worker that provides assistance in linking youth (13-24years) to medical care. OAPP supports the linkage worker in providing access to OAPP-funded testing sites and assist in the sites efforts to link youth into care.

5) To ensure partners of PLWHA who tested HIV-positive are linked to care, Los Angeles County has begun to implement the Antiretroviral Treatment Access Study (ARTAS) Linkage Case Management (ALCM) program, where a STD Program public health investigator (PHI) delivers up to five sessions of strength-based case management to newly diagnosed persons and persons out of care. The program is rolling out currently, and data as to its effectiveness in improving linkage to care should be available at the end of 2011.

6) To facilitate the referral process, OAPP funds HIVLA, a comprehensive online and printed directory of HIV/AIDS services available in English and Spanish. The directory contains fact sheets on each service and information on training and technical assistance. When users search the online database for a service category, they are presented with the results as well as a fact sheet describing the service. A toll

free hotline also provides information on how to use the directory as well as service referrals and information on public benefits. HIVLA will assist in referral to care.

Because linkage to care is an important component of improving individual health outcomes and decreasing viral load levels thereby reducing the risk of HIV transmission, predictors to not being linked to HIV care were analyzed using a multivariate regression model. Data from newly diagnosed HIV-positive clients identified through OAPP-funded testing sites from 2006-2008 were used in this model (n=804). Linkage to HIV care was determined by identifying the HIV-positive testers in the HIV/AIDS surveillance database, which is housed at the County of Los Angeles, Department of Public Health, HIV Epidemiology Program. Unlinked to care was defined as not receiving a CD4 count or viral load measure within one year of testing positive for HIV. Independent covariates included in the model were: race, age, gender, injection drug use, MSM behavior, living situation, and HIV testing site type.

**Overall, in among those newly diagnosed with HIV in 2008, 59% of individuals diagnosed at OAPP-supported testing sites are linked to care within 3 months and 54% county-wide are linked to care within 3 months.**

**Table 5. Behavioral Predictors of Individuals from OAPP-funded HIV Testing Sites Not Linked<sup>1</sup> into Care, 2006-2008**

| Characteristic   | Multivariate Analysis Modeling<br>Not Linked to Care |           |          |
|--|--|-----------|----------|
|  | Adjusted OR  | 95% CI    | P-value* |
| <b>Gender</b>  |  |           |          |
| Female   | 0.57   | 0.30-1.06 | 0.07     |
| Transgender  | 2.68   | 1.09-6.62 | 0.03     |
| Male (reference)   | --   | --        | --       |
| <b>Race</b>  |  |           |          |
| African-American   | 3.07   | 1.88-5.01 | <0.01    |
| Asian/Pacific-Islander                                       | 1.80   | 0.88-3.69 | 0.11     |
| Latino/Hispanic  | 1.73   | 1.13-2.66 | 0.01     |
| Other  | 0.95   | 0.18-5.03 | 0.95     |
| White (reference)  | --   | --        | --       |
| <b>Age</b>   |  |           |          |
| Youth (12-24 yrs.)   | 0.61   | 0.35-1.08 | 0.09     |
| Adult (25-44 yrs.)   | 0.85   | 0.54-1.35 | 0.50     |
| Older Adult (45+ yrs.) -- reference                          | --   | --        | --       |
| <b>Living Situation</b>                                      |  |           |          |
| Homeless/Transitional  | 3.39   | 1.94-5.94 | <0.01    |
| Permanent Housing (reference)                                | --   | --        | --       |
| <b>Injection Drug Use (within last 2 years or last test)</b> |  |           |          |
| Yes  | 1.70   | 0.97-2.98 | 0.07     |
| No (reference)   | --   | --        | --       |
| <b>Testing Site Type</b>                                     |  |           |          |
| Mobile   | 1.59   | 1.13-2.23 | 0.01     |
| Fixed (reference)  | --   | --        | --       |
| <b>Behavioral Risk Group</b>                                 |  |           |          |

|                     |      |           |      |
|---------------------|------|-----------|------|
| MSM only            | 1.28 | 0.86-1.90 | 0.23 |
| Non-MSM (reference) | --   | --        | --   |

<sup>†</sup>Time frame from within last 2 years or since last test.  
 \* p-value < 0.05

**Data Source:** HIV Information Resources System (HIRS) and HIV/AIDS Reporting System (HARS), 2006-2008. Represents lab data collected through December 31, 2009

Based on the findings from the analysis (see Table 5), characteristics/factors associated with being unlinked to care included being:

- African American and Latino
- Homeless
- Transgender
- Tested at Mobile Testing Unit (vs. fixed)

As a result of these findings, OAPP will continue to focus linkage to care activities prioritizing the populations listed above. All linkage programs listed above have written policies and procedures and training was provided to agency staff performing the linkage activities.

**B: Goal Setting**

|  |
|--|
| <p>Primary HIV prevention goals:</p> <ol style="list-style-type: none"> <li>1. Improve linkage to care among persons newly diagnosed with HIV.</li> <li>2. Develop strategies to use existing public health/surveillance data to identify individuals newly diagnosed with HIV not in care.</li> </ol> <p><b>Rationale:</b> There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new infections in LAC each year with over 800 new diagnoses identified through OAPP-funded testing programs, and an additional 1,200 new diagnoses identified in the combined private and non-OAPP funded public sector. OAPP’s highest priority is linking the newly diagnosed to care within 3 months. Current data (see situational analysis above) show that 59% of individuals diagnosed at OAPP-supported testing sites are linked to care within 3 months, and 54% county-wide are linked to care within 3 months. Both estimates are below the NHAS goals. By increasing, implementing, and refining the following activities we expect to improve linkage to care within LAC:</p> <ul style="list-style-type: none"> <li>• Aligning HIV testing provider incentives to optimize linkage to care</li> </ul> |
|--|

- Adopting new HIV rapid testing algorithms that will result in expediting linkage to care activities
- Expanding partner services (including ARTAS and community embedded DISs)
- Expansion and improved targeting of early intervention and retention services
- Placement of linkage workers to facilitate expedited access to care among hard to reach out of care populations

An internal TLC+ workgroup has been established to plan, develop, implement, and evaluate TLC+ activities and system-wide programming to optimize linkage to HIV care, treatment and prevention services for those testing HIV positive and not currently in care. Given the immense size and diversity of LAC, LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to linkage to care locally. OAPP already supports a wide range of services designed to link the newly diagnosed to care and promote care and treatment engagement, including: early intervention services, medical care coordination (a hybrid of medical and nonmedical case management), substance abuse treatment, mental health therapies, transportation, residential and housing services, benefits screening and enrollment, etc. Data show that each service will help some people in accessing and retaining medical treatment. The modeling activities will assist us in determining which services are most likely to influence access and retention, and will guide LAC in redistributing resources to those services most likely to engage people who are otherwise unlikely to remain in medical care.

**Required Intervention #7: “Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons”**

**A: Situational Analysis**

Los Angeles County has 62,800 people living with HIV/AIDS (PLWHA). California implemented code-based HIV reporting in July 2002, and name-based HIV reporting in April 2006. Thus, HIV data are still preliminary and underestimate true HIV prevalence in the County.

The HIV continuum of care in Los Angeles County (LAC) is a comprehensive path from HIV prevention to treatment for individual clients affected by HIV. The system of care is designed to promote awareness of and access to HIV prevention, care and treatment services to reduce HIV incidence and relieve disease burden. As the grantee and administrator for the local Ryan White Program, OAPP has developed a robust care and treatment program that is linked to our HIV testing programs. OAPP contracts with over 33 medical outpatient delivery sites, and over 100 sites that deliver one or more of the following services to encourage client assessment, referral, linkage and retention in care:

- Medical outpatient and medical specialty services
- ADAP enrollment
- Benefits screening and enrollment
- Case Management
- Oral health services



- Early intervention
- Residential care services (OAPP-funded)
- Housing services (HOPWA-funded)
- Substance use treatment (in collaboration with the County's Substance Abuse Prevention and Control Program)
- Mental health treatment (in collaboration with the County's Department of Mental Health)
- Nutrition support
- Medical transportation

LAC RW funding portfolio consists of \$39 million for Part A and \$9million for Part B (from CA State).

Listed below are OAPP-supported programs in place to ensure retention/re-engagement in care for HIV-positive persons.

1) Early Intervention Programs (EIP) to Identify Unaware PLWHA and Support Them in Their Entry in and Adherence to HIV Treatment. As described in Required intervention #6 – linkage to care section, EIPs supported through Ryan White Part A, Minority AIDS Initiative and County funds play a pivotal role in connecting newly diagnosed PLWHA to medical care in LAC, especially populations with special needs, such as African Americans, Latinos and women.

2) Medical Care Coordination to Ensure Access, Retention and Adherence to Treatment. Referral and linkage to medical care is only the first step in the journey to good health for an individual diagnosed with HIV. Challenges that prevent or delay diagnosis often also prevent retention and adherence. Los Angeles County is adopting a medical care coordination model that is designed to optimize patient's health status through enhanced coordination with medical providers. Various case management services (e.g., medical, psychosocial, and transitional) form the basis of medical care coordination that focuses on coordinating medical and ancillary services for patients to ease initial access to care and treatment, and overcome barriers to staying in care. Case management without direct coordination with medical providers is no longer acceptable for the changing epidemic. Focused on primary medical care and operated through a team led by a Registered Nurse and a Master-level Social Worker, the medical care coordination model will further the seamlessness of service delivery and enhance system responsiveness to connecting the newly aware PLWHA to medical care.

In 2009-2010, of the 14,875 clients receiving Ryan White (RW) medical care services, 12,725 (86%) clients had a recent viral load reported in the RW data system of whom 82% (n= 10,435) were retained in care over this period. Retention in care was defined using the HRSA/HAP definition of at least 2 medical visits in a 12 month period at least 3 months apart.

To identify poor in retention in care among clients in the Ryan White (RW) medical care system, an analysis was conducted to identify predictors of poor retention in RW HIV medical care system. A multivariate regression model was constructed using data from RW clients who went to at least one medical outpatient visit during February 2009 – March 2010 (n=14,875). Poor retention in care (outcome variable) was defined as fewer than two medical outpatient visits in a span of one year, in

which one visit was at least 90 days apart from a previous visit. Independent covariates included in the model were: race, age, gender, poverty, homelessness, health insurance status, immigration status, substance use, incarceration, mental health history, antiretroviral medication use, CD4 count, and undetectable viral load status.

**Table 6. Demographic Predictors of Poor Retention in Care, Ryan White Medical Clients February 2009 – March 2010**

| Characteristic                                     | Multivariate Analysis Modeling<br>Poor Retention in Care |               |         |
|--|--|---------------|---------|
|  | Adjusted OR  | 95% CI        | P-value |
| <b>Gender</b>                                      |  |               |         |
| Female   | 0.85   | 0.73-1.00     | 0.05    |
| Transgender  | 1.19   | 0.82-1.74     | 0.36    |
| Other/Unknown                                      | <0.01  | <0.01->999.99 | 0.97    |
| Male (reference)                                   | --   | --            | --      |
| <b>Race</b>  |  |               |         |
| African-American                                   | 0.98   | 0.84-1.14     | 0.79    |
| Asian/Pacific-Islander                             | 0.74   | 0.53-1.03     | 0.08    |
| Latino/Hispanic                                    | 0.70   | 0.61-0.81     | <0.01   |
| Native-American/Alaskan Native                     | 1.32   | 0.69-2.50     | 0.40    |
| Other  | 2.19   | 0.96-4.98     | 0.06    |
| White (reference)                                  | --   | --            | --      |
| <b>Age</b>   |  |               |         |
| Youth (0-24 yrs.)                                  | 1.73   | 1.29-2.32     | <0.01   |
| Young Adult (25-39 yrs.)                           | 1.47   | 1.26-1.71     | <0.01   |
| Adult (40-49 yrs.)                                 | 1.21   | 1.04-1.39     | 0.01    |
| Older Adult (50+ yrs.) –(reference)                | --   | --            | --      |
| <b>Poverty</b>                                     |  |               |         |
| Equal to or Below Federal Poverty Level            | 0.97   | 0.87-1.09     | 0.64    |
| Greater than FPL (reference)                       | --   | --            | --      |
| <b>Living Situation</b>                            |  |               |         |
| Homeless/Transitional                              | 1.37   | 1.12-1.68     | <0.01   |
| Permanent Housing (reference)                      | --   | --            | --      |
| <b>Immigration Status</b>                          |  |               |         |
| Recent Immigrant (≤ 4 yrs.)                        | 0.91   | 0.71-1.17     | 0.47    |
| Not recent immigrant/Born in U.S. (reference)      | --   | --            | --      |
| <b>Health Insurance</b>                            |  |               |         |
| No Health Insurance                                | 0.67   | 0.54-0.83     | <0.01   |
| Public Insurance (MediCal, Medicare, Medicaid, VA) | 0.58   | 0.47-0.72     | <0.01   |
| Private Insurance (HMO, PPO) (reference)           | --   | --            | --      |
| <b>Substance Abuse History</b>                     |  |               |         |
| Recently used Substances (≤ 1 yr.)                 | 0.85   | 0.71-1.02     | 0.08    |
| Previously used Substances (> 1 yr.)               | 0.87   | 0.73-1.03     | 0.11    |
| Never used Substances (reference)                  | --   | --            | --      |
| <b>Incarceration History</b>                       |  |               |         |
| Recently in Jail (≤ 2 yrs.)                        | 1.71   | 1.42-2.06     | <0.01   |
| Previously in Jail (> 2 yrs.)                      | 1.10   | 0.91-1.33     | 0.33    |
| Never in Jail (reference)                          | --   | --            | --      |
| <b>Mental Health History</b>                       |  |               |         |
| Recently History (≤ 1 yrs.)                        | 0.90   | 0.79-1.03     | 0.13    |
| Previously History (> 1 yr.)                       | 0.06   | 0.69-1.07     | 0.16    |

|                                  |      |           |       |
|----------------------------------|------|-----------|-------|
| No History (reference)           | --   | --        | --    |
| <b>Antiretroviral Medication</b> |      |           |       |
| Currently on ART                 | 0.26 | 0.22-0.31 | <0.01 |
| Not on ART (reference)           | --   | --        | --    |
| <b>Undetectable Viral Load</b>   |      |           |       |
| < 200 copies                     | 0.60 | 0.53-0.67 | <0.01 |
| ≥ 200 copies                     | --   | --        | --    |
| <b>CD4 Levels</b>                |      |           |       |
| < 200                            | 1.37 | 1.16-1.62 | <0.01 |
| 201-350                          | 0.99 | 0.85-1.15 | 0.86  |
| 351-500                          | 0.93 | 0.81-1.06 | 0.26  |
| > 500 (reference)                | --   | --        | --    |

**Data Source:** Casewatch YR 19 (Feb. '09 – Mar. '10): Limited to RW clients w/ 1 or more MOP visits

\* Defined as fewer than 2 medical outpatient visits at least 90 days apart in a span of 1 year

\*\* p-value < 0.05

In summary, the analysis showed that African-Americans were approximately 1.5 times more likely to have a detectable VL compared to Whites and Asians who were 1.7 times less likely as Whites to have a detectable VL. Compared to those ages 50+, the likelihood of having a detectable VL increases with younger cohorts. Those whose income was equal to or below the federal poverty line were 1.2 times more likely to have a detectable VL compared to those whose incomes were greater. Other significant predictors of detectable VL included: those with no health insurance (in comparison to those with private insurance), those RW clients who used substances recently (compared to those who never used substances), and those who were recently incarcerated (compared to those who have no history of incarceration). The likelihood of having a detectable VL also increased as a client's CD4 count decreased. Those clients currently on antiretroviral medication and who were retained in HIV care over a period of one year were less likely to have a detectable VL than their counterparts.

Modeling poor retention in care (defined by less than 2 medical outpatient visits in a span of one year, with each visit being at least 90 days apart from the previous visit). Independent covariates included: race, age, gender, poverty, homelessness, health insurance, immigration, substance use, incarceration, mental health history, antiretroviral medication use, CD4 levels, undetectable VL.

Summary of results: Latinos were more likely to be retained in HIV care than Whites and the likelihood of retention decreases the younger the RW client. Those who were living in unstable housing (homeless or transitional housing) were 1.4 times more likely to fall out of care than those with permanent housing. Those clients with no health insurance or public health insurance were less likely to fall out of care compared to those with private health insurance. RW clients who were recently incarcerated were 1.7 times more likely to fall out of care. Clients currently on antiretroviral medication and those with an undetectable VL were less likely to fall out of care compared to their counterparts. Also, clients with a CD4 count less than 200 were 1.4 times more likely to fall out of care compared to those with CD4 counts greater than 500.

**B: Goal Setting**

The primary HIV prevention goal:

1. Increase rates of retention in care in the Ryan White system of care.
2. Develop strategies to use existing public health/ surveillance data to identify HIV positive individuals not in care.

Rationale: There are an estimated 62,800 PLWHA in LAC, with an estimated 13,500 who know their HIV status and are not in consistently care as defined by the NHAS goals. Among Ryan White clients, 82% are retained in care (see situational analysis above for additional detail). Engagement and retention in HIV care is a critical and necessary step for accessing HIV treatment, optimizing health outcomes, reducing health disparities, and reducing community viral load. By increasing, implementing, and refining the following activities we expect to improve retention in care within LAC:

- Expanding partner services to reach out of care populations (including ARTAS PHIs and community embedded Disease Intervention Specialists)
- Expansion and improved targeting of early intervention and retention services
- Placement of linkage workers to facilitate expedited access to care among hard to reach out of care populations
- Continued support of housing, substance use, mental health, and transportation services to optimize retention in care
- Implementation of medical care coordination (as described in the situational analysis)
- Implementation of newly NIDA funded peer navigation study targeting incarcerated populations
- As an early health reform adopter, LAC must ensure a smooth transition from the RW system to an expanded Medicaid system for approximately 10,500 PLWHA

An internal TLC+ workgroup has been established to plan, develop, implement, and evaluate TLC+ activities and system-wide programming to optimize linkage to- and retention in HIV care treatment and prevention services for those testing HIV positive and not currently in care. Given the immense size and diversity of LAC, LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to retention in care locally. The current modeling activities will help inform the scope and direction of retention in care activities needed to help meet local HIV retention in care goals consistent with the NHAS (see Appendix A).

**Required Intervention #8: “Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons”**

#### **A: Situational Analysis**

##### **Provision of ART in Ryan White System of Care:**

The Los Angeles County Department of Public Health, Office of AIDS Programs and Policy (OAPP) is the HRSA Ryan White Part A grantee for Los Angeles County and oversees the Ryan White System of care. In 2009 this

system of care provided services for approximately 19,000 of the 44,450<sup>2</sup> known HIV/AIDS patients in LAC. Approximately 14,000 of these (19,000) patients received medical care through the Ryan White (RW) system of care (approximately 5,000 received primary HIV care somewhere else, but one or more supportive service from the RW system). The RW system of primary HIV care includes 23 contracted providers and 33 unique medical clinic sites throughout the County. Through OAPP’s RW data collection system (Casewatch) information is collected on ART prescription. At the present time, data is only available for the dichotomous variable: is patient currently on a regimen of Highly Active Antiretroviral Therapy (HAART) or not on HAART. Data as to the specific regimen components has not historically been captured in Casewatch; however, starting in 2011 OAPP will be working with the Casewatch vendor to include data fields for specific ART medications in the data system. In addition, after the passage of AB 2541, which allows for matching of different care and surveillance data sources at the Department of Public Health, OAPP will be able to match Casewatch with the CA State ADAP registry in order to determine regimens for patients in the RW system of care. A similar match with the ADAP registry could also be done with HIV surveillance data, to understand ART use and penetrance in the entire HIV-positive population in the County.

OAPP’s Casewatch system also collects clinical data on all patients in the RW system of care, including HIV viral loads, and CD4 counts. For the 12-month period of March 2009 – February 2010, 14,875 RW clients had 1 or more medical visits. Of those, 12,725 (86%) had one or more viral load test during that year. Below, data is presented on how many patients: 1) are on ART; 2) are on ART in various CD4 strata and according to treatment guidelines; 3) have undetectable HIV viral load; and 4) are on ART and have undetectable HIV viral load.

**Table 7. Mean Viral Load by Los Angeles County Service Planning Area (SPA), March 2009 – February 2010**

| Characteristic                  | Overall<br>N = 14,875 |       |
|---------------------------------|-----------------------|-------|
|                                 | n                     | %     |
| Mean Viral Load (Median)        | 16,807 (48)           |       |
| % Undetectable VL (<200 copies) | 9,122                 | 71.7% |
| On Antiretroviral Therapy (ART) | 13,976                | 94.0% |
| On ART w/ CD4 < 500             | 7,952                 | 93.3% |
| Mean VL (median)                | 16,233 (48)           |       |
| % Undetectable VL               | 8,713                 | 72.6% |

| Characteristic | SPA 1<br>N = 355 |   | SPA 2<br>N = 2,067 |   | SPA 3<br>N = 1,024 |   | SPA 4<br>N = 4,928 |   |
|----------------|------------------|---|--------------------|---|--------------------|---|--------------------|---|
|                | n                | % | n                  | % | n                  | % | n                  | % |

<sup>2</sup> HIV Epidemiology Program, Los Angeles County Department of Public Health. HIV/AIDS Surveillance Summary, January 2010: 1-33.

|   |             |       |             |       |             |       |             |       |
|---|-------------|-------|-------------|-------|-------------|-------|-------------|-------|
| <b>Mean Viral Load (Median)</b>           | 22,602 (48) |       | 17,319 (48) |       | 12,659 (48) |       | 15,510 (48) |       |
| <b>% Undetectable VL (&lt;200 copies)</b> | 220         | 69.0% | 1,208       | 72.4% | 718         | 77.8% | 3,222       | 72.7% |
| <b>On Antiretroviral Therapy (ART)</b>    | 314         | 88.5% | 1,996       | 96.6% | 979         | 95.6% | 4,748       | 96.4% |
| On ART w/ CD4 < 500                       | 178         | 87.3% | 1,089       | 96.7% | 563         | 95.1% | 2,688       | 95.9% |
| Mean VL (median)                          | 23,601 (48) |       | 17,092 (48) |       | 12,104 (48) |       | 15,079 (48) |       |
| % Undetectable VL                         | 202         | 71.4% | 1,175       | 73.1% | 696         | 79.0% | 3,141       | 73.1% |

| <b>Characteristic</b>                     | <b>SPA 5</b>   |       | <b>SPA 6</b>     |       | <b>SPA 7</b>     |       | <b>SPA 8</b>     |       |
|---|----------------|-------|------------------|-------|------------------|-------|------------------|-------|
|   | <b>N = 440</b> |       | <b>N = 2,267</b> |       | <b>N = 1,115</b> |       | <b>N = 2,305</b> |       |
|   | n              | %     | n                | %     | n                | %     | n                | %     |
| <b>Mean Viral Load (Median)</b>           | 18,125 (48)    |       | 21,479 (48)      |       | 17,265 (48)      |       | 14,662 (60)      |       |
| <b>% Undetectable VL (&lt;200 copies)</b> | 282            | 73.6% | 1,257            | 65.6% | 694              | 72.4% | 1,310            | 72.9% |
| <b>On Antiretroviral Therapy (ART)</b>    | 421            | 95.7% | 2,111            | 93.1% | 1,061            | 95.2% | 2,036            | 88.3% |
| On ART w/ CD4 < 500                       | 217            | 94.4% | 1,240            | 92.4% | 621              | 94.7% | 1,160            | 87.5% |
| Mean VL (median)                          | 17,553 (48)    |       | 21,044 (48)      |       | 17,641 (48)      |       | 12,613 (50)      |       |
| % Undetectable VL                         | 273            | 74.4% | 1,200            | 66.5% | 663              | 72.6% | 1,182            | 74.4% |

Additionally, OAPP has begun to examine characteristics associated with having detectable viral load, to better define the target population of patients who may require more intensive interventions to be engaged in care, accept HIV treatment, and adhere to ART treatment regimens. This analysis was conducted on the 14,875 patients in the RW system with one or more HIV viral load in the system.

A multivariate regression model was constructed on data from RW clients who went to at least one medical outpatient services from February 2009 – March 2010 and one viral load performed (n=12,725). Detectable viral load ( $\geq 200$  copies/mL) was used as the biologic outcome. Independent covariates included in the model were: race, age, poverty, homelessness, health insurance status, substance use, mental health history, antiretroviral medication use, CD4 count, and retention in HIV care.

**Table 8. Demographic Predictors of Detectable Viral Load among Ryan White Clients, February 2009 – March**

2010

| Characteristic   | Multivariate Analysis Modeling<br>Detectable VL |           |         |
|--|---|-----------|---------|
|  | Adjusted OR                                     | 95% CI    | P-value |
| <b>Race</b>  |   |           |         |
| African-American   | 1.49  | 1.31-1.70 | <0.01   |
| Asian/Pacific-Islander                                   | 0.59  | 0.43-0.80 | <0.01   |
| Latino/Hispanic  | 0.90  | 0.80-1.02 | 0.09    |
| Native-American/Alaskan Native                           | 1.00  | 0.55-1.85 | 0.99    |
| Other  | 0.67  | 0.24-1.86 | 0.44    |
| White (reference)  | --  | --        | --      |
| <b>Age</b>   |   |           |         |
| Youth (0-24 yrs.)  | 3.93  | 3.05-5.07 | <0.01   |
| Young Adult (25-39 yrs.)                                 | 2.07  | 1.82-2.36 | <0.01   |
| Adult (40-49 yrs.)                                       | 1.36  | 1.20-1.54 | <0.01   |
| Older Adult (50+ yrs.) -- reference                      | --  | --        | --      |
| <b>Poverty</b>   |   |           |         |
| Equal to or Below Federal Poverty Level                  | 1.23  | 1.11-1.36 | <0.01   |
| Greater than FPL (reference)                             | --  | --        | --      |
| <b>Living Situation</b>                                  |   |           |         |
| Homeless/Transitional                                    | 1.20  | 1.00-1.44 | 0.05    |
| Permanent Housing (reference)                            | --  | --        | --      |
| <b>Health Insurance</b>                                  |   |           |         |
| No Health Insurance                                      | 1.59  | 1.28-1.98 | <0.01   |
| Public Insurance (MediCal, Medicare, Medicaid, VA)       | 1.25  | 1.00-1.57 | 0.05    |
| Private Insurance (HMO, PPO) -- reference                | --  | --        | --      |
| <b>Substance Abuse History</b>                           |   |           |         |
| Recently used Substances ( $\leq$ 1 yr.)                 | 1.37  | 1.19-1.58 | <0.01   |
| Previously used Substances ( $>$ 1 yr.)                  | 1.15  | 0.99-1.33 | 0.07    |
| Never used Substances (reference)                        | --  | --        | --      |
| <b>Incarceration History</b>                             |   |           |         |
| Recently in Jail ( $\leq$ 2 yrs.)                        | 1.31  | 1.11-1.55 | <0.01   |
| Previously in Jail ( $>$ 2 yrs.)                         | 1.19  | 1.02-1.39 | 0.03    |
| Never in Jail (reference)                                | --  | --        | --      |
| <b>Mental Health History</b>                             |   |           |         |
| Recent History ( $\leq$ 1 yrs.)                          | 1.02  | 0.91-1.15 | 0.70    |
| Previous History ( $>$ 1 yr.)                            | 0.96  | 0.80-1.15 | 0.64    |
| No History (reference)                                   | --  | --        | --      |
| <b>Antiretroviral Medication</b>                         |   |           |         |
| Currently on ART   | 0.63  | 0.52-0.76 | <0.01   |
| Not on ART (reference)                                   | --  | --        | --      |
| <b>Retention in Care</b>                                 |   |           |         |
| 2 or more Medical Outpatient Visits $\geq$ 90 Days Apart | 0.60  | 0.53-0.68 | <0.01   |
| Not Retained   | --  | --        | --      |
| <b>CD4 Levels</b>  |   |           |         |
| < 200  | 6.87  | 5.97-7.89 | <0.01   |
| 201-350  | 2.56  | 2.27-2.89 | <0.01   |
| 351-500  | 1.65  | 1.47-1.85 | <0.01   |
| > 500 (reference)  | --  | --        | --      |

As a part of routine annual monitoring of all RW HIV medical care sites, information is abstracted from a sample

of charts for a performance measure of ART use in compliance with HIV treatment guidelines. This measure is reviewed annually and revised to reflect any changes in HIV treatment guidelines. In 2009, all 33 HIV medical care sites were monitored for the percentage of patients with CD4 T-cell counts  $<350$  cells/mm<sup>3</sup> or an AIDS-defining condition who were prescribed ART. Results showed 100% compliance across all 33 medical care sites. This measure has been revised in 2010 in accordance with the December 2009 HIV treatment guidelines to capture the % of patients with CD4 of 500 cells/mm<sup>3</sup> or less who are on ART. Programs will be monitored for this revised measure starting in 2011.

#### **Policies and Procedures for use of ART in Accordance with Treatment Guidelines:**

OAPP and LAC has policies and procedures in place in multiple forms to address HIV treatment in accordance with guidelines in LAC. These include:

1. All contracts with OAPP funded Ryan White HIV medical care providers include a section that describes OAPP's policy of HIV treatment in accordance with current guidelines as well as a summary of the most current HIV treatment guidelines that is routinely updated. These contracts are monitored annually for compliance with HIV treatment guidelines as described above
2. The LAC Commission on HIV has established standards of care for Ryan White services, including HIV treatment in accordance with current guidelines for HIV medical care
3. The OAPP Medical Advisory Committee, composed of the Medical Directors of all RW HIV clinics and hosted by the OAPP Medical Director, meet quarterly to discuss changes in guidelines, review local RW performance data regarding quality of care, and make recommendations to OAPP on policies, procedures, and interventions/programming elements that can optimize high quality HIV care in accordance with the HIV treatment guidelines in the Ryan White system of care

#### **Funding to Support ART Use in Accordance with Treatment Guidelines:**

The activity of promoting HIV treatment in accordance with guidelines is considered a core part of the function of OAPP as the Part A grantee providing oversight and coordinating the Ryan White system of care for LAC. Therefore, OAPP's Federal Ryan White Part A grant is the primary funding source associated with these activities, in addition to the RW Minority AIDS Initiative funding, and the CA State Office of AIDS Single Allocation Model (SAM) support for HIV care services. Through June 30, 2011, the CA State ADAP program has been able to continue to provide support for ART for all uninsured patients in the RW system of care, as well as to offer sliding scale support for co-pays for medications on ADAP formulary to patients with public or private insurance who make  $< \$50,000$  a year. There are no waitlists for the ADAP program in CA at the present time. However, given the states severe fiscal crisis heading into FY 2011-12 with a \$28 billion deficit to close, there is certainly concern that the ADAP program could be affected. With the current Governor's proposal released in Jan 2011, implementing co-pays on drugs for those receiving ADAP assistance was proposed, however the remainder of the funding for the program remained intact in this round of the proposal.

#### **How many agencies in the jurisdiction addressed this activity in 2009?**

All 33 Ryan White funded Clinics addressed this activity and were monitored and evaluated for their performance in 2009 as described above.



**B: Goal Setting**

The primary HIV prevention goals:

1. Ensure all Ryan White medical care patients have access to antiretroviral therapy (ART) and are on ART consistent with Public Health Services (PHS) guidelines.
2. Minimize HIV transmission through viral load suppression among Ryan White medical care clients.

Rationale: There are an estimated 36,000 PLWHA diagnosed and in care in LAC; of those an estimated 15,000 persons are in the Ryan White (RW) system of care. The ART coverage rate in RW system of care in 2009 (see situational analysis above) was estimated to be 94%, and 72% of RW clients had an undetectable viral load (<200 copies). OAPP's goals are to ensure that ART treatment guidelines are followed in the RW system of care by implementing quality measures and pay for performance strategies to maximize ART coverage and viral load suppression. The level of ART coverage and viral suppression in the private and non-OAPP funded public sector is currently unknown, but efforts are underway within the surveillance branch to estimate. By increasing, implementing, and refining the following activities we expect to improve ART coverage and viral load suppression among PLWHA within LAC:

- Establishing and promoting clinical standards of care for HIV treatment in partnership with the local RW planning body and the Medical Advisory Committee
- Engaging the Medical Advisory Committee for improving and implementing treatment guidelines
- Advocating for a robust ADAP program in California
- Measuring quality indicators and pay for performance strategies to maximize ART coverage and viral load suppression
- As an early health reform adopter, LAC must ensure a smooth transition from the RW system to an expanded Medicaid system for approximately 10,500 PLWHA

Sophisticated mapping activities have drawn a picture of viral load burden throughout the county. OAPP is using these maps to identify areas where viral burden is elevated, as well as identify clinics and medical centers that may be having difficulty in achieving viral load suppression among their patients. Education and intensive monitoring activities will be underway in these geographic areas very soon.

An internal TLC+ workgroup has been established to plan, develop, implement, and evaluate TLC+ activities and system-wide programming to optimize linkage to- and retention in HIV care, treatment and prevention services for those testing HIV positive and not currently in care. ART treatment is predicated on ongoing engagement and retention in care. Modeling activities currently underway will assist in informing the relative impact of scaling up ART coverage rates consistent with the NHAS goals, as well as the impact of provider training and technical assistance (see Appendix A).

**Required Intervention #9: “Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons”****A: Situational Analysis****ART Adherence Interventions in LAC:**

Up until July 2009, OAPP funded a robust portfolio of treatment education programs throughout Los Angeles County, which included 19 sites delivering treatment education services to approximately 2,425 clients in 2008-2009. However, in July 2009 as a result of the elimination of the CA State OA General Fund in the 2009-2010 budget amidst California’s budget crisis, LA County lost approximately 13 million dollars in state support for HIV/AIDS prevention and care funding. In response to this cut, OAPP eliminated 33 staff positions and in accordance with the COH planning body recommendations, had to eliminate certain programs that were in place, including HIV treatment adherence. Funding to support targeted intensive interventions to promote ART adherence among PLHA in LAC outside of what is delivered as part of the medical visit and case management is currently a GAP in the LAC prevention response.

**Policy and Procedures on ART Adherence Assessments and Counseling:**

While direct OAPP funding for treatment adherence counseling programs has not been possible due to budgetary cuts, a policy, guidelines, and standards of care have been developed to ensure that treatment adherence assessment and counseling (TAC) is delivered in the HIV medical care setting routinely. Additionally there has been significant progress made in incorporating TAC into to the required scope of work of HIV medical case managers in the Ryan White system of care.

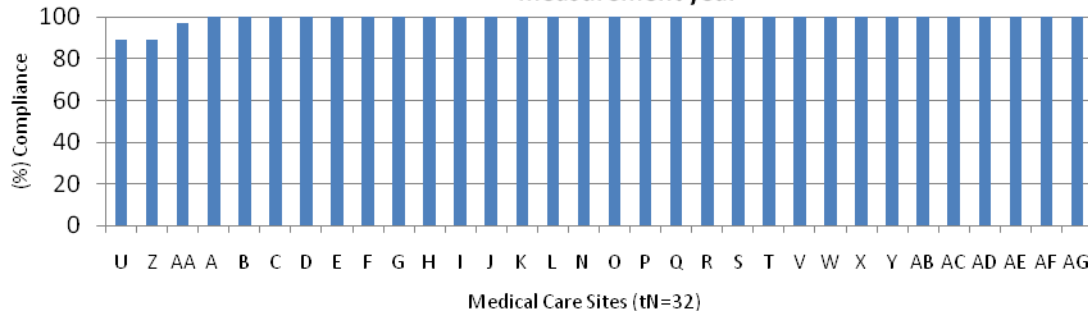
The following policies and procedures are in place regarding ART adherence counseling:

1. OAPP’s policy is that an assessment for ART adherence, and delivery of counseling for those with suboptimal adherence, is provided at a minimum of 2 medical visits a year for all patients in the Ryan White care system. Performance on this activity is monitored annually for all RW medical providers, and results of monitoring are presented below.
2. The scope of work and job descriptions for all medical case managers (nurse level) includes treatment educations, ART adherence assessment, and counseling. Starting in 2010, all medical case managers in the RW system of care were monitored and measured on performance for assessing ART adherence, delivering adherence counseling, and demonstrating improvement in HIV viral load for non adherent patients who had received intensive ART adherence counseling from the nurse case manager.
3. The LAC Commission on HIV has specific standards of care that were developed for ART treatment adherence assessment and counseling. These standards of care are incorporated into all HIV care contracts as a guide for delivery of quality HIV care.

**Adherence Counseling among HIV+ patients in RW system**

Annual chart audits of a sample of HIV+ RW patients at each RW care site demonstrate rates for patients on ART who were assessed for adherence and counseled for suboptimal adherence at least two or more times.

**Figure 1. Percentage of patients on ART who were assessed for adherence (and counseled if suboptimal adherence) two or more times in the measurement year**



Results showed a mean score of 99% on this measure, with a range of 89% to 100% by site.

**Determining the need for ART Adherence Counseling in LAC:**

OAPP has recently undertaken analyses to try to capture the need for ART adherence counseling in the RW care system, and to identify any specific populations that would particularly benefit from targeted ART adherence interventions. This includes examining the proportion of those on ART currently who continue to have detectable HIV viral load, and what patient level and provider level characteristics may be associated with this.

Data from these analyses conducted on all RW patients with one medical visit (n=14,875) from March 1, 2009-Feb 28, 2010 is presented below.

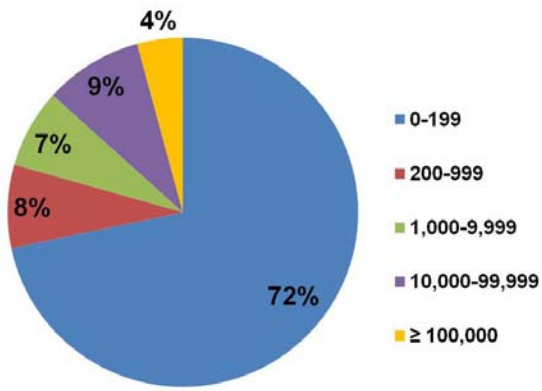
**Table 9. Mean Viral Load by Los Angeles County Service Planning Area (SPA), March 2009 – February 2010**

| Characteristic                            | Overall<br>N = 14,875 |       |
|---|-----------------------|-------|
|   | n                     | %     |
| <b>Mean Viral Load (Median)</b>           | 16,807 (48)           |       |
| <b>% Undetectable VL (&lt;200 copies)</b> | 9,122                 | 71.7% |
| <b>On Antiretroviral Therapy (ART)</b>    | 13,976                | 94.0% |
| On ART w/ CD4 < 500                       | 7,952                 | 93.3% |
| Mean VL (median)                          | 16,233 (48)           |       |
| % Undetectable VL                         | 8,713                 | 72.6% |

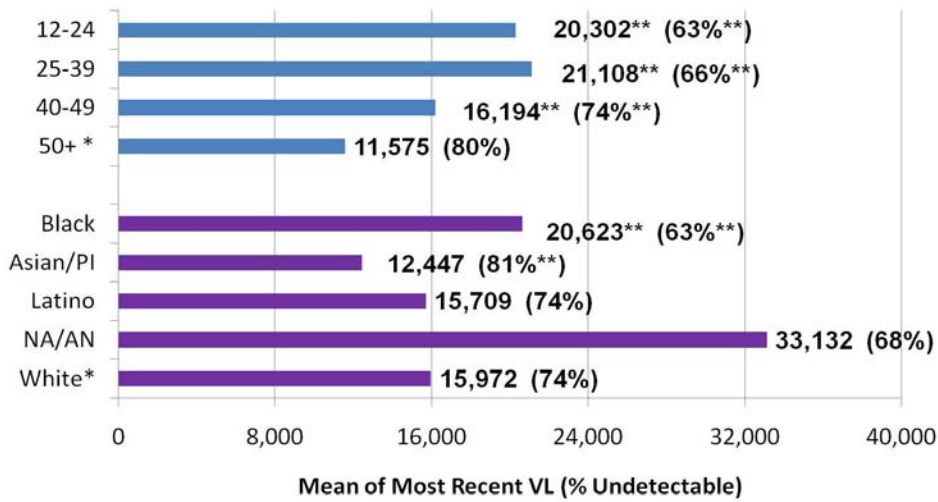
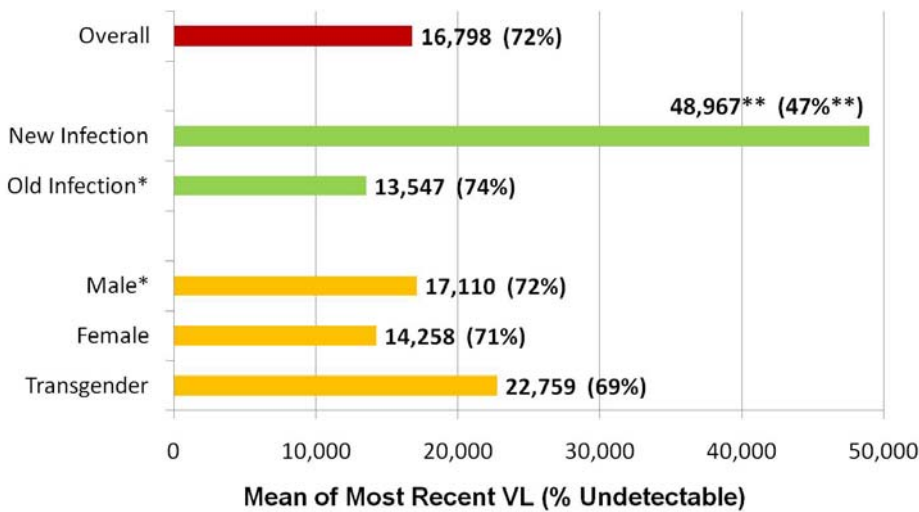
| Characteristic                            | SPA 1<br>N = 355 |       | SPA 2<br>N = 2,067 |       | SPA 3<br>N = 1,024 |       | SPA 4<br>N = 4,928 |       |
|---|------------------|-------|--------------------|-------|--------------------|-------|--------------------|-------|
|   | n                | %     | n                  | %     | n                  | %     | n                  | %     |
| <b>Mean Viral Load (Median)</b>           | 22,602 (48)      |       | 17,319 (48)        |       | 12,659 (48)        |       | 15,510 (48)        |       |
| <b>% Undetectable VL (&lt;200 copies)</b> | 220              | 69.0% | 1,208              | 72.4% | 718                | 77.8% | 3,222              | 72.7% |
| <b>On Antiretroviral Therapy (ART)</b>    | 314              | 88.5% | 1,996              | 96.6% | 979                | 95.6% | 4,748              | 96.4% |
| On ART w/ CD4 < 500                       | 178              | 87.3% | 1,089              | 96.7% | 563                | 95.1% | 2,688              | 95.9% |
| Mean VL (median)                          | 23,601 (48)      |       | 17,092 (48)        |       | 12,104 (48)        |       | 15,079 (48)        |       |
| % Undetectable VL                         | 202              | 71.4% | 1,175              | 73.1% | 696                | 79.0% | 3,141              | 73.1% |

| Characteristic                            | SPA 5<br>N = 440 |       | SPA 6<br>N = 2,267 |       | SPA 7<br>N = 1,115 |       | SPA 8<br>N = 2,305 |       |
|---|------------------|-------|--------------------|-------|--------------------|-------|--------------------|-------|
|   | n                | %     | n                  | %     | n                  | %     | n                  | %     |
| <b>Mean Viral Load (Median)</b>           | 18,125 (48)      |       | 21,479 (48)        |       | 17,265 (48)        |       | 14,662 (60)        |       |
| <b>% Undetectable VL (&lt;200 copies)</b> | 282              | 73.6% | 1,257              | 65.6% | 694                | 72.4% | 1,310              | 72.9% |
| <b>On Antiretroviral Therapy (ART)</b>    | 421              | 95.7% | 2,111              | 93.1% | 1,061              | 95.2% | 2,036              | 88.3% |
| On ART w/ CD4 < 500                       | 217              | 94.4% | 1,240              | 92.4% | 621                | 94.7% | 1,160              | 87.5% |
| Mean VL (median)                          | 17,553 (48)      |       | 21,044 (48)        |       | 17,641 (48)        |       | 12,613 (50)        |       |
| % Undetectable VL                         | 273              | 74.4% | 1,200              | 66.5% | 663                | 72.6% | 1,182              | 74.4% |

**Figure 2 – Viral Load Distribution among RW Clients with 1 or more Medical Outpatient Visit (n=12,725)**



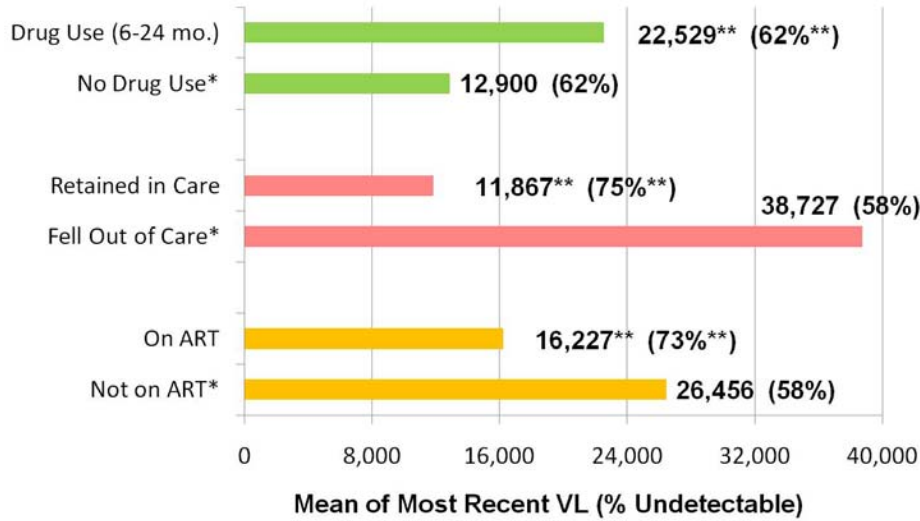
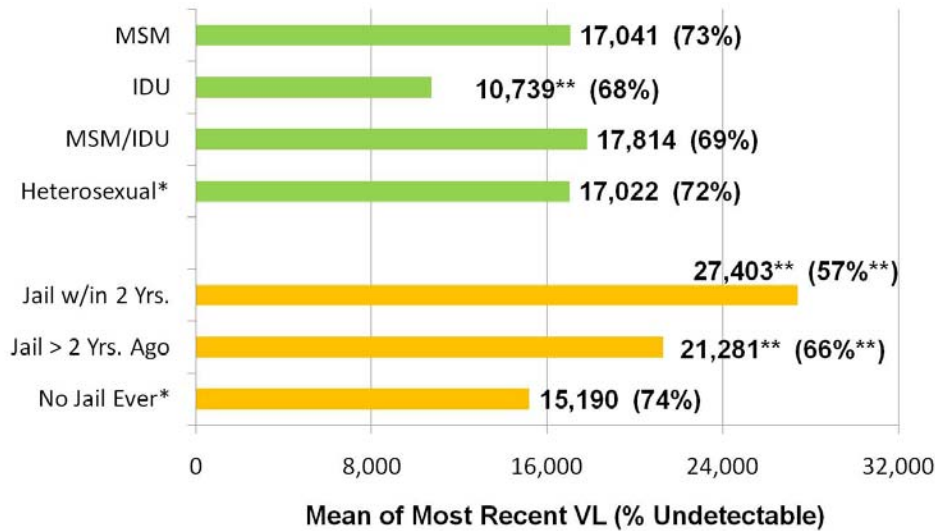
**Figure 3 – Mean Viral Load by Demographic Characteristics of RW Clients with 1 or more Medical Outpatient Visit (n=12,725)**



\*Indicates reference/comparison group.

\*\*Significantly different from the reference group (p-value < 0.05)

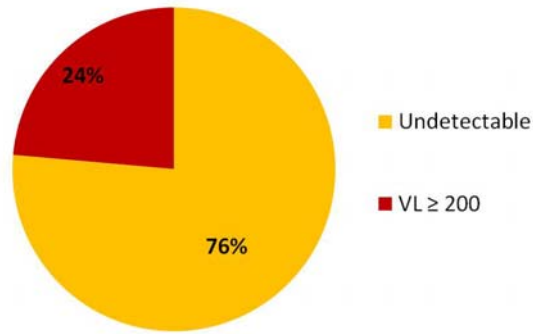
**Figure 4 – Mean Viral Load by Risk Behaviors of RW Clients with 1 or more Medical Outpatient Visit (n=12,725)**



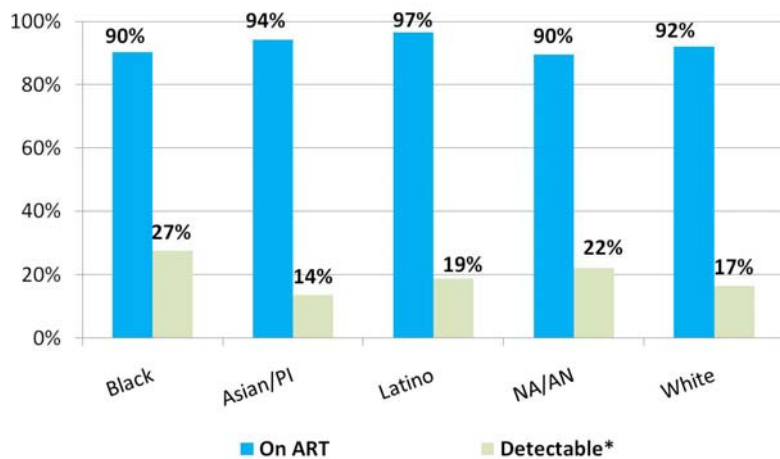
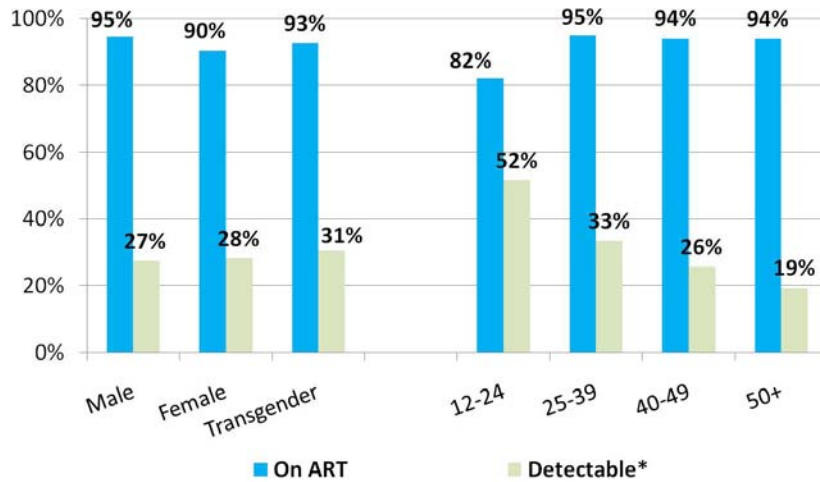
\*Indicates reference/comparison group.

\*\*Significantly different from the reference group (p-value < 0.05)

**Figure 5 – Viral Load Status of Ryan White Patients on Antiretroviral Medications (n=13,976)**



**Figure 6 – Antiretroviral Medication Use among Ryan White clients with 1 or more Medical Outpatient Visit Stratified by Demographic Characteristics (n=14,875)**



\*Detectable VL is a subset of clients that are already on antiretroviral medications.

#### Funding for Treatment Adherence Counseling:

Since the loss of state funding in July 2009, OAPP has been trying to identify a sustainable source of funding to support targeted and evidence based ART adherence interventions to HIV-positive patients most in need. We will continue to pursue new sources of funding for this activity, and will also consider alterations in our current portfolio that may allow us to shift some resources to this prevention activity.

#### **B: Goal Setting**

The primary HIV prevention goals:

1. Increase ARV treatment adherence among clients in Ryan White system of care.

**Rationale:** There are an estimated 36,000 PLWHA diagnosed and in care in LAC of whom an estimated 15,000 persons are in the Ryan White (RW) system of care. The ART coverage rate in RW system of care in 2009 (see situational analysis above) was estimated to be 94% and 72% of RW clients had an undetectable viral load (<200 copies). OAPP's data (RW) suggest that of the 28% of PLWHA who are in care but not virally suppressed, a large proportion are prescribed ART but are intermittently and inconsistently taking their medication. Sophisticated mapping activities have drawn a picture of viral load burden throughout the county. OAPP is using these maps to identify areas where viral burden is elevated, as well as identify clinics and medical centers that may be having difficulty in achieving viral load suppression among their patients. Education and intensive monitoring activities will be underway in these geographic areas very soon.

Please note that until the loss of state funding in July 2009, OAPP supported a modest treatment adherence program. Since then, OAPP has been trying to identify a sustainable source of funding to support targeted and evidence based ART adherence interventions to HIV-positive patients most in need. We will continue to pursue new sources of funding for this activity, and will also consider alterations in our current portfolio that may allow us to shift some resources to this prevention activity.

To ensure that treatment adherence is optimized, LAC will continue to monitor providers for delivery of ART adherence counseling to their patients as a performance measure for the RW system of care and will monitor viral suppression as a proxy for ART adherence. Furthermore, California has one of the most robust ADAP formularies in the US, and LAC actively supports ADAP enrollment in clinical and non-clinical setting to ensure treatment continuity.

OAPP is planning on collaborating with our local Centers For AIDS Research (UCLA) to identify and implement evidence based treatment adherence interventions for PLWHA in LAC (see Appendix A).



**Required Intervention #10: “Implement STD screening according to current guidelines for HIV-positive persons”****A: Situational Analysis****STI screening in HIV+ persons**

STI's are a well established cofactor in HIV transmission, and local data from the LAC Partner services program on HIV/STI co-morbidity show that of the 2,911 new HIV cases reported to Partner Services in 2009 36% were co-infected with Early Syphilis, 15% were co-infected with Chlamydia, and 14% were co-infected with Gonorrhea. A critical component of stemming the HIV epidemic in LAC is identifying and treating STIs both among those who are HIV negative as well as among those who are HIV-positive (where concomitant STIs contribute to forward transmission). The national HIV treatment guidelines state that STI screening should occur at baseline and regularly thereafter for HIV+ patients, at a minimum of once yearly. Regular STI screening, at a minimum annually and more frequently for patients who report risk behavior or with a recent history of an STI, is an integrated part of the primary HIV medical care delivered in the Ryan White system of care.

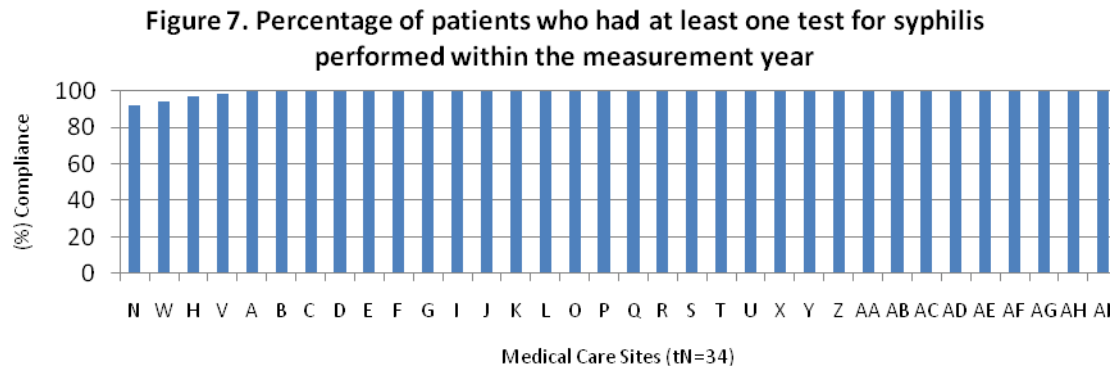
**Policies and Procedures for STI screening and treatment among HIV+ persons**

LAC has adopted a set of local policies and procedures for STI screening and treatment for HIV+ persons, these include:

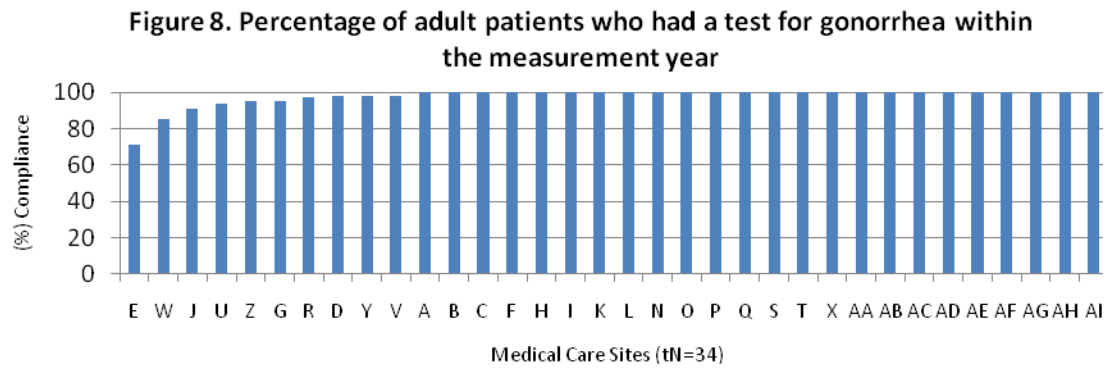
1. OAPP policy for annual STI screening for all HIV+ patients, as well as more frequent (quarterly and symptom based) screening for individuals who have a recent STI or report risk behavior. This policy is including in all contracts with RW care providers, and is monitored annually to insure compliance with these screening recommendations. Data on screening rates by disease for the RW care system are included in the next section.
2. STD Program has policies and procedures for partner services that include embedded Public Health Investigators at RW HIV clinics with high STI rates, to enhance screening, case identification, and surveillance activities for partners of these HIV+ patients
3. The LAC Commission on HIV has established Standards of Care, based on the OAPP policy and guidelines, which are standards for all HIV providers in LAC regardless of if they are a RW medical provider.

**STI screening among HIV+ patients in RW system**

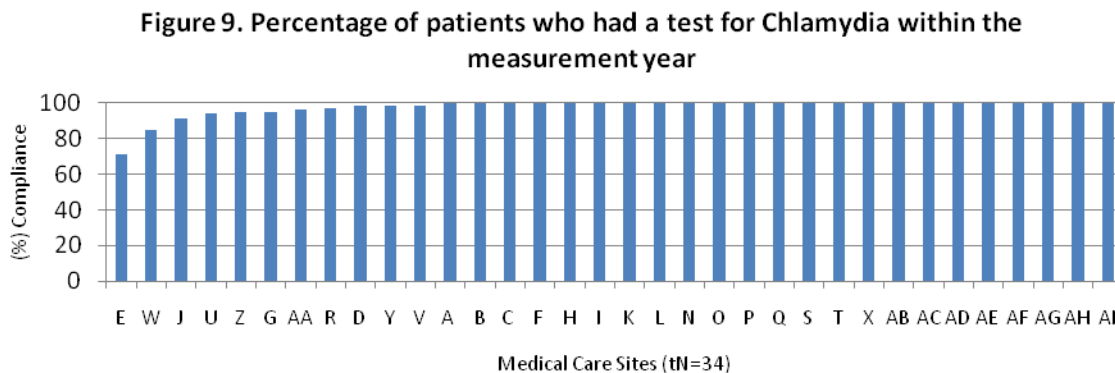
Annual chart audits of a sample of HIV+ RW patients at each RW care site demonstrate the STI screening rates described below.



In 2009, all 33 HIV medical care sites were monitored for the percentage of patients who had at least one test for syphilis performed within the measurement year. Results showed a mean score of 99% on this measure, with a range of 92% to 100% by site.



The percentage of adult patients who had a test for gonorrhea in the same year showed a mean of 98% on this measure, with a range of 71% to 100% by site.



The percentage of patients who had a test for Chlamydia showed a mean of 98%, with a range of 71% to 100% by site.

100% by site.

### STI Treatment among HIV+ patients

The LAC STD Program conducts ongoing surveillance of STIs in LAC, and prioritizes individuals co-infected with HIV and STIs for partner services and elicitation as well as follow up on STI treatment in accordance with CDC and CA STD Treatment Guidelines. Currently there is no system in place to populate the RW system data base with results of STI treatment monitoring and follow up done by the LAC STD Program. Thus the exact # of HIV+ positive persons in RW who have STIs, their treatment rates, and receipt of partner services can not currently be reported. This is a GAP in our prevention approach. Ongoing matching of STI surveillance and treatment data with RW care data will be critical in assuring comprehensive STI treatment, follow up, and partner services are deployed to the RW HIV+ population, and could serve as a model for implementation throughout the rest of the county.

LAC Department of Public Health uses funding from CDC, Ryan White, and the County of Los Angeles Department of Public Health General Fund to provide and promote STI testing throughout the County.

### B: Goal Setting

The primary HIV prevention goal:

1. Routinely screen all Ryan White clients for STDs and viral hepatitis.

**Rationale:** There are an estimated 62,800 PLWHA in LAC, with an estimated 13,500 who know their HIV status and are not in consistently in care as defined by the NHAS goals. There were over 55,000 STIs reported in 2009 (74% Chlamydia, 14 % gonorrhea, 5% syphilis). LAC partner services program HIV/STI co-morbidity data show that of the 2,911 new HIV cases reported to Partner Services in 2009 36% were co-infected with Early Syphilis, 15% were co-infected with Chlamydia, and 14% were co-infected with Gonorrhea.

A critical component of stemming the HIV epidemic in LAC is identifying and treating STIs both among those who are HIV negative as well as among those who are HIV-positive (where concomitant STIs contribute to forward transmission). The national HIV treatment guidelines state that STI screening should occur at baseline and regularly thereafter for HIV+ patients, at a minimum of once yearly. Regular STI screening, at a minimum annually and more frequently for patients who report risk behavior or with a recent history of an STI, is an integrated part of the primary HIV medical care delivered in the LAC Ryan White system of care. By increasing, implementing, and refining the following activities we expect to improve STI screening and treatment rates within LAC:

- Continuing engagement and retention in HIV care strategies which is a critical and necessary step not only for HIV treatment but also for receiving regular STI screening and treatment as

described in interventions #6 and #7

- Continuing to prioritize HIV positive individuals with STIs for partner services
- Measuring quality indicators for STI screening among HIV positive patients in Ryan White clinical settings

Screening for STIs is already an important part of the standard of medical care for the RW system in LAC, and it is a performance measure for comparison across all medical providers. OAPP will be implementing a pay-for-performance structure to provide financial incentives for adherence to critical clinical guidelines, including STI screening. The results of the modeling activities will help to determine the level of change necessary in the investment for STI screening to achieve any meaningful change in diagnosis of disease and successful STI treatment.

### Required Intervention #11: **“Implement prevention of perinatal transmission for HIV-positive persons”**

#### **A: Situational Analysis**

The Los Angeles County (LAC) Department of Public Health (DPH) follows the CDC’s guidelines for perinatal prevention and treatment (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, MMWR, September 2006). In 2008, legislation was simplified with the passage of AB 682 which requires healthcare providers to offer HIV testing to pregnant women using the “opt-out” (routine voluntary HIV testing with the right to decline) rather than the “opt-in” (non-directive patient choice) methodology. In addition, written consent or refusal of HIV testing is no longer required; however, medical providers would document in the patient’s chart the HIV test result or the declined test. AB 682 also states that if a woman does not have an HIV test documented in her prenatal record at the time of labor and delivery, she should be informed about HIV and her right to decline HIV testing. The passage of AB 682 is in line with the CDC’s “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings.”

OAPP currently provides a culturally competent Perinatal HIV training curriculum and training course for Public Health Nurses (PHNs) within LAC. The curriculum includes training regarding the epidemiology of HIV, current CDC guidance on HIV testing, California HIV laws, HIV transmission from mother to fetus, recommended antiretroviral treatments for perinatal HIV infection, culturally competent counseling for HIV positive mothers, options for pregnancy, breastfeeding, and disclosure to family, common myths and facts, small group activities and resources for care.

OAPP continues to work with community partners to ensure that proper HIV prevention, counseling, testing, and therapies are provided to women and infants during prenatal care, delivery, and postnatal care. In 2008, OAPP re-solicited the entire HIV prevention portfolio consistent with the priority populations identified in the LAC HIV Prevention Plan 2009-2013, with new HCT contracts that began in July 2009 and Health Education Risk Reduction contracts which started in October 2009. Women who have sex with partners of unknown HIV status/risk and/or women in highly impacted geographic areas/zip codes for HIV counseling and testing interventions were an identified priority population. In addition, the Prevention Planning Committee (PPC) recommended that a minimum of 70% of services targeting women target African American/Black and Latino/Hispanic women. OAPP will continue to

provide HCT services to pregnant women and provide appropriate medical care and prevention referrals.

OAPP also funds the East Los Angeles Women's Center to provide Health Education/Risk Reduction Services to adult and young women at sexual risk in Service Planning Area (SPA) 7 of LAC. Although the funding is not specifically targeting pregnant women, the agency has developed effective relationships in prenatal clinics throughout SPA 7 where they conduct outreach. The goal of outreach activities is to link these women into a Promotora Training Program or appropriate services which include HIV Counseling and Testing, Sexually Transmitted Disease Testing, and Comprehensive Risk Counseling and Services. The Promotora Training is a peer education model intended to engage, empower, and train participants to assist in the delivery of services and support the reduction of their individual risk behavior for HIV and STDs. Peers may begin assisting the program only after completion of the peer training intervention. Trainings are 16 hours in length and cover Human Anatomy basics; HIV/AIDS101, HIV prevention/risk reduction, sexually transmitted diseases, safer sex negotiation skills, HIV testing and domestic violence.

Among OAPP's subcontracted agencies providing Ryan White funded medical care, OAPP monitors their programs using a performance-based contract monitoring (PBCM) model. The PBCM model is a quantitative and qualitative approach to program reviews and uses a nationally-validated sampling methodology. Standardized scoring and data collection tools are used based on contract requirements and standards consistent with Public Health Service Guidelines, local standards of care, and Health Resources and Services Administration, HIV AIDS Bureau (HRSA HAB) recommended clinical performance measures. These recommended clinical performance measures include reporting the number of HIV positive pregnant women on ARV therapy. In 2010-2011, the performance measures will be tied to a fee-for-service structure where OAPP-funded agencies would be reimbursed at a higher rate based on performance on key clinical measures including ARV for pregnant women.

On June 9<sup>th</sup>, 2010, the LAC DPH reported that 2009 became the first year LAC could report a zero (0) transmission of HIV from infected mothers to their babies, since the implementation of pediatric HIV surveillance reporting in 1989. Based on LAC's perinatal HIV surveillance data, of the 79 HIV-infected pregnant women delivering in 2009 and identified, 98% had received critical drug therapy during pregnancy and/or during labor and delivery, leading to this success.

As of April 2010, representatives from OAPP, HIV Epidemiology Program, and LA County's LAC+USC Medical Center formed a workgroup to assess current perinatal HIV prevention activities in the County. Workgroup members have also expressed a desire to continue the Perinatal Collaborative and have mapped out a plan to re-engage former members, identify needs of the collaborative, and provide recommended goals and objectives for the group. In 2010, workgroup members met five times and participated in the Eliminating Perinatal HIV Transmission in Southern California: A Gathering of Experts (described below).

On October 8, 2010, a meeting was convened to discuss missed opportunities for prevention of mother-to-child transmission of HIV in Southern California and to strategize solutions. Attendees were physicians, clinicians, nurses, coordinators, and public health staff from across Riverside, Orange, and Los Angeles counties. A total of 40 individuals participated in this event.

During the Eliminating Perinatal HIV Transmission in Southern California: A Gathering of Experts event, data was reviewed, missed opportunities for prevention discussed, and strategies for improving PMTCT (Prevention of Mother to Child Transmission) were identified. After the meeting, smaller working groups were proposed to further develop strategies around the following areas:

1. Legislation/Policy (e.g., testing of pediatrics in foster care, exposure reporting, and mandatory testing)
2. Updating LA County Standards of Care (SOC)
3. Outreach and Education Efforts (e.g., testing male partners, labor and delivery, lactation)
4. Repeat 3rd Trimester Testing
5. Testing and Linkage to Care
6. Improved Adherence
7. Improved Linkage to Care
8. Perinatal Hepatitis B Initiative Collaboration (e.g., chart review data collection)

In December 2010, a meeting between three HIV Perinatal Collaborative members and the Perinatal Hepatitis B Coordinator for LA County convened to discuss the successes, challenges, and lessons learned from the well established Perinatal Hepatitis B Program. The outcome of this meeting was to set up a follow-up meeting with additional Perinatal Collaborative members and Perinatal Hepatitis B Program staff to explore the possibility of adding HIV testing questions to the perinatal Hepatitis B chart audits. This meeting was scheduled for March 2011. Other working groups such as the Standards of Care are expected to meet in 2011.

Los Angeles County receives CDC funding for the Enhanced Perinatal Surveillance Project (EPS). EPS is a longitudinal study linking mother-infant pairs through retrospective medical records review and data abstraction of both the mother and child's medical records. Funding for EPS is through 2011. Additional perinatal transmission activities are covered through the County of Los Angeles Department of Public General Fund and Ryan White (for pregnant women receiving Ryan White medical Care).

### **B: Goal Setting**

Primary HIV prevention goals:

1. Prevent perinatal transmission in HIV positive pregnant women in Los Angeles County.

**Rationale:** Perinatal transmission has been drastically reduced in LAC. However, OAPP continues to work with community partners to ensure that proper HIV prevention, counseling, testing, and therapies are provided to women and infants during prenatal care, delivery, and postnatal care. Although the

CDC will no longer support the EPS program as of December 2011, OAPP will continue to support the program at its current level in addition to engaging in other perinatal prevention activities. In order to preserve the low perinatal transmission rates in LAC the following activities will continue:

- Education monitoring and technical assistance for routine testing guidelines in the first and 3<sup>rd</sup> trimester as specified by CA state law and local standards of care
- Continuation of enhanced perinatal surveillance activities for exposed infants
- Monitoring and outreach, and linkage to perinatal specialty care services including access to ART for both mother and child to reduce risk of HIV perinatal transmission
- Provide HIV testing services in clinical and non-clinical settings to pregnant women and provide appropriate medical care and prevention referrals

Current investment and programming will be maintained.

## Required Intervention #12: “Implement ongoing partner services for HIV-positive persons”

### A: Situational Analysis

As the cooperative agreement grantee, OAPP is responsible for the provision of Partner Services (PS) to HIV positive persons within Los Angeles County. Within the County of Los Angeles, Department of Public Health, the Sexually Transmitted Disease (STD) Program has the only legal authority to conduct partner notifications in the field for PS. Los Angeles County has in place a policy and procedure for PS that complies with the 2008 recommendations (summarized below). In 2009, Los Angeles County’s budget for PS was \$240,000 and 18 FTE’s were devoted to PS activities. Los Angeles County does not yet utilize data from Surveillance to initiate Partner Services cases but has initiated protocol development to begin this process.

OAPP utilizes two methods to implement PS:

- 1) STD Program: Provision of PS through STD Program Public Health Investigators (PHI) which includes maintaining systems to adhere to local policies requiring that all persons reported through various mechanisms are followed-up with to ensure the provision of PS.
- 2) Community Partners: Provision of PS via trained staff at OAPP funded community partner agencies.

The two methods are summarized below.

#### STD Program

The Los Angeles County Public Health Laboratory routes each HIV positive or inconclusive lab result to STDP and is entered into an electronic database called STD\*CASEWATCH. The PS Manager at STDP evaluates each of the results from STD\*CASEWATCH to determine if it is a new case that has not received previous PS and if the client is deemed a "new" positive the PS Manager assigns them accordingly for field follow-up.

HIV positive cases from private providers who request assistance in notifying their patients as well as partners elicited from agencies that do not utilize the Los Angeles County Public Health Laboratory will fax elicitation interview information to STDP. This information is also entered into STD\*CASEWATCH to be assigned accordingly by the PS manager for field follow-up. The only reports that are not entered into STD\*CASEWATCH are HIV tests conducted as a result of court ordered testing for sex crime offenders.

The cases are assigned by rank in priority, from highest to lowest:

1. Clients identified through special projects generally refer to studies that are being conducted (e.g., NAAT positive testing).
2. Court ordered clients who are mandatory for follow-up.
3. Sexual or drug using contacts of HIV positive persons.
4. Newly identified HIV positive.
5. Co-infected HIV/STD cases usually HIV and syphilis.
6. Cases that have had an STD within the past 12 months but may have previously received PS. The priority ranking is based on staff resources and frequency of the reporting source. Case management on these cases ranges from an average of one week to two months each is dependent on the client/contact/cluster.

#### Community Partners

OAPP's contracted providers offer the range of PS to clients testing HIV positive at their counseling and testing sites, or previously positive clients receiving prevention services and/or Ryan White Care services from the agency. Community partners are trained to explore PS options with their clients including the use of inSPOT website for partner notification (<http://www.inspot.org/>). Upon the client's selection of the type of notification, the counselor provides respective services. If anonymous third party disclosure (also called provider referral) is selected then the counselor will conduct the elicitation and forward the partner information to STDP. If dual disclosure is selected then the counselor will encourage the client to bring in their partner(s), and will provide partner testing as appropriate. If self disclosure is chosen then the counselor will coach the client on how to disclose to his/her sexual or needle-sharing partner(s). Please note that community partners do not conduct partner notifications in the field as part of anonymous third party disclosure.

In 2009, LAC DPH funded the Los Angeles Gay Lesbian Center (LAGLC) and AIDS Healthcare Foundation with embedded Public Health Investigator's (PHI's) to provide PS. Due to the success of this strategy, a second PHI was placed at the J. Goodman Clinic at LAGLC in June, 2009. OAPP supports the model and plans to fund a community embedded Disease Investigation Specialist (DIS) at a clinic with a high HIV burden in calendar year 2010.

OAPP funds network tracing of partners of HIV positive clients at OAPP-funded HIV care clinics. Table 10 shows the outcomes of network tracing in this setting in 2009.



**Table 10. HIV Positive Network Tracing Testing at OAPP-funded Clinics, Rates, 2009**

| Type of Testing Program       | Number of HIV Tests | HIV Positivity Rate |       | HIV New Positivity Rate |       |
|-------------------------------|---------------------|---------------------|-------|-------------------------|-------|
|                               |                     | N                   | %     | N                       | %     |
| <b>Outpatient HIV Clinics</b> | 647                 | 39                  | 6.03% | 34                      | 5.26% |

**Data Source:** Office of AIDS Programs and Policy, Los Angeles County Department of Public Health, HIV Testing Annual Report, January through December 2009, November 2010, 1- 53. Available online: <http://publichealth.lacounty.gov/aids/reports/HCT2009Report.pdf>

Finally, as part of the Expanded Testing Initiative, OAPP will implement an innovative Partner Services intervention that combines Partner Services, case management and linkage to care principles. The intervention, named ARTAS Linkage Case Management (ARTAS), intends to increase access to and use of HIV medical care and treatment by newly identified HIV persons. The Department of Public Health’s Sexually Transmitted Disease Program (STDP) in collaboration OAPP will implement this program to successfully link newly identified HIV positive persons into medical care. The goal of this program is to improve the linkage to and retention in medical care for newly-diagnosed HIV positive persons in Los Angeles County.

Table 11 describes the outcomes of HIV partner services in 2009. Overall in 2009, 588 confirmed HIV positive tests were reported in Los Angeles County. PS staff contacted 864 partners of whom 426 received an HIV test. Of the partners that received an HIV test, 97 were newly identified confirmed positive tests.

**Table 11. Outcomes of HIV Partner Services, 2009**

| <b>Outcome</b>                     | <b>N</b>          | <b>%</b> |
|------------------------------------|-------------------|----------|
| <b>Index Patient</b>               |                   |          |
| <b>Identified</b>                  | 2,911             | -----    |
| <b>Assigned</b>                    | 2,422             | -----    |
| <b>Interviewed</b>                 | 2,134             | -----    |
| <b>Assigned / Identified</b>       | 2,422/2,911       | 83%      |
| <b>Interviewed / Assigned</b>      | 2,134/2,422       | 88%      |
| <b>Accepted</b>                    | 588               | -----    |
| <b>Accepted / Interviewed</b>      | 588/2134          | 26%      |
| <b>Partners</b>                    |                   |          |
| <b>Elicited</b>                    | 1,223             | -----    |
| <b>Accepted : Elicited (Ratio)</b> | 588:1,223 (1:2.2) | -----    |
| <b>Partner / Index</b>             | 1,223/2134        | 57%      |

|                                      |         |       |
|--------------------------------------|---------|-------|
| <b>Previous HIV Positive</b>         | 359     | ----- |
| <b>Eligible</b>                      | 864     | ----- |
| <b>Current HIV tested / Eligible</b> | 426/864 | 49%   |
| <b>Current HIV Test Result</b>       | 426     | ----- |
| <b>HIV Positive</b>                  | 97      | 23%   |
| <b>HIV Negative</b>                  | 286     | 67%   |
| <b>HIV Testing Result Unknown</b>    | 43      | 10%   |

**Data source:** 2009 LAC Department of Public Health Sexually Transmitted Diseases Program Partner Services Data.

**B: Goal Setting**

Primary HIV prevention goals:

1. To increase case finding through partner services.

**Rationale:** Implementing partner services will potentially decrease forward transmissions by HIV positive individuals unaware of their status and may improve the linkage to and retention in medical care for the newly-diagnosed HIV positive persons in LAC. We currently have a strong partner services program whereby the positivity rate of elicited partners ranges from 18-22%. However, only 26% of newly diagnosed HIV positive clients accepted PS in 2010, which is below our local goal of 50%. Therefore, we intend to improve and increase our PS program such that all newly diagnosed HIV positive persons receive PS and linkage to care through the following activities:

- Requiring all HIV testing providers to refer all HIV positive individuals to the Department of Public Health Sexually Transmitted Diseases Programs for initiating PS
- Use of surveillance data to improve case finding through PS
- Increase the percentage of HIV positive index patients accepting a PS interview
- Use PS to increase the number of people entering care (ARTAS and community embedded DIS)

OAPP is developing a comprehensive protocol for PS and will embark on an ambitious effort to retrain DIS. In addition, OAPP is developing a MOU between OAPP, HIV Epi and STD programs for the purposes of data sharing and limiting the liability to the county of improper disclosure procedures. The modeling activities currently underway will assist in informing the extent to which increased investment in PS is necessary to achieve desired outcomes, and should also help determine the most effective location for DIS staff, either embedded in CBOs (and which ones) or health department staff.

**Required Intervention #13: “Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV”**

**A: Situational Analysis**

The 2009-2013 Los Angeles County HIV Prevention Plan identifies HIV-positive individuals as a priority and critical target population at risk for acquiring/transmitting HIV. Therefore, it was determined that 20.3% of the prevention funds in Los Angeles County will be used to provide Health Education/Risk Reduction Prevention (HE/RR) Services to this target population through outreach/targeted prevention activities, interventions delivered to individuals and/or groups, community level interventions (CLIs), structural interventions, and comprehensive risk counseling services (CRCS). Given the recommendations, OAPP funded six (6) agencies to specifically target HIV-positive individuals totaling approximately \$1,000,000. This is done through programs implementing both locally developed interventions as well as evidenced based interventions (e.g., Healthy Relationships and Options). The main goal of these programs is to reduce the transmission of HIV in Los Angeles County which will be achieved through various implementation activities that are outlined in each of the program scopes of work. OAPP is also focusing efforts on ensuring HIV-positive individuals are linked into Partner Services (PS). Therefore, all of OAPP’s funded programs have an objective in their scope of work that requires them to provide a linked referral to individuals they serve who have been identified as being HIV-positive. All OAPP-funded agencies (6) received training on OAPPs HE/RR policies and procedures including data collection.

In 2009, OAPP implemented a client-level data system for all HE/RR programs which collects standardized data collection forms. Data from this system will: 1) Determine the acceptability of the intervention/program by the target population and 2) Determine the effectiveness or success of the intervention or program. These program objectives are measured by the following standardized process and outcome measures.

*Process Measures:*

- *Number of clients/participants that are part of the target population*
- *Number of clients/participants that completed all sessions of the intervention*

*Outcome Measures:*

- *HIV Knowledge*
- *Attitudes*
  - *Perceived severity of HIV*
  - *Perceived susceptibility of HIV*
  - *Perceived self-efficacy*
- *Behaviors*

- *Condom use*
- *Number of sexual partners*
- *STD incidence*
- *HIV incidence*

All interventions utilize a standardized behavioral risk screening at the first program session, last program session, and at a 60 day follow-up session. The goal for current HE/RR Programs is to assess a baseline for Process and Outcome measures.

### **Ryan White System of Care**

As part of the Standard of care for OAPP-funded medical care and med coordination services, an annual assessment of risk behavior is conducted for all Ryan White medical clients. This is a clinical quality indicator that is monitored annually at all OAPP-funded clinical sites. If site specific inadequacies are identified through monitoring activities, OAPP requires the submission of a program specific plan corrective action (POCA) for review and approval. Once approved, OAPP monitors progress of the POCA and provides TA and capacity building. If deficiencies are identified across providers we implement system-wide quality improvement initiatives when appropriate.

### **B: Goal Setting**

Primary HIV prevention goals:

1. Reduce risk behavior among HIV positive persons (including HIV-discordant couples).
2. Improve access to mental health and substance use services for HIV positive individuals in Ryan White system of Care.

**Rationale:** Behavioral risk screening followed by behavioral risk reduction interventions by themselves for HIV-positive persons will not meaningfully reduce the transmission of HIV in LAC. Given the limited demonstrated effectiveness of the behavioral interventions over time, it is important for LAC to expand the prevention portfolio to include evidence based interventions that target the individuals most at risk for transmitting HIV: stimulant users, those with STIs, and those with unsuppressed viral loads. Behavioral risk screening and interventions must be combined with engagement, retention in care, and adherence to treatment to prevent forward transmission of HIV and impact overall HIV community viral load. All these promote an overall healthy lifestyle.

Given the immense size and diversity of LAC, the high cost of behavioral risk reduction programming, limited resources, and questionable/unknown efficacy, LAC needs to prioritize the availability of intensive behavioral risk reduction services to individuals most at risk of transmitting HIV, including HIV positive stimulant users and HIV positive individuals with STIs. The modeling activities will further define the investment necessary to achieve goals consistent with NHAS among the target populations.

OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that will help inform the scope and direction of all behavioral risk screening activities, including interventions directed towards HIV positive individuals, consistent with NHAS goals (see Appendix A).

**Required Intervention #14: “Implement linkage to other medical and social services for HIV-positive persons”**

**A: Situational Analysis**

As the grantee and administrator for the local Ryan White Program, OAPP has developed a robust care and treatment program that is linked to our HIV testing programs. OAPP contracts with over 33 medical outpatient delivery sites, and over 100 sites that deliver one or more of the following services to encourage client assessment, referral, linkage and retention in care:

- Medical outpatient and medical specialty services
- ADAP enrollment
- Benefits screening and enrollment
- Case Management
- Oral health services
- Early intervention
- Residential care services (OAPP-funded)
- Housing services (HOPWA- funded)
- Substance use treatment (in collaboration with the County's Substance Abuse Prevention and Control Program)
- Mental health treatment (in collaboration with the County's Department of Mental Health)
- Nutrition support
- Medical transportation

**Customized Strategies.** To ensure referrals and linkage to services for individuals informed of their status, LAC applies these strategies: 1) providing financial incentives to agencies for these services; 2) HIVLA, a comprehensive web-based HIV service directory; 3) specialized linkage-to-care initiatives targeting specific subpopulations; 4) coordination with PHIs for field investigation; and 5) an interfaced/integrated client-level data system.

LAC follows an established protocol for care services referrals for individuals who became aware of their HIV status and supports the process through provider education and technical assistance. In LAC, only linked referrals—referrals that result in actual services being delivered—can be counted toward contract goals and receive full reimbursement for services rendered. A customized referral alone will receive just \$20 in payment while a verified medical visit, i.e., linked referral, can receive an additional \$80 to \$210. If a client tested HIV positive, written referrals to a minimum of three primary medical care providers will be provided based on the client's needs. Other linked referrals appropriate to the immediate health and social needs of the client will also be provided. HCT contractors must document all linked referrals and referral follow-up for each person served, which includes men, women, partners of PLWHA, youth, and (post) incarcerated PLWHA.

To facilitate the referral process, OAPP funds HIVLA, a comprehensive online and printed directory of

HIV/AIDS services available in English and Spanish. The directory contains fact sheets on each service and information on training and technical assistance. When users search the online database for a service category, they are presented with the results as well as a fact sheet describing the service. A toll free hotline also provides information on how to use the directory as well as service referrals and information on public benefits. HIVLA will assist in referral to care.

LAC will continue a diverse mix of programs and initiatives to target special populations with disparities in access and retention and make every effort to link them to the continuum of care. HIV RTA allows for immediate referral and linkage to care upon confirmatory results with two consecutive positive rapid tests. To date, all HIV positive clients at the RTA sites received their test results and were referred to care on the same day. OAPP will expand RTA in all routine HIV testing sites, County jails, and homeless shelters. This will increase access to care for men, women, and youth, including those who are released from jails.

Other linked referral strategies employed in LAC include: transitional case management, youth-focused linkage workers, early intervention, Antiretroviral Treatment Access Study (ARTAS) linkage case management, and a peer navigator intervention. OAPP supports an in-house coordinator to work with the PHIs and OAPP-funded HIV testing programs for partner services and field investigation, specifically targeting those who did not return for results. Upon locating the client, the PHIs will make appropriate referrals.

OAPP plans to establish an integrated data system for comprehensive client tracking from HIV testing to engagement in care. Referral for services will be automatically generated based on criteria prioritized by each client based on his/her needs. Referral to care and verification of appointments made for referred services will be performed seamlessly across agencies. Such a system will also strengthen OAPP and service providers' ability to monitor service performance and client health outcomes, and help resolve barriers to access and retention.

According to OAPP-funded HCT contracts, the certified HIV counselor must assess the need for referrals for clients who test HIV-positive and HIV-negative. The certified HIV counselor must provide specific written referrals and adequate linkages as appropriate. A linked referral is any referral that is facilitated by the providers and confirmed as met by the referring agency. At a minimum, a linked referral must include: referral information provided in writing and verification regarding client's enrollment in scheduled services. Clients diagnosed with HIV by counselors remain in the counselor's care until the client accesses the appropriate referred medical services. OAPP program staff review the referrals and linkages information and ensure congruence with data reported in OAPP's client-level database.

Collaboration between OAPP and the Veteran's Administration (VA) was established in order to offer HIV testing in local homeless shelters, where the emphasis is on referring and linking HIV-positive veterans into HIV care at the VA medical facility. OAPP counselors are located in shelters to offer rapid HIV-testing to all shelter occupants and have developed a strong partnership with local HIV clinics in order to expedite the medical appointment, by linking preliminary positive clients immediately to medical care. To further assist with moving these clients into medical care, the VA provides taxi vouchers for HIV-positive clients to facilitate the clinic appointment, since most homeless clients do not have access to reliable transportation. OAPP plans to conduct the RTA at the point of care at these sites.

OAPP is soliciting for a data system that will ultimately serve as a single client-level data management system for HCT, prevention and care services, and will export data to both CDC and HRSA and allow for client matching with the HIV surveillance database. Several initiatives that treat referral and linkages as one process, as described below, specifically target the subgroups identified in the EIIHA matrix to ensure linked referrals for services they need.

**Essential Activities to Ensure Access to Care.** OAPP increased the full HCT reimbursement structure for HIV-positive testers, including linkage to medical care, from \$185 to a range of \$375-\$395 per client. This provides HCT agencies a considerable financial incentive to complete linkages to medical care for newly diagnosed individuals. OAPP will continue this practice for FY 2011. HCT agencies can receive highest reimbursement for successful linkages. HCT contractors are required to have an approved linked referral/no-show follow-up plan on file at OAPP. The linked referral follow-up must include, but not be limited to, the agency the person was referred to, any appointment(s) made, the client's failure to appear for said appointment, and a follow-up plan, if the confidential tested individual failed to show.

LAC endeavors to ensure access to care for newly identified PLWHA through several data sharing and matching efforts across OAPP divisions and County departments. OAPP collaborates with LAC Public Health Lab, HIV Epidemiology and STD Program to conduct data matching of various HIV databases to more accurately identify gaps in linking PLWHA to medical care. Individuals who had been tested for HIV but had no lab values for viral load or CD4 in the datasets—indicating that they had not accessed medical care—can be identified and linked to treatment. OAPP is moving toward having an integrated data system for seamless client tracking from HIV testing to access to prevention, care and treatment services, as outlined above.

Other jail-based initiatives will be implemented to strengthen access to care for the post-released PLWHA, who present tremendous challenges in access. Transition Case Managers work in jails to refer HIV-positive inmates and establish linkage to HIV medical care and other services upon release. Two pilot projects of Peer Navigator Interventions will be used to improve linkage to care and retention for Latino MSM and recently released inmates. In collaboration with the County Sheriff's Department and UCLA, peer navigators will link post-released HIV-positive inmates to HIV care and substance abuse services to improve access to HIV care, rates of antiretroviral therapy (ART) use, and reduce viral loads. A second peer navigator intervention is a collaboration with a local community clinic, and UCLA. The project aims to link out-of-care Latino MSM back to care and improve their retention in HIV care and ART adherence.

Early Intervention Programs (EIPs) play a pivotal role in linkage to care for the newly diagnosed PLWHA in LAC. Partly funded by MAI, LAC EIPs target minority men and women who need assistance to access and engage in their HIV care. The EIP workers actively locate unaware and out of care PLWHA and, once identified, offer them comprehensive risk assessments and connect them to comprehensive medical care. EIP workers must document outreach contacts, follow up, and care access.

OAPP collaborates with the local Adolescent Medicine Trials Network for HIV/AIDS Interventions clinical trial site—Childrens Hospital Los Angeles—to implement Youth-Focused Linkage Workers to improve the identification and linkage to care of youth with undiagnosed HIV infection. An MOU was established between OAPP and CHLA to implement a model whereby all newly diagnosed youth in LAC are referred to a linkage worker, who then ensures that the youth are linked to HIV medical care. The program will

be evaluated for effectiveness and feasibility to implement as a model program to improve linkage to care for all HIV positive testers.

To ensure partners of PLWHA who tested HIV-positive are linked to care, LAC uses the *Antiretroviral Treatment Access Study (ARTAS) Linkage Case Management* (ALCM) program, where a STD Program public health investigator (PHI) delivers up to five sessions of strength-based case management to newly diagnosed persons and persons out of care. To date, results of the ALCM program showed a 37% improvement in the number of new HIV cases who were linked to medical care between new HIV cases that received the ALCM intervention and new HIV cases that received a standard referral to care.

***Verification of Care Access to Ryan White Programs.*** According to OAPP-funded HCT contracts, contractors must document where the client was referred for HIV medical care services using agency-specific linked referral forms. The referring agency must follow up and verify that the client was in medical care through verification with the client (self-report) or the surveillance coordinator, and through verification by the medical clinics. As described previously, OAPP imposes different fee scales for various levels of care access verification regardless of whether they are RW-funded programs. OAPP performs data matching periodically between the HCT and RW client databases to validate the self-report information. The majority of RW-funded programs (medical clinics and others) are also funded for HIV testing to achieve immediate linkage to care, and can provide confirmation of care access.

For all individuals who are identified as HIV-positive, contractors track and confirm all completed medical referrals. Routine opt-out HIV testing offered in clinical sites in high burden areas have a requirement of same-day linkage to care after a positive diagnosis. OAPP program managers review the referrals and linkages information and ensure congruence with data reported in OAPP's client-level database. If discrepancies are confirmed, OAPP requests payment reconciliation refunds for services not provided. OAPP intends to establish an integrated HIV prevention and care data management system in the near future to follow clients throughout the continuum of care, and automate the verification process for linkage to RW-funded care programs.

***Verification of Care Access to Private HIV Providers.*** As described previously, the HCT contractors are required to verify linked referrals to medical care services for clients identified as HIV-positive. The verification is expected whether the client was referred to a private or public funded provider, and the same standards and procedures for reimbursement apply. For clients referred to private providers, the initial verification of care access is most frequently documented by the HCT counselors contacting clients to obtain client self-reported information about when they made it to their medical appointments. Such information is further verified by the PHIs.

Additional verification can be obtained through the medical care coordination (MCC) program, whose target populations include the newly-diagnosed PLWHA. MCC is designed to optimize patient's health status through enhanced coordination with medical providers, including private HIV providers. When implemented, the HCT contractors will obtain care access verifications from RW-funded MCC programs.

***Efforts to Address Local and State Legal Barriers.*** Within California, the State law has adopted language to facilitate routine HIV testing. Minimal legal barriers exist in LAC to implement routine HIV testing. However, challenges exist with HIV case reporting as described earlier. In response, coordination between OAPP and HIV Epidemiology Program continues to resolve data matching and data sharing



issues while adhering to state confidentiality and privacy laws. OAPP is considering providing additional staff support to HIV Epidemiology Program for the reinforcement of laboratory reporting laws in order to ensure that every reportable lab result is being appropriately reported and captured by HIV surveillance.

**NOTE:** All linkage services are designed to link individuals to medical care and social services for HIV-positive persons. The same programs described above provide both services. See interventions 6 and 7 for further information on funding and persons served.

**B: Goal Setting**

Primary HIV prevention Goals:

1. Improve treatment engagement and health status of persons with HIV.
2. Develop strategies for identifying HIV positive individuals not in care.

**Rationale:** OAPP is adopting a medical home model that provides a holistic approach to HIV care and treatment. Patients are linked through their medical home to supportive services (e.g. substance use services, benefits enrollment services, housing and mental health services). The medical care coordination model is the vehicle by which integrated care is delivered (as described in detail in interventions #6, 7, 8, and 14). It is currently offered in five sites across the county, and many more sites will go online in the next several months.

In addition, comprehensive benefits screening and enrollment services provide critical linkages to other medical and social services that are not necessarily supported by OAPP funding, effectively expanding the network of services available for people with HIV who live throughout the county. These services are currently available at nine sites throughout the county, and the investment in screening and enrollment services is going to be increased in order to allow patients to take advantage of support programs available to them.

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**Recommended Intervention #15: “Condom distribution for the general population”**

**A: Situational Analysis**

Fifty-three (53) OAPP-contracted Health Education/Risk Reduction (HE/RR) programs have a line item in their budgets to purchase condoms and distribute to the prioritized target populations targeted through HE/RR including HIV-positive persons and persons at highest risk of acquiring HIV infection. Currently OAPP spends approximately \$74,401 on purchasing condoms for HE/RR programs. Since HCT programs are fee-for-service, no direct funding is provided for condom purchase; however, all funded HCT providers have condoms available for people who test at their sites. STD clinics also distribute condoms on-site. OAPP is working with STD Program to leverage resources in order to purchase more condoms in bulk for distribution across clinics, funded agencies, and selected venues throughout the County where both HIV-positive and high-risk HIV-negative persons can access condoms. Development of an “LA

condom” and associated marketing program are underway.

### **B: Goal Setting**

Primary HIV prevention goals:

1. Increase condom distribution to all sites offering HIV, STD, and/or viral hepatitis screenings.
2. To design, market and distribute an “LA Condom” to brand condom use as a part of the Erase Doubt social marketing campaign.

**Rationale:** Given the population size of LAC (10.4 million residents, greater than the population of 43 states) and a vast geographic terrain, it would be cost prohibitive and impractical to make condoms available to the entire population using public funds. Consistent with our local priority setting needs please refer to required intervention #3 for more information.

## **Recommended Intervention #16: “HIV and sexual health communication or social marketing campaigns targeted to relevant audiences”**

### **A: Situational Analysis**

OAPP invests \$640,000/year in the current “Erase Doubt” social marketing campaign, which focuses on increasing awareness of HIV risk, HIV testing services, care and treatment services, and combines HIV social marketing campaigns with community events (e.g. health fairs, HIV Counseling and Testing Week activities) to increase HIV awareness and normalize HIV testing within the community and increase identification of unaware PLWHA. Media include billboards and bus advertising, radio broadcasts, collateral materials, and extensive viral marketing.

The “Erase Doubt” campaign and launch of erasedoubt.org (a comprehensive online HIV testing resource) have been completed. Also created were Erase Doubt sites on Facebook, Twitter, and YouTube. OAPP will use this funding opportunity to enhance the existing social marketing campaign to: 1) promote PEP services to high risk priority populations; 2) promote linkage to care for all individuals recently diagnosed or out of care individuals; and 3) improve LAC’s HIV online services resource (HIVLA.org).

Efforts are also underway to leverage social marketing efforts among OAPP-funded providers like LA Gay and Lesbian Center, AIDS Healthcare Foundation, STD Program and others to provide consistent messaging about HIV risk, testing, stigma reduction, and availability of free care and treatment, and to include the Erase Doubt logo on all marketing materials regardless of campaign developer. In addition, it is through this campaign that the development of a Los Angeles condom distribution plan is in progress. Specially designed condom packaging introduces an LA Condom, similar to the condom introduced by NYC, in an effort to increase condom visibility and incorporate condoms into the branding

of Erase Doubt.

An Erase Doubt event tent, mobile van, and collateral materials have been developed and deployed at health fairs, community fairs, and special events to promote HIV awareness and HIV testing. Frequent media collaboration results in print and broadcast messaging that is free of charge.

Through this funding opportunity, OAPP will partner with County of Los Angeles, Department of Public Health Sexually Transmitted Program to fund a 1.0FTE Research Analyst who would be responsible for determining effective use of internet sites for HIV and STD prevention activities, as well as promote the PEP program on the internet.

**OAPP will inventory the reach, “call to action statements”, targeted populations/communities of the four major campaigns (EraseDoubt, Act Against AIDS, AHF’s Testing and Access, and Greater than AIDS).**

#### **B: Goal Setting**

Primary HIV prevention goals:

1. To increase the visibility of the Los Angeles County Erase Doubt campaign.
2. To increase awareness of free testing and treatment services available throughout Los Angeles County.

Rationale: Increased visibility of the Erase Doubt campaign aims to increase awareness of free testing and treatment services available throughout LAC by putting relevant information at the fingertips of the target audiences. Messages are posted on billboards and buses throughout high burden areas of LAC, and limited radio and television advertising enhance the promotion of free testing and treatment. .

Los Angeles is the second most expensive media market in the US. The combination of the cost and the geographic vastness require OAPP to finely focus social marketing activities as well as leverage other national and local HIV awareness campaigns. Viral media such as Facebook and Twitter are being used to promote awareness of the campaign and the website at relatively little cost. The website provides continually updated information on the location and availability of local HIV/STD screening locations, as well as updates on specific events promoting HIV prevention throughout the county. The campaign also promotes the availability of the mobile testing fleet that provides free HIV and STI screening in high risk areas and special events.

**Recommended Intervention #17: “Clinic-wide or provider-delivered evidence-based HIV prevention interventions for HIV-positive patients and patients at highest risk of acquiring HIV”**

**A: Situational Analysis**

Within medical clinics, the consistent delivery of medical-provider-delivered HIV prevention messaging for patients with HIV is a part of the local standard of care for medical services. However, the messaging varies by clinician and by patient. Some clinics are located within agencies that also provide HIV education and risk reduction services in addition to HIV testing, care and treatment. In those agencies, prevention, care and treatment programs are linked seamlessly to promote disease detection and linkage to care. Evidence-based interventions are frequently used within these settings, and partner notification services are also made available.

OAPP funded six (6) agencies to provide Health Education/Risk Reduction (HE/RR) services specifically targeting HIV-positive individuals totaling approximately \$1,000,000. This is done through programs implementing both locally developed interventions as well as evidenced based interventions (e.g., Healthy Relationships and Options). The main goal of these programs is to reduce the transmission of HIV in Los Angeles County which will be achieved through various implementation activities that are outlined in each of the program scopes of work. OAPP is also focusing efforts on ensuring HIV-positive individuals are linked into Partner Services (PS). Therefore, all of OAPP’s funded programs have an objective in their scope of work that requires them to provide a linked referral to individuals they serve who have been identified as being HIV-positive.

Additional HE/RR services are also provided as described in Required Intervention #13: “Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV”.

**B: Goal Setting**

Primary HIV prevention goals:

1. Assess the use of Evidence Based Interventions (EBIs) in clinical settings.

**Rationale:** OAPP is currently implementing this intervention (please see the rationales for interventions #1, 4, 6, 7, 8 and 13 above). The modeling activities currently underway will further help inform the scope and direction of all clinic and provider delivered interventions for positives and high risk negatives, consistent with NHAS goals (see Appendix A).

**Recommended Intervention #18: “Community interventions that reduce HIV risk”**

**A: Situational Analysis**

Note, OAPP does not routinely define interventions at the community-level; therefore, it is not possible to determine the exact number of community-level interventions provided in LAC. US Census data from 2006 show 35% of LAC residents were foreign born and over 100 languages are spoken across the

county. As such, with relatively little homogeneity within and across geographically defined communities, defining community in a consistent way is a challenge. However, OAPP does invest in social marketing campaigns that target specific geographic areas with high disease burden.

### **Social Marketing Campaign**

OAPP invests \$640,000/year in the current “Erase Doubt” social marketing campaign, which focuses on increasing awareness of HIV risk, HIV testing services, care and treatment services, and combines HIV social marketing campaigns with community events (e.g. health fairs, HIV Counseling and Testing Week activities) to increase HIV awareness and normalize HIV testing within the community and increase identification of unaware PLWHA. Media include billboards and bus advertising, radio broadcasts, collateral materials, and extensive viral marketing.

The “Erase Doubt” campaign and launch of [erasedoubt.org](http://erasedoubt.org) (a comprehensive online HIV testing resource) have been completed. Also created were Erase Doubt sites on Facebook, Twitter, and YouTube. OAPP will use this funding opportunity to enhance the existing social marketing campaign to: 1) promote PEP services to high risk priority populations; 2) promote linkage to care for all individuals recently diagnosed or out of care individuals; and 3) improve LAC’s HIV online services resource ([HIVLA.org](http://HIVLA.org)).

Efforts are also underway to leverage social marketing efforts among OAPP-funded providers like LA Gay and Lesbian Center, AIDS Healthcare Foundation, STD Program and others to provide consistent messaging about HIV risk, testing, stigma reduction, and availability of free care and treatment, and to include the Erase Doubt logo on all marketing materials regardless of campaign developer. In addition, it is through this campaign that the development of a Los Angeles condom distribution plan is in progress. Specially designed condom packaging introduces an LA Condom, similar to the condom introduced by NYC, in an effort to increase condom visibility and incorporate condoms into the branding of Erase Doubt.

An Erase Doubt event tent, mobile van, and collateral materials have been developed and deployed at health fairs, community fairs, and special events to promote HIV awareness and HIV testing. Frequent media collaboration results in print and broadcast messaging that is free of charge.

### **B: Goal Setting**

Primary HIV prevention goals:

1. To increase the visibility of the Los Angeles County Erase Doubt campaign.
2. To increase awareness of free testing and treatment services available throughout Los Angeles County.

**Rationale:** OAPP does not routinely define interventions at the community-level; therefore, it is not possible to determine the exact number of community-level interventions provided in LAC. US Census data from 2006 show 35% of LAC residents were foreign born and over 100 languages are spoken across the county. As such, with relatively little homogeneity within and across geographically defined communities, defining community in a consistent way is a challenge. However, OAPP does invest in social marketing campaigns that target specific geographic areas with high disease burden.

Increased visibility of the Erase Doubt campaign and campaign recognition will lead to awareness of free testing and treatment services available throughout Los Angeles County.

**Recommended Intervention #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”**

**A: Situational Analysis**

The Los Angeles HIV Prevention Planning committee prioritized serving individuals at high risk for acquiring HIV and recommended that approximately 80% of prevention funding should serve those populations. OAPP supports 47 health education/risk reduction programs targeting individuals at high risk for acquiring HIV. All programs are evidenced based with 17 of these programs specifically from the CDC’s Diffusion of Effective Behavioral Intervention program. Approximately \$6.7 million fund these services that cover all of Los Angeles County. Other funding sources available in the jurisdiction include CDC directly funded CBOs, Cities of Los Angeles and West Hollywood, private funders.

In 2009, OAPP implemented a client-level data system for all HE/RR programs which collects standardized data collection forms. Data from this system will: 1) Determine the acceptability of the intervention/program by the target population and 2) Determine the effectiveness or success of the intervention or program. These program objectives are measured by the following standardized process and outcome measures.

*Process Measures:*

- *Number of clients/participants that are part of the target population*
- *Number of clients/participants that completed all sessions of the intervention*

*Outcome Measures:*

- *HIV Knowledge*
- *Attitudes*
  - *Perceived severity of HIV*
  - *Perceived susceptibility of HIV*
  - *Perceived self-efficacy*

- *Behaviors*
  - *Condom use*
  - *Number of sexual partners*
  - *STD incidence*
  - *HIV incidence*

All interventions utilize a standardized behavioral risk screening at the first program session, last program session, and at a 60 day follow-up session. The goal for current HE/RR Programs is to assess a baseline for Process and Outcome measures.

### **B: Goal Setting**

Primary HIV prevention goals:

1. Identify high risk HIV-negative persons (including those for HIV-discordant couples) at risk of acquiring HIV.
2. Increase the availability of EBIs for high risk HIV-negative persons (including those for HIV-discordant couples) at risk of transmitting HIV.

**Rationale:** 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 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 risk for HIV 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.

**Recommended Intervention #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”**

### **A: Situational Analysis**

Since 2004, the County of Los Angeles, Department of Public Health, Office of AIDS Programs and Policy (OAPP) has contracted with three community-based organizations (CBOs) to provide an integrated set of HIV, STD and hepatitis counseling, testing, education and referral services to individuals at high risk for one or more of these morbidities. These agencies provide integrated services via mobile testing units called Multiple Morbidity Testing Units (MMTUs). The mobile units provide services in populations with relatively high prevalence of hepatitis C; including drug treatment centers, inpatient detoxification and sober living facilities, drug diversion programs, twelve step and other alcohol treatment programs throughout Los Angeles County. Additional venues targeted by the MMTUs are homeless shelters, bathhouses, clubs, and special events (i.e., health fairs). In addition to hepatitis C testing, the MMTUs also provide hepatitis B testing.

Los Angeles County has in place a CDC-funded Adult Viral Hepatitis Prevention Coordinator (AVHPC) who is housed at OAPP. The AVHPC plays a large role in engaging community partners, planning councils, and Department of Public Health programs currently involved in hepatitis prevention and treatment, to develop policies, standards, and a coordinated response to adult viral hepatitis.

As part of the Los Angeles County (LAC) Department of Public Health's efforts to coordinate, integrate and enhance adult viral hepatitis efforts across the county a Los Angeles County Department of Public Health Adult Viral Hepatitis Prevention Plan was developed and finalized in May 2010 with the collaborative efforts of many partners, stakeholders, and Department of Public Health (DPH) staff from across Los Angeles County. This prevention plan will provide LAC DPH programs and partners a guide for viral hepatitis program planning and implementation. The principal intent of this effort is to design and implement a multi-faceted hepatitis prevention approach directed towards reducing the burden of disease from viral hepatitis. This plan outlines how LAC proposes to address viral hepatitis through three overarching goals: 1) Reduce the number of people newly infected with viral hepatitis, 2) reduce morbidity and mortality due to viral hepatitis, and 3) improve quality of life for people chronically infected with and affected by viral hepatitis. Four strategic directions were developed to address these goals that will serve as the central elements in this plan. The four strategic directions that will guide the adult viral hepatitis prevention efforts in LAC are: 1) improving surveillance and data use, 2) targeting and integrating services, 3) educating the public and providers, and 4) driving policy change. This prevention plan is a living document and will be continually amended as needed.

OAPP continues to collaborate with Sexually Transmitted Disease Program (STDP) and community-based organizations to provide an integrated set of HIV, STD and hepatitis counseling, testing, screening, education, vaccination and referral services to individuals at high risk for one or more of these morbidities. Twelve DPH STD clinics throughout LAC provide free hepatitis screenings. STDP, OAPP and Los Angeles Sheriff's Department (LASD) collaborate to provide integrated HIV, STD, and hepatitis screenings upon intake in the Men's Central Jail. These services are made possible through the continued collaboration between OAPP, STDP, LASD and the Immunization Program.

Through the 317 funds, Los Angeles County receives HAV and HBV vaccines from the State of California. These vaccines are received by the LAC Immunization Program (LAC IP) as they have the capacity for storing and distributing vaccines to LAC Community Health Services STD clinics, the LASD and community-based clinics throughout LAC in order to reach unvaccinated adults. Even though this program has been discontinued, there is enough hepatitis A and B vaccine in LAC to distribute until the



end of 2011.

Viral hepatitis prevention services for HIV-infected persons are provided as a standard of care at OAPP's Ryan White funded clinics throughout LAC. In addition, HIV standards of care and those developed by the Los Angeles Commission on HIV require hepatitis B and C screening and HBV vaccination of newly identified HIV clients entering care and for high risk populations that are currently in care. Furthermore, the HIV standards of care require hepatitis B and C screening and HBV vaccination of newly identified HIV clients entering care.

### **B: Goal Setting**

Primary HIV prevention goals:

1. Increase integrated HIV, STD, and viral hepatitis screening sites in Los Angeles County.
2. Increase provider capacity to provide integrated prevention messages and services.

**Rationale:** Consistent with the principles outlined in the 2009 CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) White Paper related to Program Coordination/Service Integration (PCSI), LAC continues to expand programmatic integration across multiple morbidities. Integrating HIV, STD, and viral hepatitis screening will potentially improve cross program reach and efficiencies as well as reduce incident HIV and STD infections, and improved hepatitis screening, vaccination, and treatment referral efforts. It is clear from 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.

**Recommended Intervention #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”**

### **A: Situational Analysis**

State regulations have historically limited the use of HIV and STD surveillance data including laboratory data to prioritize risk reduction counseling and partner services, to evaluate linkage to care, and to provide linkage services for individuals not in care.

These regulations were revised with the passage of California Assembly Bill (AB) 2541 that allows the use of HIV surveillance information for public health purposes including partner services. OAPP, HIV Epidemiology Program, and STD Program are currently assessing the logistics of data sharing including the matching of HIV and STD cases to allow for programmatic use of surveillance and laboratory data including partner services and linkage to care follow up.

**B: Goal Setting**

Primary HIV prevention goal:

1. Use HIV and STD surveillance data to prioritize risk reduction counseling and partner services, and to evaluate linkage to care.

**Rationale:** Access to real-time surveillance and laboratory data to inform programmatic activities including partner services and linkage to care follow-up is critical in order to effectively target interventions that will reduce forward HIV transmission to individuals at highest risk. OAPP is currently working towards implementing use of HIV surveillance data for partner services as outlined in 2008 CDC's Partner Services guidance and in accordance with California Assembly Bill (AB) 2541, as well as utilizing surveillance data to identify and track linkage to care and out of care populations. 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, and promote treatment adherence strategies to reduce viral load and the possibility of forward transmission.

**Recommended Intervention #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”**

**A: Situational Analysis**

The HIV Prevention Planning Committee and OAPP have acknowledged the role “co-factors” or “social factors” play in contributing to a person’s risk for acquiring or transmitting HIV. Co-factors is defined as a condition that can increase risk for HIV, increase susceptibility to infection, or decrease the ability to act upon HIV prevention messages. Population groups such as homeless individuals, person with STDs, commercial sex workers, etc. were identified. The consideration of co-factors is especially important at the agency level when describing the needs, as well as barriers to services of specific target populations. These co-factors need to be considered when selecting and/or designing interventions for the population. For example, for agencies targeting gay men who use crystal methamphetamine, the agency may need to describe how crystal methamphetamine increases sexual risk-taking behavior. Broadening linkages to and provision of services for the co-factors to HIV transmission is critical.

In addition to traditional Health Education/Risk Reduction and HIV Counseling and Testing programs considering these factors when providing services, OAPP also supports community agencies specializing in women services, domestic violence prevention, services, mental health, substance use, youth services

etc. are also funded by OAPP to provide HIV health education/risk reduction and HIV testing services to their clients as well as HIV-negative persons at highest risk of acquiring HIV.

More specifically, OAPP:

- a. Supports HIV counseling and testing programs at substance use prevention and treatment programs;
- b. Collaborates with the Veteran's Administration (VA) to provide HIV counseling and testing services in homeless shelters while linking homeless veterans into VA services;
- c. Allows HIV negative men who have sex with men (MSM) crystal methamphetamine users in care-funded HIV substance use facilities;
- d. Collaborates with the Department of Public Health's Crystal Methamphetamine Work Group, and provided guidance and facilitated the development of a Charter and Work Plan for this Work Group
- e. Provides HE/RR and HIV testing services in the Los Angeles County jail system and facilitate a condom distribution program within the jails.
- f. Supports residential housing services for HIV positive individuals as well as HIV positive and high risk substance using individuals through Ryan White Care Act funds and the Department of Public Health's Substance Abuse Prevention and Control Office.

In addition, OAPP is particularly concerned with the evidence that links methamphetamine use among gay men with increased rates of new HIV infection. Within MSM, stimulant abuse, particularly abuse of methamphetamine, continues to be a major factor in driving new infections, as users engage in extremely high-risk sexual transmission behaviors. To address this, an evidence-based biomedical and behavioral prevention intervention for use in groups of MSM who use methamphetamine and engage in high-risk sexual transmission behaviors. This includes the biomedical intervention of Post-exposure Prophylaxis (PEP) for HIV prevention and the behavioral intervention of contingency management (CM), which targets reduction of methamphetamine use as a way of reducing concomitant high-risk sexual behaviors among HIV-negative methamphetamine-using gay, bisexual, and other MSM (G/B/MSM).

Post-Exposure Prophylaxis (PEP): PEP involves providing a 28-day regimen of highly active anti-retroviral therapy (similar to the regimens used to treat HIV disease) and HIV risk-reduction education to high-risk individuals after a potential HIV exposure in order to abort HIV seroconversion after that exposure. The safety and feasibility of PEP after sexual exposure has been demonstrated in numerous trials and programs, and is recommended by the federal Department of Health and Human Services, as well as the California Office of AIDS.

Contingency Management (CM): Participants will be provided with an 8-week course of contingency

management for methamphetamine use concurrent with PEP. This approach with methamphetamine using G/B/MSM has been demonstrated in controlled treatment trials and in uncontrolled community demonstrations to aid participants in significantly reducing methamphetamine use and concomitant HIV-risk behaviors.

### **B: Goal Setting**

Primary HIV prevention goal:

1. Decrease social factors impacting HIV risk among HIV-negative persons at highest risk of acquiring HIV.
2. Provide substance use treatment of HIV negative men who have sex with men and transgender individuals who also use crystal meth.

**Rationale:** Consistent with the CDC's White Paper on the Social Determinants of Health, LAC agrees that addressing the social and economic conditions contributing to HIV risk is critical. LAC also maintains that any meaningful change in health outcomes will most efficiently be accomplished by intervening "upstream" (e.g., education, income generation, etc.). LAC also recognizes that changes to multiple systems may be beyond the scope of the ECHPP initiative. However, OAPP has identified specific factors that are of critical importance to address the local epidemic. As described in the situational analysis above, OAPP has prioritized substance abuse treatment and bio-behavioral intervention packages for high risk men who have sex with men and transgender individuals.

### **Recommended Intervention #23: "Brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV"**

#### **A: Situational Analysis**

For HIV-positive individuals receiving medical or social services through the OAPP-funded sites, substance use is screened at least annually, and more frequently for individuals at higher risk. The annual screening and health assessment form that is a part of the overall screening and enrollment process (required for all RW clients) is being reprogrammed to provide an updated health and quality-of-life measure that will be used to help guide referral to appropriate ancillary and support services like substance use and mental health treatment. The tool already includes these variables, but the calculation of an overall functionality score is being updated.

Substance use, including alcohol use, is assessed during the risk assessment for high-risk negatives in both HCT and HE/RR programs. Individuals who report high risk for substance abuse are referred to

substance use treatment providers.

### **B: Goal Setting**

Primary HIV prevention goals:

1. Increase capacity of providers to implement brief alcohol screening and interventions for HIV-positive persons and HIV-negative persons at highest risk of acquiring HIV.

**Rationale:** 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.

**Recommended Intervention #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”

### **A: Situational Analysis**

The Office of AIDS Programs and Policy (OAPP) supports and facilitates community mobilization activities with community members to raise HIV awareness, build support for and involvement in HIV prevention efforts, motivate individuals to work to end HIV stigma, and encourage HIV risk reduction among their family, friends, and neighbors with a variety of methods.

### **Community Planning**

OAPP coordinates and directs the overall response to the HIV epidemic in Los Angeles County, in cooperation with the Los Angeles County HIV Prevention Planning Committee (PPC), the Commission on HIV (COH), community-based organizations, governmental bodies, advocates, and people living with HIV. In collaboration with its partners OAPP establishes the standards of care for HIV services throughout the County.

*Prevention Planning Committee (PPC) and the Commission on HIV (COH)*

HIV prevention and care community planning is based on the principle planning reflect an open, candid, and participatory process in which differences in cultural and ethnic background, perspective, and

experience are essential and valued. Although the two main planning bodies, PPC and COH, are charged with planning, they provide forums for consumers of care and prevention services to provide guidance and feedback to OAPP when planning, developing, implementing and evaluating programs. In addition, the PPC and COH also liaise with community members to provide educational forums to raise awareness regarding services, policies, budget issues and major funding decisions, new prevention and treatment interventions (e.g., PEP and Prep) and other critical topics.

#### *Medical Advisory Committee*

In addition and in an attempt to improve services offered, OAPP has identified medical and public health experts, and community partners, who make recommendations regarding the provision of HIV service via the OAPP Medical Advisory Committee (MAC). The Medical Advisory Committee creates the opportunity to enhance HIV services and OAPP operations. The objective of the Medical Advisory Committee (MAC) is to provide a forum where medical and public health professionals can advise the Office of AIDS Programs and Policy (OAPP) in 1) the development and implementation of HIV care, treatment and prevention programs, and 2) HIV related quality assurance and quality management policies.

#### **Social Marketing**

OAPP implements a comprehensive social marketing campaign with KCBS, titled "Erase Doubt", is dedicated to increasing HIV testing in Los Angeles County, driving awareness of HIV prevention, and providing updated information about HIV/AIDS treatment and care. Through advocacy and education, Erase Doubt promotes a greater understanding and respect for individuals living with HIV/AIDS and those at higher risk of contracting HIV. In 2011, OAPP expanded the message beyond just becoming aware of HIV and HIV status to becoming an advocate for yourself, your partner, and your community. The goal this year is to bring a humanistic element by creating the opportunity for community members to become the "face" or "ambassadors" of the campaign. In addition, all social marketing activities are coordinated with prevention providers to ensure that services are advertised and available in the promotion areas.

#### **Faith Based Activities**

OAPP recognized that institutions and communities of faith are trusted sources of information and mediators of social change, cultural norms and safer behavior for many individuals. The impact of faith organizations is particularly significant within communities of color. Religious institutions often influence and define the acceptable parameters for discussing HIV and AIDS as well as the sexual and drug-related behaviors that put people at risk for HIV infection. As social change agents, faith leaders, through their institutions, can broaden the acceptable social parameters by educating communities about HIV and AIDS. They can also encourage compassion by reminding congregants of the importance of accepting people living with and affected by HIV and AIDS who are part or may become part of their community.

**Act Now Against Meth Coalition Advocacy Group**

Starting as a grassroots signature-gathering effort by concerned community members regarding the crystal methamphetamine epidemic in Los Angeles County, the Act Now Against Meth Coalition was victorious in advocating for the County of Los Angeles Board of Supervisors to pass a motion instructing the Director of Public Health's Substance Abuse Prevention and Control (SPAC) and OAPP, and the Director of Mental Health to develop a comprehensive strategy for meth use prevention and intervention. The County of Los Angeles Board of Supervisors approved a \$1.75 million multi-pronged investment for methamphetamine which included specific activities targeting the high risk populations of young women and men who have sex with men. The DPH implemented this strategy by supporting community planning efforts, prevention, intervention, education and treatment programs for young women and gay men. OAPP continues to work closely with the Act Now Against Meth Coalition to raise awareness about crystal meth and its effect on communities and families.

**Social Network Testing and Popular Opinion Leader Interventions**

OAPP funds programs that create opportunities for community members to educate and recruit their social affiliates to participate in HIV health education/risk reduction and HIV testing services.

*Social Network Testing*

The Social Network Testing program goal is to enlist HIV positive or high risk HIV negative persons to encourage people in their network (i.e., network associates) to be tested for HIV. This has been found to be an efficient and effective route to accessing individuals are HIV positive, or at very high risk for becoming infected with HIV and linking them to prevention and care services. OAPP utilized CDC's one-time supplemental cooperative agreement funding to fund a social network testing program which yielded a 6-7% HIV positivity rate. With these results, OAPP funded a long term social network testing program that serves men who have sex with men, regardless of sexual orientation, who are crystal methamphetamine users. OAPP hope to expand the number of programs using these techniques.

*Popular Opinion Leader*

Popular Opinion Leader (POL) is an intervention based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. The program is based on diffusion of innovation/social influence principles, which states that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population. Once innovations are visibly modeled and accepted, they then diffuse throughout a population, influencing others. OAPP funds 4 POL programs targeting young and adult gay men.

**B: Goal Setting**

Primary prevention goals:

1. Engage community planning groups to address community mobilization.

2. Increase HIV awareness via faith-based communities, social networks, and popular opinion leaders.

**Rationale:** LAC is currently assessing the community mobilization expectations in reach and influence and 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.