

Los Angeles County ECHPP Project

Workbook #2: GOALS, STRATEGIES, AND OBJECTIVES

This workbook is to document:

- **Goals set for each intervention or public health strategy (from Workbook #1)**
- **Strategies to achieve each goal**
- **“SMART” Objectives associated with each goal**

Instructions:

1. The purpose of this Workbook is to document strategies and SMART objectives for the goals established in Workbook #1.
2. List all goals for *each* intervention described in Workbook #1.
 - a. Goals: 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.
3. List all specific funding sources that will be utilized to achieve each goal (e.g. federal agency, federal program, state resources).
 - a. Separate funding sources by strategy if appropriate.
4. List specific strategies associated with each goal.
 - a. Strategies: Step-by-step descriptions of necessary activities for achieving each goal.
5. List “SMART” objectives (Specific, Measureable, Achievable, Realistic, and Time-based) that support each goal.
 - a. SMART Objectives: Specific and quantifiable targets that measure the overall accomplishment of a goal over a specified period of time. They should describe actions that are distinct, able to be documented or quantified, feasible to execute, realistic to accomplish in the given time frame for the one-year plan and be linked to time-based milestones.
 - b. Where goals explain where you are going, objectives are the metrics showing whether or not you got there. SMART objectives will allow grantees to monitor the progress of achieving programmatic implementation goals for each intervention. Provide specific data sources that will be used to monitor progress on each objective.
 - c. If a data source does not currently exist, provide a brief description of how a specific objective will be measured.

Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"

<p>Goal 1: Implement routine opt-out HIV screening in urgent care and emergency departments located in areas with the highest burden of HIV.</p>	<p>Funding sources: CDC</p>
<p>Strategy 1: Assess the willingness of urgent care and emergency departments to implement routine opt-out screening. Strategy 2: Provide technical assistance to clinicians to enable implementation of a routine testing program including reimbursement mechanisms.</p>	
<p>Objective 1: By September 30 2011, implement at least 1 routine opt out screening program in an Emergency Department (LAC+ USC Medical Center) in Los Angeles. Objective 2: By December 2011, conduct at least 15,000 HIV tests at LAC USC. Objective 3: By December 2011, provide at least 6 trainings/ technical assistance sessions for healthcare providers to enable implementation of a routine testing program and reimbursement.</p>	<p>Data sources: OAPP HIV Testing Services (HTS) data system, OAPP training database</p>

<p>Goal 2: Increase the number of individuals who know their HIV status and normalize testing in health care settings.</p>	<p>Funding sources: CDC</p>
<p>Strategy 1: Increase the number of tests done through opt-out HIV testing in health care settings.</p>	
<p>Objective 1: By September 30, 2011, implement an opt-out routine testing model in 100% of OAPP supported healthcare testing sites to normalize HIV testing. Objective 2: By December 2011, at least 45,000 individuals tested at OAPP supported routine HIV testing programs will know their HIV status. Objective 3: By December 2011, identify at least 300 HIV positive individuals at OAPP supported routine HIV testing sites.</p>	<p>Data sources: OAPP HTS data system</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 1: Re-assess provision of non-clinical HIV testing services to better target the epicenters of disease burden.</p>	<p>Funding sources: CDC, CA State, DPH GF, CSAP</p>
<p>Strategy 1: Use syndemic spatial analysis (mapping) to better target HIV testing in non-clinical settings Strategy 2: Streamline data collection procedures to allow for increase in # tests performed</p>	
<p>Objective 1: By September 30, 2011, 85% of targeted HIV testing sites fall within the identified epicenters of disease burden. Objective 2: By September 30, 2011, 85% of targeted testing sites are transitioned to using a scannable non-manual data entry process. Objective 3: By June 2012, expect a 25% (approximately 9,500 tests) increase in number of tests conducted after implementing a scannable, non-manual data entry process (objective 2).</p>	<p>Data sources: OAPP HTS data system</p>

<p>Goal 2: Identify new/innovative targeted testing strategies to identify new infections.</p>	<p>Funding sources: CDC, CA State, DPH GF, CSAP</p>
<p>Strategy 1: Implement social network testing among hard to reach populations, e.g. Latino and African American young men who have sex with men. Strategy 2: Implement rapid HIV testing algorithm at all rapid testing sites.</p>	
<p>Objective 1: By September 30 2011, implement at least 1 additional social network testing programs in Los Angeles County. Objective 2: By September 30 2011, implement RTA at 40% of targeted HIV Counseling and Testing (HCT) sites. Objective 3: By December 2011, implement RTA at 75% of targeted HIV Counseling and Testing (HCT) sites. Objective 4: By December 2011, identify at least 475 new HIV positive testers across all targeted HCT programs.</p>	<p>Data sources: OAPP HTS data system</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 1: Increase condom distribution to target priority populations.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Increase condom distribution to all sites offering HIV, STD, and/or viral hepatitis screenings and Ryan White Medical care. Strategy 2: Work with the Los Angeles Sheriff’s Department (LASD) to make condoms readily available in the K6G unit of the men’s jails for men who self identify as gay or transgender.</p>	
<p>Objective 1: To increase availability of condoms at approximately 40% (30 of 70 agencies) of HCT, HE/RR, and Ryan White medical sites by September 30, 2011. Objective 2: To increase availability of condoms at 75% (53 of 70 total agencies) of HCT, HE/RR, and Ryan White medical sites by December 2011. Objective 3: By December 2011, distribute at least 53,000 condoms to the sites identified in objectives 1 and 2. Objective 4: By December 2011, work with the LASD to change policy on increasing number of condoms distributed to greater than 1/week/inmate (current standard).</p>	<p>Data sources: OAPP-contractor monthly invoices LASD – OAPP meeting notes</p>

<p>Goal 2: To design, market and distribute an “LA Condom” to brand condom use as a part of the Erase Doubt social marketing campaign.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Use \$100,000 in funds in the social marketing budget to design, purchase and distribute condoms within Los Angeles County at clinics, commercial sex venues, bars, clubs and other social gathering sites.</p>	
<p>Objective 1: Complete LA condom design by June 2011. Objective 2: Identify at least 30 community distribution sites by August 2011. Objective 3: Begin condom distribution by September 2011 and distribute at least 40,000 condoms by December 2011.</p>	<p>Data sources: OAPP contractor monthly invoices</p>

1. With whom you plan to partner: **all HE/RR and HCT agencies as listed in workbook 1. New sites to be determined as part of ECHPP process.**
2. If it is a new or existing partnership: **existing (HE/RR and HCT agencies, all STD and Ryan White clinics). New partnerships to be determined as part of ECHPP process.**
3. If you will subcontract with the partner, the amount: **existing amounts and agencies are listed in workbook 1. New partnerships and amounts will be determined as part of ECHPP process.**

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

<p>Goal 1: Implement a nPEP service delivery program within Los Angeles County.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Transition from nPEP pilot program to a public health service delivery model for nPEP that is sustainable and integrated with other HIV prevention interventions. Strategy 2: Develop referral network for nPEP service delivery, including the Los Angeles County sexual assault response team, community clinics serving patient populations with high rates of STDs and risk behavior, local Emergency Departments and Urgent Care Clinics, HIV providers and providers of services to high risk individuals, particularly transgender individuals and youth.</p>	
<p>Objective 1: Complete a manual of procedures for nPEP service delivery by March 2011. Objective 2: Deliver nPEP services to at least 150 individuals by December 2011. Objective 3: Convene at least 1 meeting of the LAC nPEP workgroup by December 2011. Objective 4: Develop provider and client outreach materials by July 2011. Objective 5: Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2011.</p>	<p>Data sources: nPEP data system and monthly reports</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing, new partnerships will be determined through ECHPP process.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

Goal 1: Implement effective syringe access program.	Funding sources: CDC
Strategy 1: Prevent disease and protect public safety through increased access to sterile syringes.	
Objective 1: By December 2011, implement at least 2 syringe access programs in Los Angeles County with the highest need.	Data sources: To be determined

Goal 2: Improve data collection and tracking for HIV testing in medical settings to facilitate measurement of HIV screening rates.	Funding sources: To be determined
Strategy 1: Work with LAC health care centers on accurately and consistently reporting HIV testing data to the Department of Public Health.	
Objective 1: By July 2011, identify and prioritize 3 non-OAPP funded clinics to work with on reporting their HIV testing data to LAC DPH.	Data sources: To be determined

1. With whom you plan to partner: **to be determined through ECHPP process.**
2. If it is a new or existing partnership: **to be determined through ECHPP process.**
3. If you will subcontract with the partner, the amount: **to be determined through ECHPP process.**

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

<p>Goal 1: Improve linkage to care among persons newly diagnosed with HIV.</p>	<p>Funding sources: CDC, NIH</p>
<p>Strategy 1: Implement innovative strategies to improve linkage to care among newly diagnosed individuals e.g. Youth linkage specialist, delivering ARTAS as part of partner services, peer navigation. Strategy 2: Convene a Testing, Linkage to Care+ (TLC+) workgroup among Los Angeles Department of Public Health programs.</p>	
<p>Objective 1: By June 2012, 100% of persons who receive their HIV positive test results at OAPP funded testing agencies will be referred to medical care. Objective 2: By June 2012, 75% of persons who receive their HIV positive test results at OAPP funded testing agencies will attend an initial medical evaluation within 90 days of diagnosis. Objective 3: By September 2011, convene at least 4 TLC+ workgroup meetings. Objective 4: By September 2011, a protocol for integrating ARTAS into HIV partner services program will be completed. Objective 5: By September 2011, ARTAS partner services will be initiated at 6 CDC-funded Expanded Testing Initiative (ETI) testing sites. Objective 6: By January 2011, implement a youth linkage pilot program, where a linkage specialist contacts all youth (up to age 24) diagnosed at OAPP funded testing programs. Objective 7: By December 2011, implement RCT of peer navigation program for all HIV positive inmates released from Los Angeles County jails (NIDA funded study).</p>	<p>Data sources: OAPP Ryan White data system, HIV Surveillance data, OAPP HTS data system</p>

<p>Goal 2: Develop strategies to use existing public health/surveillance data to identify individuals newly diagnosed with HIV not in care.</p>	<p>Funding sources: CDC, DPH GF, CA State</p>
<p>Strategy 1: Match OAPP HIV testing data with surveillance data to evaluate linkage to care rates from OAPP funded testing programs, and identify individuals who have not linked to care. Strategy 2: Incentivize HIV testing providers for successful linkage to care for HIV positive persons.</p>	
<p>Objective 1: By March 2011 establish an MOU with HIV Surveillance Program for matching HIV testing and HIV surveillance data systems. Objective 2: Implement data matching (from objective 1) every 6 months starting in July 2011. Objective 3: Starting August 2011, begin using data from matched data (from objective 1) to identify newly diagnosed HIV positive individuals not in care as part of outreach provided by 1) youth linkage worker; 2) Partner services delivering ARTAS; 3) Outreach workers at Early Intervention Programs in Ryan White system. Objective 4: By September 2011, Implement incentives that reimburse OAPP funded HIV testing providers for linking each HIV positive person tested into care within 3 months (verified by HIV clinic site, or presence of CD4/Viral Load in surveillance system).</p>	<p>Data sources: OAPP HTS data system, HIV surveillance data</p>

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2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 1: Increase rates of retention in care in the Ryan White system of care.</p>	<p>Funding sources: RW, DPH GF</p>
<p>Strategy 1: Implement innovative strategies to improve retention in care among PLWHA diagnosed individuals by implementing an HIV Medical Care Coordination (MCC) model in Los Angeles.</p> <p>Strategy 2: Convene a testing, linkage to care+ (TLC+) workgroup among Department of Public Health programs.</p>	
<p>Objective 1: By February 2012, achieve an 85% retention in care rate among Ryan White medical clients (at least 2 medical visits with a year 3 months apart).</p> <p>Objective 2: By June 2011, finalize MCC model and assessment tools.</p> <p>Objective 3: Pilot MCC model at 2 medical care sites by September 2011.</p> <p>Objective 4: Evaluate MCC model impact on retention rates at 2 medical care sites (Objective 3) by June 2012.</p> <p>Objective 5: By September 2011, develop protocols for 2 pilot projects aimed out re-engagement and retention in care as part of TLC+ workgroup.</p>	<p>Data sources: HIV Surveillance data, Care services monthly report, Meeting agendas</p>

<p>Goal 2: Develop strategies to use existing public health/ surveillance data to identify HIV positive individuals not in care.</p>	<p>Funding sources: CDC, DPH GF, CA State</p>
<p>Strategy 1: Matching OAPP HIV testing data with surveillance data to identify individuals who are out of care/ not retained in care.</p>	
<p>Objective 1: By March 2011, establish an MOU with HIV Surveillance Program for matching Ryan White and HIV surveillance data system to identify those out of care.</p> <p>Objective 2: Conduct data matching (from objective 1) every 6 months starting in July 2011.</p> <p>Objective 3: Starting in August 2011, begin using data identifying HIV positive out of care (from objective 1 &2) to inform delivery of MCC services at Ryan White funded medical clinics by December 2011.</p>	<p>Data sources: OAPP HTS data system, HIV surveillance data</p>

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2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

<p>Goal 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.</p>	<p>Funding sources: RW</p>
<p>Strategy 1: Ensure high quality HIV medical care is available in the Ryan White system of care Strategy 2: Continue to monitor and promote ART for all people living with HIV/AIDS (PLWHA) who meet treatment guidelines</p>	
<p>Objective 1: By December 2011, have HIV ART coverage rate of 90% in Ryan White system. Objective 2: By December 2011, achieve viral load suppression levels of 75% or greater for patients receiving primary HIV care in Ryan White system. Objective 3: By September 2011, monitor 100% of all Ryan White contracts to determine whether ARV use is consistent with treatment guidelines. Objective 4: By September 2011, develop process for ongoing matching between Ryan White data and ADAP data to better define ARV regimens and ARV coverage rates for Ryan White system.</p>	<p>Data sources: Ryan White data system, Care Services monitoring report summary</p>

<p>Goal 2: Minimize HIV transmission through viral load suppression among Ryan White medical care clients.</p>	<p>Funding sources: RW</p>
<p>Strategy 1: Monitor community level viral load among Ryan White clients. Strategy 2: Deploy interventions for individuals with detectable viral load e.g. Prevention with Positives, treatment adherence programs. Strategy 3: Referral to substance use and mental health services through the Los Angeles County Ryan White Medical Care Coordination (MCC) program.</p>	
<p>Objective 1: By September 2011, 90% of Ryan White clients are screened for HIV risk behavior at least twice a year. Objective 2: By September 2011, achieve viral load suppression levels of 75% or greater for patients receiving primary HIV care in Ryan White system. Objective 3: By September 2011, monitor 100% of all Ryan White contracts to determine whether ARV use is consistent with treatment guidelines. Objective 4: By December 2011, increase the number of individuals in HE/RR programs targeting HIV positive individuals by 25%. Objective 5: By December 2011, establish a goal for referral to substance use and mental health services based on MCC acuity assessment tool.</p>	<p>Data sources: Ryan White data system</p>

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2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

Required Intervention #9: “Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons”

<p>Goal 1: Increase ARV treatment adherence among clients in Ryan White system of care.</p>	<p>Funding sources: RW</p>
<p>Strategy 1: Measure ARV treatment adherence rates for Ryan White patients. Strategy 2: Implement evidence-based interventions to optimize ART adherence for Ryan White patients.</p>	
<p>Objective 1: By January 2011, establish baseline ARV treatment adherence rates for Ryan White clients. Objective 2: By September 30 2011, conduct systematic review of literature to identify candidate evidence-based ART adherence interventions that could be implemented/ adapted for Los Angeles County. Objective 3: By September 30 2011, identify resources for ARV treatment adherence interventions. Objective 4: Identify target populations, provider sites, communities, that demonstrate greatest need by December 2011. Objective 5: Develop an evaluation plan for examining impact of ARV treatment adherence interventions by March 2012. Objective 6: Implement targeted treatment adherence interventions commensurate with available resources by March 2012.</p>	<p>Data sources: OAPP reports and meeting notes, Ryan White data system</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

Required Intervention #10: “Implement STD screening according to current guidelines for HIV-positive persons”

<p>Goal 1: Routinely screen all Ryan White clients for STDs and viral hepatitis.</p>	<p>Funding sources: RW, CDC</p>
<p>Strategy 1: Establish Standards for all Ryan White providers regarding STD/hepatitis screening. Strategy 2: Develop protocol for regular matching / data sharing with STD program surveillance and treatment monitoring data to identify opportunities to improve STD treatment rates and partner services delivery to HIV-positive individuals in Ryan White system of care</p>	
<p>Objective 1: By January 2011, establish performance measures (based on guidelines) for STD and hepatitis screening for all HIV positive patients in Ryan White system of care. Objective 2: By September 30 2011, monitor 100% of contracts using STD/viral hepatitis screening and performance measures. Objective 3: By September 30 2011, 90% of all Ryan White clients screened for STDs/hepatitis C at least annually. Objective 4: By December 2011, establish matching protocol with STD program Partner Services data base and Ryan White data base to identify rates of HIV/STD co-morbidity and STD treatment rates among Ryan White patients. Objective 5: By December 2011, 90% of Ryan White clients with an STD were referred to partner services.</p>	<p>Data sources: Monitoring summaries</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 1: Prevent perinatal transmission in HIV positive pregnant women in Los Angeles County.</p>	<p>Funding sources: CDC, RW, DPH GF</p>
<p>Strategy 1: Increase HIV screening among pregnant women in Los Angeles County. Strategy 2: Ensure pregnant HIV-positive women in the Ryan White system of care are receiving appropriate HIV perinatal medical care and ART.</p>	
<p>Objective 1: By December 2011, work with the CA state OA and Perinatal HIV collaborative to build capacity in Los Angeles County labor and delivery units to expand HIV screening protocols among pregnant women to include a rapid HIV test at the time of delivery. Objective 2: By September 30 2011, incorporate perinatal standards of HIV care into the Los Angeles County Commission on HIV Ryan White standards of care. Objective 3: By December 2011, increase Ryan White provider awareness of perinatal HIV specialty clinics and LA County Standards of Care for pregnant women to receive perinatal HIV specialty care. Objective 4: By September 30, 2011, 100% of HIV positive pregnant women in Ryan White system of care received a referral to perinatal HIV specialty clinics. Objective 5: By September 30, 2011, 100% of HIV-positive pregnant women in RW system of care have undetectable HIV viral load (<200 copies).</p>	<p>Data sources: Meeting notes, Standards of Care report</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 1: To increase HIV case finding through partner services.</p>	<p>Funding sources: CDC</p>
<p>Strategy 1: Utilize HIV surveillance data for increasing delivery of partner services. Strategy 2: To increase the number of newly diagnosed HIV positive clients who are offered partner services.</p>	
<p>Objective 1: By December 2011, implement ongoing reporting of all new HIV positive cases in Los Angeles County HIV surveillance system to the HIV/STD partner services program. Objective 2: By September 30, 2011, 85% of eligible index patients will be interviewed for Partner Services. Objective 3: By September 30, 2011, 50% of newly diagnosed HIV positive clients will accept Partner Services. Objective 4: By September 30, 2011, 50% of notified partners, not previously HIV-positive, will receive an HIV test. Objective 5: By December 2011, 95% of all HIV positive test results will be disclosed for those tested in the Partner Services program.</p>	<p>Data sources: STD Program data and reports, HIV surveillance data</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

<p>Goal 1: Reduce risk behavior among HIV positive persons (including HIV-discordant couples).</p>	<p>Funding sources: CDC</p>
<p>Strategy 1: Deliver Evidence Based Interventions (EBIs) to reduce risk behavior among HIV-positive persons. Strategy 2: Improve the data collection system to assess process and outcome measures for Health Education/Risk Reduction (HE/RR) programs.</p>	
<p>Objective 1: Target 25% of HE/RR interventions toward HIV positive individuals by December 2011. Objective 2: By December 2011, 90% of Ryan White clients receive a risk behavior screening in clinical settings every 6 months. Objective 3: By December 2011, begin tracking/monitoring referrals of Ryan White clients with high risk behavior screening to HE/RR interventions targeting HIV positive persons. Objective 4: Train 100% of all OAPP funded HE/RR sites on using standardized HE/RR data collection forms by June 2011. Objective 5: By June 2011 establish HE/RR performance measures to be reported by all OAPP funded HE/RR programs.</p>	<p>Data sources: OAPP HE/RR data system, Ryan White data system</p>

<p>Goal 2: Improve access to mental health and substance use services for HIV positive individuals in Ryan White system of care.</p>	<p>Funding sources: RW</p>
<p>Strategy 1: Provide comprehensive screening, referrals, and linkage to mental health and substance use services.</p>	
<p>Objective 1: By September 30, 2011, 95% of all Ryan White clients should be screened for need of mental health and/or substance use services. Objective 2: By September 30, 2011, 90% of Ryan White clients screened received a referral. Objective 3: By September 30, 2011, 80% of Ryan White clients with a referral received a mental health and/or substance use service intake to initiate services.</p>	<p>Data sources: Ryan White data system and chart review (through monitoring)</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 1: Improve treatment engagement and health status of persons with HIV.</p>	<p>Funding sources: RW, CDC, NIH</p>
<p>Strategy 1: Implement medical care coordination (MCC) to improve linkage to medical care and social services among HIV-positive individuals. Strategy 2: Convene a Testing, linkage to care+ (TLC+) workgroup among DPH programs</p>	
<p>Objective 1: By June 30, 2011, finalize MCC model and assessment tools. Objective 2: Pilot MCC model at 2 medical care sites by September 30, 2011. Objective 3: Evaluate MCC model impact on retention rates at 2 medical care sites (Objective 3) by June 2012. Objective 4: By December 2011, convene at least 4 TLC+ workgroup meetings to identify additional strategies and pilot programs that could be implemented to improve retention in care and referral to needed social services in the Ryan White system of care.</p>	<p>Data sources: OAPP Ryan White data system, HIV Surveillance data, OAPP HIV testing data system</p>

<p>Goal 2: Develop strategies for identifying HIV positive individuals not in care.</p>	<p>Funding sources: RW, CDC, DPH GF, CA State</p>
<p>Strategy 1: Matching OAPP HIV testing data with surveillance data to evaluate linkage to care rates from OAPP funded testing programs, and identify individuals who have not linked to care</p>	
<p>Objective 1: By March 2011, establish an MOU with HIV Epidemiology, Surveillance Program for matching HIV testing and HIV surveillance data systems. Objective 2: Conduct data matching every 6 months starting in July 2011.</p>	<p>Data sources: OAPP HIV testing data system, HIV surveillance data, MOU</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

SEE RESPONSES FOR INTERVENTION #3 AND RATIONALE IN WORKBOOK 1, LAC WILL FOCUS CONDOM DISTRIBUTION ONLY ON HIGH RISK INDIVIDUALS

<p>Goal 1: Increase condom distribution to all sites offering HIV, STD, and/or viral hepatitis screenings.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Increase condom distribution to all sites offering HIV, STD, and/or viral hepatitis screenings.</p>	
<p>Objective 1: To increase availability of condoms at approximately 40% (30 of 70 agencies) of HCT, HE/RR, and Ryan White medical sites by September 30, 2011. Objective 2: To increase availability of condoms at 75% (53 of 70 total agencies) of HCT, HE/RR, and Ryan White medical sites by December 2011. Objective 3: By December 2011, distribute at least 53,000 condoms to the sites identified in objectives 1 and 2.</p>	<p>Data sources: OAPP-contractor monthly invoices</p>

<p>Goal 2: To design, market and distribute an “LA Condom” to brand condom use as a part of the Erase Doubt social marketing campaign.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Use \$100,000 in funds in the social marketing budget to design, purchase and distribute condoms within Los Angeles County at clinics, commercial sex venues, bars, clubs and other social gathering sites.</p>	
<p>Objective 1: Complete LA condom design by June 2011. Objective 2: Identify at least 30 community distribution sites by August 2011. Objective 3: Begin condom distribution by September 2011 and distribute at least 40,000 condoms by December 2011.</p>	<p>Data sources: OAPP contractor monthly invoices</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing (HE/RR and HCT agencies, all STD and Ryan White clinics). New partnerships to be determined as part of ECHPP process.**
3. If you will subcontract with the partner, the amount: **existing amounts and agencies are listed in workbook 1. New partnerships and amounts will be determined as part of ECHPP process.**

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

<p>Goal 1: To increase the visibility of the Los Angeles County Erase Doubt campaign.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: To increase the types of media being purchased in LAC (outdoor billboards, radio adverts, etc) Strategy 2: Launch viral marketing campaign (Facebook, Youtube, Twitter)</p>	
<p>Objective 1: Increase media purchase by 100% by September 30, 2011. Objective 2: Increase hits on Erase Doubt website by 50% by September 30, 2011. Objective 3: Increase visibility of Erase Doubt messaging through targeted media placement throughout geographic “hot spots” by September 30, 2011.</p>	<p>Data sources: Monthly report, Program summary</p>

<p>Goal 2: To increase awareness of free testing and treatment services available throughout Los Angeles County.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: To increase the types of media being purchased in Los Angeles County (outdoor billboards, radio adverts, etc). Strategy 2: Sponsor testing events and participate in health fairs throughout Los Angeles County.</p>	
<p>Objective 1: Increase media purchase by 100% by September 30, 2011. Objective 2: Sponsor at least 2 community HIV testing events by September 30, 2011. Objective 3: Participate in at least 2 Los Angeles County health fairs by September 30, 2011.</p>	<p>Data sources:</p>

1. With whom you plan to partner: **existing social marketing agency listed in workbook 1.**
2. If it is a new or existing partnership: **existing partnerships. New partnerships will be determined as part of ECHPP process.**
3. If you will subcontract with the partner, the amount: **existing partnership and amounts. New partnerships and amounts will be determined as part of ECHPP process.**

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”

<p>Goal 1: Assess the use of Evidence Based Interventions (EBIs) in clinical settings.</p>	<p>Funding sources: RW</p>
<p>Strategy 1: Provide health care providers training and technical assistance in improving prevention messaging to HIV-positive patients and patients at highest risk of acquiring HIV. Strategy 2: Integrate HE/RR messages among clinicians to HIV-positive and patients at highest risk of acquiring HIV.</p>	
<p>Objective 1: Review contract deliverables and monthly reports to identify EBIs in practice by June 2011. Objective 2: Improve prevention session documentation in the Ryan White care data system September 30, 2011. Objective 3: Begin monitoring delivery of EBIs in clinical setting in RW system of care by December 2011.</p>	<p>Data sources: OAPP reports, monitoring summary</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

Recommended Intervention #18: "Community interventions that reduce HIV risk"

SEE GOALS AND OBJECTIVES FOR INTERVENTION #16

<p>Goal 1: To increase the visibility of the Los Angeles County Erase Doubt campaign.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: To increase the types of media being purchased in Los Angeles County (outdoor billboards, radio adverts, etc). Strategy 2: Launch viral marketing campaign (Facebook, Youtube, Twitter).</p>	
<p>Objective 1: Increase media purchase by 100% by September 30, 2011. Objective 2: Increase hits on Erase Doubt website by 50% by September 30, 2011. Objective 3: Increase visibility of Erase Doubt messaging through targeted media placement throughout geographic "hot spots" by September 30, 2011.</p>	<p>Data sources: OAPP contractor monthly reports</p>

<p>Goal 2: To increase awareness of free testing and treatment services available throughout Los Angeles County.</p>	<p>Funding sources: CDC,DPH GF</p>
<p>Strategy 1: To increase the types of media being purchased in LAC (outdoor billboards, radio adverts, etc) Strategy 2: Sponsor testing events and participate in health fairs throughout LAC</p>	
<p>Objective 1: Increase media purchase by 100% by September 30, 2011. Objective 2: Sponsor at least 2 community HIV testing events by September 30, 2011. Objective 3: Participate in at least 2 Los Angeles County health fairs by September 30, 2011.</p>	<p>Data sources: OAPP contractor monthly reports</p>

1. With whom you plan to partner: **existing social marketing agency listed in workbook 1.**
2. If it is a new or existing partnership: **existing partnerships. New partnerships will be determined as part of ECHPP process.**
3. If you will subcontract with the partner, the amount: **existing partnership and amounts. New partnerships and amounts will be determined as part of ECHPP process.**

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”

Goal 1: Identify high risk HIV-negative persons (including those for HIV-discordant couples) at risk of acquiring HIV.	Funding sources: CDC
Strategy 1: increase partner services among HIV positive individuals. Strategy 2: Improve the data collection system to assess process and outcome measures for HERR programs.	
Objective 1: Implement 1.5 FTE ARTAS partner service Public Health Investigators in high disease burden areas within Los Angeles County by September 30, 2011. Objective 2: Increase the number of embedded PHIs at clinics with high rates of STDs by 50% by September 30, 2011. Objective 3: Train 100% of all OAPP funded HE/RR sites on using standardized HE/RR data collection forms by June 2011.	Data sources: STD Program reports , OAPP training agendas

Goal 2: Increase the availability of EBIs for high risk HIV-negative persons (including those for HIV-discordant couples) at risk of transmitting HIV.	Funding sources: CDC
Strategy 1: Increase availability of biomedical interventions (PEP, PrEP, CM-PEP). Strategy 2: Develop provider education and client outreach materials. Strategy 3: Inventory effectiveness of current EBIs in place in Los Angeles County.	
Objective 1: Implement 2 biomedical intervention contracted program sites by September 30, 2011. Objective 2: Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2011. Objective 3: Conduct 2 community forums with presentations to discuss PrEP by June 30, 2011. Objective 4: Identify training and TA for sites implementing EBIs by September 30, 2011.	Data sources: OAPP reports

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing. New partnerships to be determined through ECHPP process.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

<p>Goal 1: Increase integrated HIV, STD, and viral hepatitis screening sites in Los Angeles County.</p>	<p>Funding sources: CDC</p>
<p>Strategy 1: Increase the number of targeted HIV testing venues that provided integrated screening e.g. commercial sex venues and jails. Strategy 2: Increase Program Collaboration Service Integration (PCSI) opportunities within Los Angeles County Department of Public Health (DPH).</p>	
<p>Objective 1: Convene quarterly DPH PCSI workgroup meetings by February 2011. Objective 2: Identify an OAPP jails programs coordinator by January 2011. Objective 3: Redefine the scope of work for the commercial sex venue testing initiative by December 2011. Objective 4: Purchase 2 additional multiple morbidity testing units by December 2011.</p>	<p>Data sources: Meeting agendas, OAPP reports</p>

<p>Goal 2: Increase provider capacity to provide integrated prevention messages and services.</p>	<p>Funding sources: RW, CDC</p>
<p>Strategy 1: Provide clinician and health care worker training to include prevention messages about HIV, STDs, and viral hepatitis. Strategy 2: Provide viral hepatitis A and B vaccines to prioritized high risk populations.</p>	
<p>Objective 1: Partner with AIDS Education Training Centers (AETC) to provide at least 2 clinician trainings with continuing education credits by December 2011. Objective 2: Implement Hepatitis A and B vaccination protocols in multiple morbidity mobile testing units, and nPEP programs by December 2011. Objective 3: By June 2011, go live with DPH viral hepatitis website that includes information on viral hepatitis, screening diagnostic, and treatment referral information, as well as vaccination information for providers. Objective 4: By June 2011, post updated list of local free hepatitis A and B vaccination sites, as well as STD and TB treatment sites at online resource: www.hivla.org website.</p>	<p>Data sources: OAPP meeting summaries, contractor monthly reports</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing. New partnerships to be determined through ECHPP process.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

<p>Goal 1: Use HIV and STD surveillance data to prioritize risk reduction counseling and partner services, and to evaluate linkage to care.</p>	<p>Funding sources: DPH GF, CDC</p>
<p>Strategy 1: Use Ryan White, HIV surveillance, and STD surveillance data to identify HIV positive individuals with STDs and their sexual network partners. Strategy 2: Use matched data to prioritize linkage to care for known HIV positive individuals using ARTAS partner services.</p>	
<p>Objective 1: By March 2011 establish an MOU with HIV Surveillance Program for matching Ryan White, STD, and HIV surveillance data systems. Objective 2: Conduct data matching every 6 months starting in July 2011. Objective 3: Develop and implement ARTAS partner services protocol for those newly diagnosed with HIV by September 30, 2011.</p>	<p>Data sources: HIV surveillance data, STD Program data, Ryan White system of care data</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

<p>Goal 1: Decrease social factors impacting HIV risk among HIV negative persons at highest risk of acquiring HIV.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Support HIV testing and HE/RR services at substance use programs, jails and social service community based organizations (e.g. intimate partner violence shelters, homeless shelters).</p> <p>Strategy 2: Increase awareness of biomedical and bio-behavioral programs (e.g. nPEP, CM-PEP, PrEP).</p>	
<p>Objective 1: By January 2011, Support at least 20 social service agencies to provide HE/RR and other social services to high risk negative individuals.</p> <p>Objective 2: By September 30, 2011, provide at least 2500 HIV tests at substance abuse clinics.</p> <p>Objective 3: Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2011.</p>	<p>Data sources: OAPP reports, HTS data system</p>

<p>Goal 2: Provide substance use treatment to HIV negative men who have sex with men and transgender individuals who also use crystal meth.</p>	<p>Funding sources: CDC, DPH GF</p>
<p>Strategy 1: Increase outreach activities to recruit and enroll individuals into substance use treatment services.</p> <p>Strategy 2: Increase awareness of biomedical and bio-behavioral programs.</p>	
<p>Objective 1: By September 30, 2011, enroll 60 HIV negative crystal meth using MSM and transgender individuals into substance use treatment services.</p> <p>Objective 2: Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2011.</p>	<p>Data sources: Care data system, OAPP reports</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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

<p>Goal 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.</p>	<p>Funding sources: RW, CDC, CA State</p>
<p>Strategy 1: Program new assessment tool into Ryan White data system. Strategy 2: Train Public Health Investigators to implement alcohol and drug screening as part of the Los Angeles County partner services protocol. Strategy 3: Assess all individuals testing at HIV counseling and testing sites for alcohol use.</p>	
<p>Objective 1: By September 30, 2011, train 100% of Ryan White agencies implementing Medical Care Coordination (MCC) on the use of an acuity assessment tool that includes alcohol screening. Objective 2: By December 2011, 85% of Public Health Investigators delivering HIV and STD partner services will be trained on how to conduct an alcohol and drug screening.</p>	<p>Data sources: OAPP reports, training agendas, HTS data system</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

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”

<p>Goal 1: Engage community planning groups to address community mobilization.</p>	<p>Funding sources: RW, CDC, DPH GF</p>
<p>Strategy 1: Continue working with the Prevention Planning Committee (PPC), the Commission on HIV (COH), and Act Now Against Meth Coalition. Strategy 2: Implement Phase II of OAPP’s Social Marketing campaign.</p>	
<p>Objective 1: By September 30, 2011, convene at least 24 community planning meetings. Objective 2: Increase media purchase by 100% by September 30, 2011. Objective 3: Increase hits on Erase Doubt website by 50% by September 30, 2011. Objective 4: Increase visibility of Erase Doubt messaging through targeted media placement throughout geographic “hot spots” by September 30, 2011.</p>	<p>Data sources: Meeting agendas, Contractor monthly reports</p>

<p>Goal 2: Increase HIV awareness via faith-based communities, social networks, and popular opinion leaders.</p>	<p>Funding sources: CDC</p>
<p>Strategy 1: Continue to fund Faith-based HIV prevention activities. Strategy 2: Implement additional social network testing programs in Los Angeles County.</p>	
<p>Objective 1: By September 30, 2011, support at least 1 HIV prevention and faith-based HE/RR program. Objective 2: By September 30, 2011, support at least 4 Popular Opinion Leader interventions targeting gay men. Objective 3: By September 30, 2011, support at least 2 social network testing programs for high risk negative and HIV positive individuals among African American, Latino, MSM, and crystal meth users.</p>	<p>Data sources: Contractor monthly reports</p>

1. With whom you plan to partner: **agencies listed in workbook 1.**
2. If it is a new or existing partnership: **existing. New partnerships to be determined through ECHPP process.**
3. If you will subcontract with the partner, the amount: **amounts and agencies listed in workbook 1.**

National Strategic Goals Tool

This tool is designed to document how the elements of the Enhanced Plan work together to achieve goals set forth in the National HIV/AIDS Strategy (NHAS). It is acknowledged that each jurisdiction is in a different position regarding their capacity to reach these goals. Nevertheless, a critical step toward ensuring that maximum effort is given to achieving these national goals is to make them a key component in the planning process.

Specific 2015 targets* have been set to help reach the three broad NHAS goals. In the space provided below, please describe how the Enhanced Plan is designed to make the most progress toward achieving each target (grouped by higher level NHAS/DHAP goals). Describe the key activities from the Enhanced Plan that will serve as the principle means for reaching the 2015 target and address how other activities included in the plan work in combination to achieve this target. Specifically, descriptions for each 2015 target should address how the combination of interventions and public health strategies used in the Enhanced Plan achieve the following:

1. Utilizes an optimal combination of cost-effective and efficacious public health approaches at the right scale
2. Work together to maximize their intended impact
3. Addresses the need within your jurisdiction based on all available information (i.e., local epidemiology, situational and gap analyses, etc.)
4. Takes advantage of opportunities for optimal resource leveraging and coordination across funding streams

*These targets are based on the National HIV AIDS Strategy and the proposed DHAP strategic plan for 2015, which will be finalized soon.

Reducing New HIV Infections

1. Reduce the annual number of new HIV infections by 25% and reduce the HIV transmission rate by 30%

There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new HIV 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%); therefore, IDU (6.2% 2010 data) is not a driver of new infections. Given its geographic vastness (over 4,000 square miles), LAC can only support combinations of interventions that best target populations with the highest disease burden. As such, OAPP is in the beginning stages of HIV prevention portfolio modeling exercises (see Appendix A) that will help inform the scope and direction of LAC's prevention portfolio needed to address the NHAS goals and objectives.

OAPP identifies the interventions below as being key to meeting these objectives; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

Strategies to reduce the annual number of new infections by 25%:

- Routine opt-out HIV screening in HIV clinical settings
- HIV testing in non-clinical settings
- STD screening

- Biomedical/bio-behavioral interventions (nPEP, PrEP, CM-PEP)
- Health Education/ Risk Reduction
- Social marketing
- Condom distribution
- Partner services

Strategies to reduce HIV transmission rate by 30%:

- Implement interventions to improve linkage and retention in care for individuals testing HIV positive (TLC+)
- Increase ART treatment coverage in Ryan White care system
- ART adherence interventions
- Health Education Risk Reduction targeting HIV positive persons
- Partner services delivering ARTAS to newly diagnosed HIV positive persons
- Social marketing
- Condom distribution

2. Increase the percentage of people living with HIV who know their serostatus to 90%

LAC is home to an estimated 62,800 people living with HIV/AIDS, of whom an estimated 13,500 are unaware of their status. Given its geographic vastness (over 4,000 square miles and 88 times larger than San Francisco), LAC can only support combinations of interventions that best target populations with the highest disease burden. As such, OAPP's HIV prevention portfolio modeling exercises (currently in varying stages of completion – see Appendix A) will help inform the scope and direction of LAC's prevention portfolio needed to address the NHAS goals and objectives.

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Routine opt-out HIV screening in HIV clinical settings
- HIV testing in non-clinical settings
- STD screening
- Social marketing
- Partner services

3. Increase the percentage of people newly diagnosed with HIV infection who have a CD4 count of 200 cells/ μ l or higher by 25%

There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new HIV 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.

LAC has an estimated 12,000-15,000 undiagnosed individuals living with HIV/AIDS. Routine opt out screening is one of several HIV case finding modalities that will be scaled up to ensure that LAC has a 10% undiagnosed HIV infection level consistent with the goals of the NHAS,

and that detection at earlier disease stage is achieved. OAPP is in the final stages of its HIV testing modeling exercise to determine the level of routine testing scale up needed to meet this goal (see Appendix A). Given the geographic vastness (over 4,000 square miles and 88 times larger than San Francisco), LAC can only target routine opt-out screening in clinical settings located in zip codes with the highest HIV burden. Zip codes will be determined based on the cluster analysis that is currently in progress (see Appendix A). Routine opt-out screening will assist us with reaching 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 testing will also identify HIV positive individuals at an earlier disease stage consistent with this NHAS goal.

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Expand routine testing programs to Emergency Departments and Urgent Care clinics, in addition to continuing to improve capacity for routine testing in community clinics in high burden communities
- Implement interventions to improve linkage and retention in care for individuals testing HIV positive (TLC+)
- Continue to prioritize partner services to all new HIV positive persons and HIV positive with new STDs

4. Reduce the proportion of MSM who reported unprotected anal intercourse during their last sexual encounter with a partner of discordant or unknown HIV status by 25%

Behavioral risk screening followed by behavioral risk reduction interventions for HIV-positive persons alone will not meaningfully reduce the transmission of HIV in Los Angeles County. Given the limited effectiveness of the behavioral interventions 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 transmitting HIV. Behavioral risk screening and interventions must be combined with engagement, retention in care, and adherence to treatment among HIV+ MSM in order to leverage effective tools in preventing forward transmission of HIV and impact overall HIV community viral load. However, the combination of interventions that will address this NHAS objective is dependent on the modeling activities that are currently in process (Appendix A).

Listed below are some interventions that will be key in addressing this objective. Any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Health Education/ Risk Reduction
- Social marketing
- Condom distribution
- Behavioral risk screening in Ryan White patients with referral to behavioral interventions

5. Reduce the proportion of IDU at risk for transmission/acquisition of HIV by XX% [Indicator TBD pending DHAP strategic plan]

There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new HIV infections in LAC each year. Most new HIV infections are attributed to sexual contact (94%); therefore, IDU (6.2% 2010 data) is not a driver of new infections. However, several structural barriers to optimal prevention remain related to accessing syringes and providing sterile syringes, sterile injection equipment, and education to people who inject drugs, steroids, and hormones in order to prevent acquiring or transmitting HIV and other co-morbidities (e.g. hepatitis C).

OAPP is in the beginning stages of HIV prevention portfolio modeling exercise (see Appendix A) that will help inform the scope and direction of LAC's prevention portfolio needed to address this objective. OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Needle exchange programs (see intervention #5)
- Integrated HIV, STD, and Hepatitis screening at drug treatment sites
- Social network testing targeting IDU populations
- Health Education/ Risk Reduction
- Social marketing
- Condom distribution
- Improve linkage to and retention in care for HIV positive individuals
- ART adherence interventions

6. Decrease the number of perinatally acquired pediatric HIV cases by 25%

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 (see intervention #11 in workbook 1 for more detail):

- Expand routine rapid HIV testing at time of delivery
- Refer and link HIV positive pregnant women to perinatal HIV specialty care clinics/services
- Increasing Access to Care and Improving Health Outcomes for People Living with HIV

7. Reduce AIDS diagnoses by 25%

There are an estimated 36,000 PLWHA diagnosed and in care in LAC; 15,000 of those are in the Ryan White (RW) system of care. The ART coverage rate in the RW system of care in 2009 (see situational analysis in Workbook 1) 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.

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 or not optimizing care. Given its geographic vastness (over 4,000 square miles), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to linkage to care locally. OAPP is in the beginning stages (see Appendix A) of its HIV prevention portfolio modeling exercise that will help inform the scope and direction of activities needed to help meet this NHAS goal.

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Implement linkage and retention in care interventions for individuals testing HIV positive (TLC+)
- Implement ART adherence interventions
- Increase access to medical care and supportive services
- Implement medical care coordination at Ryan White clinic sites to improve linkage and retention in medical care as well as other services (substance use, mental health, housing, transportation, food)
- Implement partner services with ARTAS for newly diagnosed HIV positive individuals to link to care

8. Increase the percentage of persons diagnosed with HIV who are linked to clinical care as evidenced by having a CD4 count or viral load measure within 3 months of HIV diagnosis to 85%

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 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:

- **Aligning HIV testing provider incentives to optimize linkage to care;**
- **Adopting new HIV testing algorithms that will result in expediting linkage to care activities;**
- **Expanding partner services (including ARTAS and community embedded DIS);**
- **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 geographic vastness (over 4,000 square miles and 88 times larger than San Francisco), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to linkage to care locally. OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that will help inform the scope and direction of linkage to care activities needed to help meet local HIV linkage to care goals consistent with the NHAS (see Appendix A).

9. Increase by 10% the percentage of HIV-diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable

There are an estimated 36,000 PLWHA diagnosed and in care in LAC; an estimated 15,000 of those persons are in the Ryan White (RW) system of care. The ART coverage rate in RW system of care in 2009 (see intervention #9 workbook 1) 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 including development of quality measures and pay-for-performance strategies to maximize ART coverage and viral load suppression.

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. OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that includes viral load suppression as a key outcome of the model and can help inform the relative impact of scaling up ART coverage rates, linkage and retention activities consistent with the NHAS goals (see Appendix A).

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Implement targeted linkage and retention in care interventions for PLWHA
- Implement medical care coordination model
- Continue to offer supportive services for HIV+ in RW system of care (substance use, mental health, housing, transportation, food)
- ART adherence interventions
- Improve ART coverage rates in RW system of care
- Continue to utilize Ryan White and surveillance data to capture viral load

10. Reduce the percentage of HIV-diagnosed persons in care who report unprotected anal or vaginal intercourse during the last 12 months with partners of discordant or unknown HIV status by 33%

Behavioral risk screening followed by behavioral risk reduction interventions for HIV-positive persons alone will not meaningfully reduce the transmission of HIV in LAC. Given the limited demonstrated effectiveness of the behavioral interventions, 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 transmitting HIV. Behavioral risk screening and interventions must be combined with engagement, retention in care, and adherence to treatment to leverage effective tools in preventing forward transmission of HIV and impact overall HIV community viral load.

Given its geographic vastness (over 4,000 square miles and), 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 STDs.

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 the NHAS goals (see Appendix A).

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Health Education/ Risk Reduction (provider-level and client level) for HIV positive individuals
- Partner services for HIV positive individuals
- Condom distribution
- Social marketing

11. By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least two visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80%

There are an estimated 62,800 PLWHA in LAC, with an estimated 13,500 who know their HIV status and are not consistently in care as defined by the NHAS goals. Among Ryan White clients, 82% are retained in care (see workbook 1). 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.

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 its geographic vastness (over 4,000 square miles), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to retention in care locally. OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that 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).

OAPP identifies the interventions below as being key to continuing to exceed this objective. However, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Implement targeted linkage and retention in care interventions for PLWHA
- Implement medical care coordination model
- Continue to offer supportive services for PLWHA in Ryan White system of care (substance use, mental health, housing, transportation, food)

12. By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86%

OAPP will continue to collaborate with the Los Angeles City Housing Department (LAC HOPWA administrator) to streamline services, referrals and linkages to housing services for clients with HIV.

Reducing HIV-Related Disparities

13. Increase the percentage of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%

There are an estimated 62,800 PLWHA in LAC, with an estimated 13,500 who know their HIV status and are not consistently in care as defined by the NHAS goals. Among Ryan White clients, 82% are retained in care (see workbook 1). 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.

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 its geographic vastness (over 4,000 square miles), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to retention in care locally. OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that 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).

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Increase access to medical care and supportive services (substance use, mental health, housing, transportation, food)
- Implement medical care coordination model
- Implement linkage and retention in care interventions for individuals testing HIV positive (TLC+)
- Improve provider knowledge about treatment guidelines and individual and public health benefits of HIV treatment, particularly those serving gay and bisexual men
- Improve ART coverage rates in clinics serving gay and bisexual men
- Targeted ART adherence interventions

14. Increase the percentage of HIV-diagnosed Blacks with undetectable viral load by 20%

There are an estimated 62,800 PLWHA in LAC, with an estimated 13,500 who know their HIV status and are not consistently in care as defined by the NHAS goals. Among Ryan White clients, 82% are retained in care (see workbook 1). 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.

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 its geographic vastness (over 4,000 square miles), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to retention in care locally. OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that 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).

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Increase access to medical care and supportive services (substance use, mental health, housing, transportation, nutrition support)
- Implement medical care coordination model
- Implement linkage and retention in care interventions for individuals testing HIV positive (TLC+) targeting African Americans
- Improve provider knowledge about treatment guidelines and individual and public health benefits of HIV treatment, particularly those serving African Americans
- Ensure access to HIV medical care and services that is culturally relevant and geographically convenient for African American communities in Los Angeles County
- Improve ART coverage rates in clinics serving African American communities
- Targeted ART adherence interventions

15. Increase the percentage of HIV-diagnosed Latinos with undetectable viral load by 20%

There are an estimated 62,800 PLWHA in LAC, with an estimated 13,500 who know their HIV status and are not consistently in care as defined by the NHAS goals. Among Ryan White clients, 82% are retained in care (see workbook 1). 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.

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 its geographic vastness (over 4,000 square miles), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to retention in care locally. OAPP is in the beginning stages of its HIV prevention portfolio modeling exercise that 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).

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Increase access to medical care and supportive services (substance use, mental health, housing, transportation, nutrition support)
- Implement medical care coordination model
- Implement linkage and retention in care interventions for individuals testing HIV positive (TLC+) targeting Latino/as
- Improve provider knowledge about treatment guidelines and individual and public health benefits of HIV treatment, particularly those serving Latino/as
- Ensure access to HIV medical care and services that is culturally relevant and geographically convenient for Latino communities in Los Angeles County
- Improve ART coverage rates in clinics serving Latino communities
- Targeted ART adherence interventions

16. Reduce the disparity in HIV incidence for Blacks versus Whites (Black: White ratio of new infections) by 25%; by 2015, reduce the disparity in HIV incidence for Hispanics versus Whites (Hispanic: White ratio of new infections) by 25%

There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new HIV infections in LAC each year and over 55,000 STDs reported in 2009 (74% Chlamydia, 14 % gonorrhea, 5% syphilis). African-Americans have a disproportionate disease burden in LAC. OAPP is in the beginning stages of HIV prevention portfolio modeling exercise (see Appendix A) that will help inform the scope and direction of LACs prevention portfolio needed to address this objective.

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Social marketing
- Community mobilization
- Condom distribution
- Health Education/ Risk Reduction
- Biomedical/bio-behavioral interventions (nPEP, PrEP, CM-PEP)
- Improve ART coverage rates for African American HIV positive patients
- ART adherence interventions for African American HIV positive patients
- Increase % with suppressed VL for African American HIV positive patients

17. Reduce the disparity in HIV incidence for MSM versus other adults in the United States by 25%

There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new HIV 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%); mainly male to male sexual contact. Men who have sex with men in LAC have a high disease burden. LAC can only support combinations of interventions that best target populations with the highest disease burden. As such, OAPP is in the beginning stages of HIV prevention portfolio modeling exercise (see Appendix A) that will help inform the scope and direction of LAC's prevention portfolio needed to address this objective.

OAPP identifies the interventions below as being key to meeting this objective; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- Social marketing
- Community mobilization
- Condom distribution
- Health Education/Risk Reduction
- Biomedical/bio-behavioral interventions (nPEP, PrEP, CM-PEP)
- Improve ART coverage rates for MSM HIV positive patients
- ART adherence interventions for MSM HIV positive patients
- Increase percentage with suppressed viral load for MSM HIV positive patients

18. Ensure the percentage of persons diagnosed with HIV who have a CD4 count within 3 months of HIV diagnosis is 75% or greater for all racial/ethnic groups

There are an estimated 62,800 PLWHA in LAC, with 2,000-3,000 new HIV infections in LAC each year; over 800 new diagnoses are identified through OAPP-funded testing programs and an additional 1,200 new diagnoses are 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.

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 its geographic vastness (over 4,000 square miles), LAC needs a variety of activities and programming that consider geographic and socio-economic challenges to linkage to care locally. OAPP is in the beginning stages (see Appendix A) of its HIV prevention portfolio modeling exercise that will help inform the scope and direction of activities needed to help meet this NHAS goal.

OAPP identifies the interventions below as being key to meeting this goal; however, any re-programming of current resources and scale of interventions will be based on our modeling activities described in Appendix A. The rationales for each intervention are described in detail in workbook 1.

- HIV surveillance data to prioritize linking to care PLWHA out of care
- Implement linkage and retention in care interventions for individuals testing HIV positive (TLC+)
- Partner services with ARTAS
- Social marketing