

Centers for Disease Control and Prevention

Application for HIV Prevention Projects Program Announcement PS12-1201

Submitted By

**Los Angeles County
Department of Public Health
Office of AIDS Programs and Policy**



September 13, 2011



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September 12, 2011

Angie Tuttle, Grants Management Specialist
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Dear Ms. Tuttle:

The Los Angeles County, Department of Public Health, Office of AIDS Programs and Policy (OAPP) located at 600 South Commonwealth Avenue, Los Angeles, CA 90005, is pleased to submit the enclosed application for Comprehensive Prevention Activities for Health Departments under Funding Opportunity Announcement (FOA): PS12-1201. Los Angeles County will be the service area for program implementation. OAPP is applying for the following categories:

Category A- HIV Prevention Programs for Health Departments- Through Category A of this FOA, OAPP will support the following required activities in Los Angeles County: 1) HIV testing in non-healthcare settings (HIV screening in healthcare settings are proposed in Category B); 2) comprehensive prevention with positives; 3) condom distribution; 4) policy initiatives; 5) jurisdictional HIV planning; 6) capacity building and technical assistance; and 7) program planning, monitoring and evaluation, and quality assurance. In addition, OAPP will increase or redirect efforts for each of the three recommended program components: 1) evidence-based HIV prevention interventions for HIV-negative persons (i.e., behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons, community evidence-based interventions, and syringe services programs); 2) social marketing, media, and mobilization; and 3) nPEP.

Category B- Expanded HIV Testing for Disproportionately Affected Populations- Through Category B, OAPP proposes to support routine HIV screening activities in a total of 29 sites: eight primary care clinics, one emergency department, and two urgent care settings; six correctional sites and twelve STD clinics. Among these, OAPP plans to implement new routine

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testing programs at five new sites.

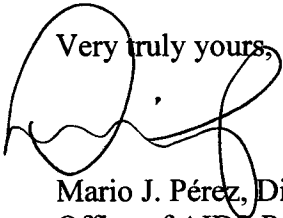
Category C- Demonstration Projects to Implement and Evaluate Innovative, High Impact HIV Prevention Interventions and Strategies- Under this funding category OAPP will implement a demonstration project to use HIV and STD surveillance data to strategically deploy key interventions in areas within the County most impacted by HIV and STDs. Through Category C of this FOA, this demonstration project will address Focus Area 3: Enhanced linkage to and retention in care for persons with new and prior diagnosis of HIV infection, and Focus Area 5: Programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk.

Mario J. Pérez is the Principal Investigator, and Michael Green is the Program Director.

The total funding amount requested in response to this FOA is \$20,542,732.

If you have any questions or need additional information, please let me know.

Very truly yours,



Mario J. Pérez, Director
Office of AIDS Programs and Policy

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c: Jeffrey Brock, CDC
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A. Background and Need

Overall HIV epidemic in the jurisdiction

At 4,084 square miles, with 88 incorporated cities and nearly 10 million residents, Los Angeles County (LAC) is the most populous in the nation and is home to an estimated 61,700 persons living with HIV/AIDS (PLWHA)¹ which includes an estimated 13,250 persons who are unaware of their status. LAC has the second largest number of people living with AIDS (25,876²) and estimated HIV (non-AIDS) infections (19,734³) among the 12 ECHPP (enhanced comprehensive HIV prevention planning) metropolitan statistical areas (MSAs). The number of PLWHA in LAC is approximately one-third of the California state total, and 5% of the US total.

LAC is ethnically diverse, with 47% Latinos, 29% Whites, 13% Asian/Pacific Islanders, 9% African-Americans, 2% multiple or other races/ethnicities, and 0.3% American Indians/Alaskan Natives⁴. In 2010, the highest proportion of prevalent HIV/AIDS cases was among Latino(a)s at 39%; however, African-Americans had the highest rate at 951 per 100,000 persons⁵. Clients new to the system of HIV services are more likely to have multiple morbidities, complicating co-factors, unstable or no housing, lack of health insurance, poverty, and substance addiction. These social determinants of poor health continue to be drivers of the epidemic⁶. A description of LAC's social determinants of health is provided in Appendix A.

MSA or MD within the jurisdiction with at least 30% of persons living with HIV

Geographic distribution of disease differs between and within the eight Service Planning Areas (SPAs) of LAC. In ECHPP, a syndemic planning model based on geospatial analysis was used to focus on connections among co-factors as determinants of risk for HIV disease. A more thorough description of the syndemic planning activities and geospatial analysis is provided in Appendix B.

While the syndemic planning exercise or geospatial analysis identified five concentrated geographic areas that comprise 82.3% of all newly diagnosed cases (Appendix B), this preliminary analysis was based on newly diagnosed cases rather than the total number of PLWHA (prevalence). Among the 42,364 PLWHA in LAC⁷, 16,455 (39%) reside in SPA 4. Approximately 99% of the living HIV/AIDS cases in SPA 4 are 18 years of age or older, 92% male, 89% MSM, 37% Hispanic/Latino, and 17% African-American. African-Americans in SPA 4 had the highest case rate (3,960 per 100,000) compared to any other SPA or racial/ethnic group⁸.

Highest risk populations in the target area

In LAC, sexual transmission with an infected male remains the most common route of HIV infection for all racial and ethnic groups and genders. Population estimates for *Men who have sex with men* (MSM) in LAC range from 4-13%, yet approximately 80% of PLWHA in LAC are MSM. Local National Health Behavioral Surveillance (NHBS) data reported that 53% of MSM had unprotected anal sex with a male partner and had an average of nine partners in the past 12 months⁹. Findings from another local needs assessment¹⁰ show that 27% of MSM used the internet to find a sexual partner, 23.4% had a serodiscordant partner, and 11.7% had sex while under the influence of methamphetamine (meth) in the past six months. And yet, 40.1% of these men reported low susceptibility or perception of risk for acquiring HIV. A number of MSM, particularly MSM of color, do not identify as gay or bisexual. These individuals are often deterred from seeking HIV services because conventional service models that focus on men who identify as gay or bisexual are not culturally appropriate. Isolation, drug use, incarceration, sexual abuse, and exchanging sex for money or drugs have been identified as co-factors experienced by non-gay identified MSM of color that impact their service use.

MSM of color face additional barriers managing their care. Over one-quarter (27%) reported a history of mental illness in the past year, and approximately 6% were homeless. MSM of color tend to be poorer and lack health insurance compared to their White counterparts. Language barriers are prevalent among MSM who are immigrants. Gender role expectations, homophobia, stigma, social isolation and rejection from friends, family, and community can create overwhelming emotional pressures when dealing with an HIV diagnosis.

MSM who use meth- MSM who use meth are much more likely to have casual sex, multiple sexual partners, and report inconsistent condom use than MSM who do not use meth. LAC HIV Counseling and Testing (HCT) data estimate that meth-using MSM are at least two times more likely to be HIV-positive than MSM who do not use meth. Studies show that as the level of meth use increases among MSM, HIV prevalence rates also increase. For example, 23% of MSM meth users surveyed during street outreach reported that they were HIV-positive. Among MSM seeking intensive outpatient treatment for their meth addiction, 61% self-reported that they were HIV-positive. The highest rate (86%) was observed among MSM seeking residential treatment for meth dependency¹¹. Meth users have numerous clinical challenges such as poor treatment engagement rates, high drop-out rates, high relapse rates, severe paranoia, and declining oral health.

Transgender Individuals- In 2009, the new HIV positivity rate among transgender individuals (9.2%) was eight times greater than the jurisdictional average (1.2%)¹². Although there is limited population-based data for this target population, local data present an alarming portrait of risk. Almost half of the transgender participants (TG) in the 2009 NHBS study were unemployed, 56% engaged in unprotected sex, and self-reported HIV prevalence was 27%¹³. Findings from another local needs assessment¹⁴ show that 26.3% had a serodiscordant partner,

50.0% inconsistently used condoms, 17.5% had sex under the influence of meth, 40.0% were unemployed, 30.0% exchanged sex for something they needed, 26.3% used the internet to find a sexual partner, and 21.3% were treated for a sexually transmitted disease (STD) in the past six months.

Current HIV prevention situation including gaps in scope, reach, coordination, and services

OAPP is collaborating with other LAC Department of Public Health (DPH) partners and RAND researchers on several modeling activities to determine the optimal use of prevention strategies to achieve the highest impact in addressing the National HIV/AIDS Strategy (NHAS) goals and objectives. OAPP will use the results from the modeling activities to help inform the scope and direction of LAC's prevention portfolio and to identify any service gaps. A detailed description of these activities is provided in Appendix C. Following the completion of the RAND modeling activity (2011), OAPP will determine what services are needed, what gaps in services exist, which prevention activities to scale-up, what population each prevention activity should address/target, where services should be provided, staffing resources needed to provide services, staffing resources to monitor and evaluate service provision, capacity building needs for service providers and Health Department (HD) staff, how to effectively coordinate services, what systems and processes need to be developed, what structural challenges need to be addressed, and what collaborations and partnerships need to be formed.

OAPP supports a variety of HIV testing models including: Targeted HCT services in storefronts, substance abuse clinics, courts, mobile units, and in commercial sex venues; testing within social networks; jail-based testing; multiple morbidity testing; and routine HIV screening in health care settings to assist with identifying undiagnosed infection as well as counsel and educate those at elevated risk for acquiring HIV. OAPP currently supports 32 HCT and 53

health education/risk reduction (HE/RR) contracts. In 2012, OAPP will continue to support PEP (post-exposure prophylaxis) services in two clinical settings, research and develop a program plan for PrEP and other bio-behavioral interventions, and expand the use of the rapid testing algorithm (RTA).

Data show that 21.5% of the estimated 61,700 PLWHA in LAC are not aware of their HIV-positive status. Two out of five recently diagnosed HIV-positive individuals (40.4%) are not linked to care within three months¹⁵. Studies have shown that health outcomes for recently-diagnosed HIV-positive individuals can be greatly increased if treatment regimens are implemented within the first three months. Other studies have demonstrated that there is a strong association between the average viral load of a community and the number of new infections diagnosed. Disproportionate community viral load, late entry into care, inconsistent care utilization, poor treatment adherence, lack of awareness of HIV test results, and dual diagnoses (i.e. concomitant STD, hepatitis C, tuberculosis, substance addiction, and mental illness) all contribute to HIV transmission and increases in HIV incidence.

The number of HIV tests needed to identify the 13,250 undiagnosed cases of HIV and reduce HIV incidence by 25% far exceed current available resources County-wide. Recently, data use 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 (PS). In addition, data collection and management activities for HIV and STD surveillance and program data are being integrated. The changes to surveillance data regulations as well as integrated data management activities will allow for increased data sharing and more effective matching of HIV and STD surveillance and program data. In 2012, routine matching of

surveillance and program data will provide a more complete picture of HIV and STD co-infection as well as linkage and retention in care.

To address the gaps in scope, reach, and coordination of services in LAC's prevention portfolio, the following interventions/public health strategies will be scaled up in 2012 at different stages: routine opt-out HIV screening in healthcare/clinical settings; PEP services; support additional Community Embedded Disease Intervention Specialists (CEDIS) and Public Health Investigators (PHIs) to conduct PS; activities to support linkage to care, promote retention in care, and adherence to antiretroviral treatment (ART); multiple morbidity (MM) screening/testing; and support additional modeling activities. Other strategies to address the gaps are to identify new testing partners; program integration (OAPP, LAC DPH HIV Epidemiology Program (HEP), and LAC DPH STD Program (STDP)); refine HIV testing services (HTS) program model; reduce data collection burden; facilitate HTS case reporting to HD surveillance systems; and implement a locally-developed ARTAS (anti-retroviral treatment and access to services) ALCM (ARTAS linkage case management) program.

Experience, expertise, and existing capacity to provide services

Prior to 2011 HEP, STDP, and OAPP operated as independent programs. Consistent with CDC's 2009 recommendations and guidance for HD program coordination and service integration (PCSI), effective February 2011, the LAC DPH began the integration of OAPP, STDP, and HEP into one consolidated program, the Division of HIV and STD Programs. By October 2011, the newly formed division will coordinate the County's response to HIV and all STDs using an integrated prevention and treatment approach that combines surveillance, planning, data management and analysis, and geographic mapping to design and implement data-driven programming in the geographic areas with highest disease morbidity.

OAPP is responsible for planning and managing the annual investment of more than \$90 million in local, State, and federal resources that support a responsive and comprehensive local HIV/AIDS service delivery system for LAC. OAPP will continue to collaborate with sister DPH programs, California State Office of AIDS (OA), and federal partners in leveraging resources and maximizing service delivery and reach.

In addition, as the administrator of both HRSA and CDC funding, OAPP is uniquely positioned to manage the full spectrum of HIV prevention, care, and treatment services through a single administrative agency. OAPP uses these funding streams to manage approximately 200 contracts within a network of nearly 100 community-based organizations (CBOs) and ten County entities in an effort to maximize access to HIV services. See organizational structure and description in Appendix D.

It is OAPP's responsibility to ensure quality-of-care, best practices, and service and cost effectiveness at the system and provider levels. It does so with an overall quality of care framework in which service standards are established and subsequently implemented in contracts; benchmarks and outcome measures are defined and applied; provider care is monitored through audits and client feedback; reimbursement reviews are conducted to ensure cost efficiencies; grievance claims are investigated and resolved; and technical assistance is provided where needed. OAPP conducts fiscal reviews and program monitoring site visits annually for every contracted service provider. OAPP is charged with data collection, tracking and reporting activities related to HIV testing, prevention, care, and treatment services. OAPP continuously evaluates its health information data management systems, trains providers in order to ensure patient data safety and confidentiality, and strives to improve health outcomes and service effectiveness.

B. Program Description

HIV Testing

To achieve the NHAS goal of reducing HIV transmission by 30% and the number of new infections by 25% in LAC by 2015, it is estimated that 159,222 HIV tests must be conducted in 2012; 215,655 in 2013; 225,701 in 2014; and almost 250,000 tests in 2015, based on estimated positivity rates in LAC (see Appendix E for methodology). A total of 29 healthcare settings and 32 targeted HTS programs in non-clinical settings are proposed for 2012 (see tables 1-3 in Appendix F for listing of contracted providers). OAPP will also establish partnerships with additional healthcare facilities to provide routine HTS. The 2012 goal of testing 159,222 LAC residents will be reached through the combined efforts of OAPP's partners and contracted HTS providers.

It is critical that LAC resources are used to test individuals at highest risk and support testing modalities with the highest new positivity rates (see table 4 in Appendix F). Routine testing at clinics, hospitals, and emergency departments (EDs) within areas with high HIV burden; is LAC's primary strategy in testing hard to reach populations and individuals unaware. Two other highly effective strategies are testing partners of newly-diagnosed HIV cases through Partner Services and social network testing (SNT). Both of these activities consistently yield high new positivity rates (28.0%¹⁶ and 6.22% respectively in 2010) in LAC. However with an overall new positivity rate of 1.0%, preliminary analyses (2010 OAPP HTS data) show that one of the most effective HTS model in identifying the 13,250 individuals who are unaware of their HIV status is routine testing in high volume healthcare settings located in highly impacted geographic areas. In 2012, OAPP will directly support routine, opt-out HTS in both healthcare and non-healthcare settings (supported by Cat B funds).

Routine Opt-out Testing in Healthcare Settings

Criteria for selecting healthcare facilities and HIV testing experience- OAPP uses the following criteria in selecting healthcare facilities for routine testing programs: 1) high volume and continuous influx of new patients (more than 40,000 patients), 2) demographic characteristics and risk behaviors of patient population (part of one or more target populations), 3) geographic location of the facility (located in a high disease burden area/cluster), 4) high level of support from administrators and medical providers, 5) sufficient provider capacity to implement and sustain a routine testing program, and 6) ability to collect and submit data. Target populations include African-American and Latino men, MSM (gay and non-gay identified), TG, and women of color. Capacity building and technical assistance will be provided to low performing sites (i.e., new positivity rates lower than the jurisdictional target, low testing volume, low number of new testers). If performance does not increase, continued support at that facility will be re-assessed. Currently, the jurisdictional performance goal for routine testing sites is a 0.5% new positivity rate. The criteria for selecting existing healthcare facilities and their HIV testing experience are also provided in tables 1-3 (Appendix F).

Implement and/or coordinate opt-out HIV testing for patients ages 13-64 in healthcare settings-

In 2012, OAPP will support opt-out routine testing in at least eight clinic sites, one ED, two urgent care settings, six correctional settings, and 12 LAC DPH STD clinics (see tables 1-3, Appendix F). OAPP will also assist at least two EDs or urgent care centers with the implementation of opt-out routine testing programs during 2012. Approximately 60,000 African-Americans, Latinos, and MSM will be tested at an OAPP-funded routine testing site and at least 300 new HIV-positive individuals will be identified over the next year.

Implement and/or coordinate HIV testing in non-healthcare settings to identify undiagnosed HIV infection

Over 45,000 tests were conducted by targeted testing providers in 2010¹⁷ (see table 4, Appendix F) and the average new positivity rate was 1.08%. New positivity rates varied dramatically (0.86% to 6.22%) among non-healthcare testing modalities. A brief description of each type of non-healthcare testing modality is provided in Appendix G.

Support HIV testing activities in venues which reach persons with undiagnosed HIV infections

OAPP is committed to implementing opt-out routine testing in at least two new EDs or urgent care settings in 2012, bringing the total number of sites to 31 healthcare settings. In addition, a re-assessment and expansion of routine testing in other healthcare settings must also occur to reach case finding goals. Locally, this strategy will focus on high disease burdened areas or clusters identified through geospatial analysis.

Routine opt-out testing will complement high performance targeted testing programs (based on new positivity rates, linkage to care, testing volume, and PS referral rates) in non-clinical settings. The combination of these programs will enable OAPP to identify individuals with no perceived risk of HIV infection. Syndemic planning and geospatial analysis, future risk behavior and social marketing needs assessments, scale-up of SNT and Popular Opinion Leader (POL) programs, and input from DPH and community partners (e.g. Medical Advisory Committee) will also aid in identifying new venues in which to reach persons with undiagnosed HIV infections.

Promoting routine, early HIV testing to target populations including pregnant women

HIV testing will be promoted through OAPP's HIV prevention campaign, Erase Doubt (see *Social Marketing* section p.34 for program description and additional information).

Through the expansion of routine testing programs in 2012, OAPP will continue to promote routine, early HIV testing to pregnant women. Further promotion will occur through discussions with contractors, local Medical Advisory Committee (MAC), local perinatal workgroups, and DHS and DPH administrators. OAPP will continue to provide trainings and technical assistance to both funded and non-funded service providers to promote early HIV testing for pregnant women.

LAC has been an Enhanced Perinatal Surveillance (EPS) site since 1999. With the emphasis on further reducing perinatal HIV transmission in high prevalence areas, EPS activities were implemented to target and follow the process toward maximal reduction of mother-to-child transmission (see *Comprehensive with Positives* section page 16).

Expected outcomes for each proposed HIV testing service

In 2012 OAPP expects to achieve the following HTS outcomes: new HIV positivity rate in opt-out routine testing in healthcare settings at 0.5%; new HIV positivity rate in non-healthcare settings at 1.0%. Additional outcomes are provided in Appendix H (Program Goals and SMART Objectives).

New directions in HIV testing-Los Angeles County's new testing model

Encourage and support health department and non-health department providers to increase the number of persons diagnosed with HIV- In order to achieve the 2012 target of 159,222 HIV tests, modifications to the existing service delivery process were necessary. LAC's new testing model includes improvements and changes in the following program areas: Data collection and reporting, HIV counselor training and re-certification, HIV testing technology, PS, integrated HIV/STD testing, laboratory services, and performance-based fee-for-service reimbursement schedule. Further details on LAC's new testing model are provided in Appendix I. These

program improvements and new directions were developed to advance LAC's HIV testing program; increase effectiveness and the efficiency of HIV testing programs; increase the validity, timeliness, and efficiency of data collection and reporting; improve opportunities for people to test, get linked into care, and receive appropriate referrals; and facilitate provision of more cost effective, high quality HTS by contracted agencies.

Ensure the provision of test results, particularly to clients testing positive

In 2009, a confirmed positive result was not obtained for 56% of preliminary HIV-positive testers. To address this limitation, through LAC's new testing model (see Appendix I for a detailed description), OAPP-funded providers will now notify the client of their HIV-positive status based on the following criteria: 1) Conventional or one rapid test- the initial reactive result and 2) a result based on two reactive rapid HIV tests. For all testing modalities except for conventional testing (blood-draw), clients are told that they have the option of returning for their confirmatory results as they have already been referred to treatment and care services. To facilitate linkage to care at sites implementing a two-test RTA, OAPP recommends viral load testing to be conducted in lieu of the Western Blot (WB). The viral load test results will be sent to the testing agency and referral care site to aid in initiating a medical visit.

Description of how prevention counseling, linkage to medical care, and initiation of partner services will be conducted with new and persons previously diagnosed.

The new LAC testing model will facilitate the provision of prevention counseling, linkage to medical care, and initiation of PS (see Appendix I). Counselor training and re-certification requirements (Appendix I) will ensure that providers receive training on client-centered counseling to improve their skills. Data collection forms were modified to collect information on referrals provided and to document successful linkage to services. OAPP staff

will report all HIV- positive cases to HEP (surveillance) and STDP (PS) to eliminate the burden on the service provider. Because of the streamlined data collection and reporting process, counselors will have more time to spend with clients to offer or initiate PS and conduct follow-up contacts with the client and the referral sites to ensure linkage to medical care. LAC is also proposing the provision of enhanced linkages to care and PS through a locally-developed ARTAS ACLM strategy proposed under Category C of this FOA.

Ensure that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing

Some OAPP-funded HCT and HTS providers utilize private labs for confirmatory testing however OAPP is recommending the use of LAC Public Health Lab (PHL). OAPP partners with the PHL to support referenced HIV laboratory tests from OAPP, OAPP contracted agencies, commercial sex venues (CSVs), and STD Clinics providing HTS. The referenced HIV laboratory tests include enzyme immunoassay (EIA) or immunofluorescence assay (IFA), WB, NAAT, and viral tests. OAPP conducts an evaluation once a year to assure the quality in testing services. These monitoring and evaluation activities are described in the attached MOA (see Appendix J) between PHL and OAPP.

The PHL adheres to a Quality Assessment (QA) Program that focuses on methods and standards that continuously monitor and improve the level of diagnostic testing service provided. The PHL QA Program incorporates policies and practices that ensure that diagnostic testing results are reported in a timely manner and are monitored and verified to detect, control, and prevent the occurrence of errors. Quality control of media, reagents, and equipment are performed prior to/or concurrently with all test procedures. Standards and/or test controls ensure accuracy, reliability, and reproducibility of test results. The PHL subscribes to Clinical

Laboratory Improvement Amendments (CLIA) approved proficiency testing programs, and implements internal proficiency testing as means of monitoring the quality and accuracy.

Facilitate voluntary testing for other STDs (e.g. syphilis, gonorrhea, Chlamydia infections), HBV, HCV, and TB

OAPP is integrating with STDP, and collaborates with both the Department's Tuberculosis (TB) Control Program and the Communicable Disease Control Program to broaden opportunities to offer HIV tests County-wide. OAPP's Medical Director will continue to develop partnerships to facilitate voluntary testing for co-morbidities and will employ the assistance of the MAC and local community planning groups to identify other opportunities for integrated testing. OAPP will implement integrated HIV, STD, and viral hepatitis screening in a subset of targeted HIV testing programs as part of ECHPP Phase II, not only to identify new HIV infections, but also to treat incident syphilis and gonorrhea infections. Category A will support integrated testing in MM testing units and integrated testing will also occur at all STD clinic sites through Category B funding.

Delivering all services in a culturally and linguistically appropriate manner

OAPP contracts require that agencies provide culturally and linguistically appropriate services, and that agencies have competency training programs for all staff. To ensure this, OAPP provides technical assistance and training to all service providers. In addition, all educational materials are reviewed for content accuracy; cultural and linguistic appropriateness; and applicability to CDC, State, and local guidelines developed by OAPP staff. OAPP staff also conducts observational audits of services to monitor cultural competency of contracted service providers annually.

Delivering all services in a manner consistent with applicable CDC guidelines and recommendations

All OAPP funded program service delivery plans are based on current CDC guidelines for HIV testing (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings), PS (Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection), and PCSI (Program Collaboration and Service Integration: Enhancing the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis in the United States An NCHHSTP White Paper 2009). Service delivery plans must also be compliant with HIPAA, CLIA requirements, state guidelines, and California Health and Safety codes. OAPP ensures that services are delivered in a manner consistent with applicable guidelines, rules, and regulations through annual audits, observational site visits, chart reviews, and by managing a client grievance warm line.

State laws or regulations regarding written consent for HIV testing vary based on type of setting (healthcare versus non-healthcare) and whether the client is a pregnant woman. In 2004, California's Health and Safety Code was amended making prenatal HIV testing a part of the routine battery of tests required for all pregnant women with her informed consent. In 2008, this legislation was simplified and now allows 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 (nondirective patient choice) methodology. In addition, written consent or refusal of HIV testing is no longer required.

State law AB 682 not only removed the requirement of a separate written consent specific to HIV for pregnant women obtaining services from a healthcare provider, but for all individuals

testing at a healthcare facility. The law follows CDC's finding that written consent was a barrier to routine HIV testing in clinical settings. However AB 682 did not provide the same freedoms for non-healthcare settings. Currently there is a bill (AB 491) which would remove this requirement for non-healthcare settings pending approval. Until the bill is passed, HCT at non-healthcare settings can only be conducted if written consent is obtained.

Comprehensive Prevention with Positives

OAPP has identified comprehensive prevention with positives programming as one of the most effective strategy in helping achieve the NHAS goals in our jurisdiction. Early testing, linkage into care, retention in care, and ART adherence are critical to achieving viral suppression and better health outcomes. Following the TLC+ (Testing, Linkage to Care, plus treatment) model, comprehensive prevention for positives begins with identifying the 13,250 individuals in LAC that have HIV or AIDS and are unaware of their status¹⁸. This will be accomplished by increasing the volume of tests, expanding opt-out routine testing, and re-assessing location and testing protocols for targeted testing sites.

HIV Treatment as Prevention

For 2012, LAC activities will include: new substance use contracts and integration of behavioral interventions, deployment of 30 new linkage to care workers, convening of a community planning integration workgroup, providing MM screening for all Ryan White (RW) clients and referrals to prevention programs (i.e. substance addiction, mental health, and STD treatment), provision of community-level interventions (i.e. SNT, POL, social marketing, and condom distribution); case management (ACLM), medical care coordination (MCC), and increased emphasis on medical adherence to ART to reduce forward transmission.

Linkage to HIV care, treatment, and prevention services

Approximately two out of three individuals diagnosed with HIV in LAC are not linked to care within one year from their test date¹⁹. African-Americans were three times less likely to be linked into care compared to Whites. Latinos were half as likely to be linked²⁰. Preliminary analysis depicts that the lowest percentage of cases (<40%) not linked into care is predominantly in SPAs 4 and 6 (figure 1, Appendix F).

In 2012, OAPP will scale-up services that integrate care and prevention services in healthcare and non-healthcare settings in LAC. These services include routine HTS, PS, PEP, HE/RR, and other programs that promote the complete wellness of the client and community. A pilot project will also be implemented to link and retain HIV-positive persons in consistent HIV care. Increase in scale of the strategies listed below will be addressed by a four year demonstration project to use surveillance to enhance and facilitate linkage to care and to continue to identify new emerging areas of disease burden under Category C.

OAPP's New Directions HTS model has a combined cost reimbursement and performance-based fee-for-service structure for all OAPP-contracted HTS service providers. HTS contracts must document successful linkage to care for at least 85% of new HIV-positive persons, and submit 100% of all HIV-positive clients (index case) and any partner information to DPH to obtain maximum compensation.

An internal TLC+ workgroup was established to 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. OAPP already supports a wide range of services designed to link newly diagnosed HIV-positive persons to care and promote care and treatment engagement, including: Early intervention services, MCC (a hybrid of medical and nonmedical case management employing nurses and social workers to

facilitate comprehensive care planning), 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 through ECHPP will assist OAPP in determining which services are most likely to influence linkage and retention in care.

Retention or re-engagement in care for HIV-positive persons

In order to optimize health and reduce community viral loads, retention in care must be addressed. Among the HIV cases diagnosed at OAPP-funded HIV testing sites who were successfully linked to care, 81% were retained in care one year after diagnosis²¹. However, disparities in demographic and socio-economic factors exist among PLWHA who had poor retention in care. For example, recent incarceration was a significant predictor (OR 1.71; CI 1.42-2.06) of poor retention in care²². The same challenges that prevent or delay diagnosis often prevent retention and adherence.

In 2012, LAC will roll out the TLC+ project. Year 1 will focus on a study to identify HIV-positive persons out of care, and year 2 will include the deployment of linkage workers to link individuals to medical care. Referrals and linkages to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV-positive persons are part of the TLC+ project.

By increasing, implementing, and refining the following activities we expect to improve retention in care within LAC: a) Expanding PS to reach out of care populations (including ARTAS and CEDISs); b) expansion and improved targeting of early intervention and retention services; c) placement of linkage workers to facilitate expedited access to care among hard to

reach out of care populations; d) continued support of housing, substance use, mental health, and transportation services to optimize retention in care; and e) implementation of MCC.

OAPP routinely matches data from the RW data system to HIV surveillance data to improve surveillance completeness. As of 2011, the data matches (as permitted by California state law) will also be used to systematically identify out of care patients. A TLC+ workgroup is developing pilot programs to target out of care populations such as using social networks and intensive strengths-based case management to re-engage and retain those out of care.

Use of data for estimating linkage and retention in care, community viral load, quality of care- LAC DPH continuously monitors trends and rates of new infections within communities across LAC. All OAPP-funded HIV prevention and care agencies receive an annual monitoring site visit, which includes review of HIV documentation for accuracy of data entry and timeliness of data submission. OAPP staff review the following: HIV-positive results being reported; documentation of follow-up on medical linked referral; HIV testing quality assurance logs; and maintenance of HTS counselor certifications. In addition, OAPP and HEP conduct semi-annual data matches between HIV testing data, HIV care services data and the LAC HIV/AIDS Surveillance system to ensure reporting of HIV cases.

Ongoing partner services for HIV-positive persons and their partners

PS are a broad array of services that are offered to persons with HIV, syphilis, gonorrhea, or Chlamydia infections and their partners. Identifying partners and notifying them of their exposure through partner notification are two critical elements of these services. Other elements of PS include: Prevention counseling; testing for other STDs, hepatitis, and TB; and linkage to medical evaluation, treatment, and referral to other services. PS services are described in detail in Appendix K.

The New Directions HTS model and related trainings will move the focus on PS from the agency staff to DPH staff. OAPP staff will notify Division PHIs of all new HIV-positive cases to ensure consistent offering of PS. OAPP-funded HE/RR and HTS agency staff will still be required to review and offer PS to all HIV-positive clients, notify the client that HD staff will provide the service, and elicit the names of the partners if the client is willing to offer the information.

There are approximately 1,500 new cases of HIV reported per year in LAC. In addition, the number of syphilis, Chlamydia, and rectal gonorrhea cases are staggering. With the proposed increases in routine screening of HIV and STDs starting in 2012, the number of PS cases will grow. Currently, the seropositivity rate of HIV among clients elicited through PS is 10.8%. Considering these two factors, OAPP expects that the new HIV-positive case load will increase by approximately 900 cases per year. In 2012, a sizable number of staff will need to be trained and recruited to meet the demands of PS.

Partner Service efforts will be enhanced by placing six new CEDIS in CBOs with the highest HIV and STD morbidity. Increase in scale of this intervention strategy will assist in reducing the number of unaware infections, combat health disparities, and increase access to care/improve health outcomes for PLWHA. See Appendix H for program goals and SMART objectives.

Use of Surveillance Data

California regulations were revised with the passage of the State bill AB 2541 that allows the use of HIV surveillance information for public health purposes including PS. In 2012, OAPP and STDP will have a new hierarchy for determining PS case reporting initiation and follow-up. Additional information is provided in the data sharing plan in Appendix L.

Partnerships with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide partner services

All public health service providers regardless of their affiliation with the HD are required to report newly diagnosed HIV-positive cases to the HD (HEP and STDP) and offer PS. Due to the challenges and limitations listed in the *HIV Testing* section, CBOs and medical treatment providers (both public and private) have varying success at offering PS to all newly diagnosed HIV-positive cases. Following the results of the ECHPP modeling activity and further organizational development of the Division of HIV and STD Programs, a new PS plan should be available in 2012.

The OAPP Routine Testing Workgroup which includes OAPP's PS coordinator, is developing an engagement work plan, focused on identifying methods to engage and implement opt-out routine testing at EDs and urgent care clinics (public and private health care settings) in highly impacted geographic areas. A component of the engagement plan will also determine the individual needs of public and private healthcare settings in order to integrate PS as a standard business practice in clinical settings. Efforts in identifying more opportunities to provide PS will be spearheaded by a team of Office of the Medical Director, Prevention Services Division (PSD), and STDP staff.

Provide HIV-positive pregnant women with necessary interventions for the prevention of perinatal transmission

One of the biggest public health success stories in LAC is that the perinatal transmission rate has declined from a high of 18% in 1996 to 0% in 2009. Despite declines both nationally and locally, the need for prevention services for HIV-positive women of childbearing age still remains. Every perinatal HIV infection represents a sentinel health event, often indicating a

woman who had undiagnosed HIV infection before pregnancy or did not receive appropriate interventions to prevent transmission of HIV to her infant.

Comprehensive HIV services for pregnant women are provided at both the County DPH level and at each of the seven pediatric HIV-specialty clinics (see Appendix M), who together report more than 90% of all perinatal HIV exposures in LAC. Promotion and availability of perinatal HIV services are done through presentations and meeting announcements, LAC's HIVLA online resource directory, and through OAPP's website. In 2012, the DPH will continue to convene the Perinatal Prevention Collaborative which provides a forum for information sharing, and provides educational and training opportunities.

Sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities by utilizing the FIMR-HIV Prevention

Methodology

LAC has been an EPS site since 1999. With the emphasis on further reducing perinatal HIV transmission in high prevalence areas, EPS activities were implemented to target and follow the progress toward maximal reduction of mother-to-child transmission. With EPS activities currently in place in LAC, staff will be able to collaborate on and implement much of the FIMR/HIV Prevention Methodology to further improve perinatal HIV prevention systems.

LAC has a sizeable number of HIV-infected women of childbearing age, thus necessitating the need for intensified monitoring efforts. With more than 150,000 births annually, LAC expects more than 270 HIV-infected women to give birth each year. This underscores the need for new and improved strategies to ensure that HIV-infected females have access to adequate prenatal care, timely HCT, and access to HIV-related care and services. FIMR-HIV Methodology in LAC will provide an in-depth look at the systems that result in a perinatal HIV

exposure or transmission. It will provide a mechanism to better understand factors associated with perinatal transmission which routine surveillance data cannot achieve.

Health Education Risk Reduction for HIV-positive Individuals

OAPP supports a broad range of programs targeting HIV-positive individuals that includes targeted outreach, interventions designed for individuals (IDIs), interventions designed for groups (IDGs), CLI, and comprehensive risk counseling services (CRCS). Prevention for HIV-positive persons has been fully integrated into OAPP's service plan for HE/RR. In the 2009-2013 HIV Prevention Plan, HIV-positive individuals are identified as a priority target population at risk for transmitting HIV. Both the Expanded Testing Program (ETP) Part B and ECHPP activities identified a need to scale-up HE/RR prevention for HIV-positive interventions and programs. The current programs (listed in table 5, Appendix F) will be in place until December 2013 (see Appendix N for list of contracts in place).

Because the ECHPP modeling activities are not concluded and a few follow-up needs assessment activities will be conducted, LAC's prioritized interventions or programs for HIV-positive clients are not yet finalized in this application. Based on preliminary findings, interventions for HIV-positive persons should be tailored to each client, include motivational interviewing, contingency management (if needed), active follow-up by counselors or health educators, enhanced referral and linkage to ancillary services, and include a social network recruitment component.

Coordinate integrated hepatitis, TB, and STD screening, and PS, for HIV-infected persons

Given the overlapping syndemics of HIV, syphilis, and gonorrhea in LAC, there is a need to enhance integrated HIV/STD screening among MSM, TG, and others in LAC at sexual risk. OAPP will implement integrated HIV, STD, and viral hepatitis screening in a subset of targeted

HIV testing programs as part of ECHPP Phase II, with the goal of identifying not only new HIV infections, but also identifying and treating incident syphilis and gonorrhea infections.

All HE/RR programs including interventions for HIV-positive individuals provide STD education. With the integration of OAPP and STDP, the HE/RR education materials and curricula regarding STDs will be reviewed and revised to reflect the new local PS protocol (anticipated date 2012), most current CDC guidelines, and local surveillance data. From a cross-morbidity coordination standpoint, OAPP houses the Department's Adult Viral Hepatitis Coordinator, is integrating with STDP, collaborates with the DPH TB Control Program and the Communicable Disease Control Program and has integrated with the HEP to broaden opportunities to offer HIV tests County-wide. OAPP's integration with the STDP is specifically enhancing opportunities for notifying, testing, and counseling sexual and needle-sharing partners of HIV-positive individuals, referring them to appropriate services, and linking those who tested positive for HIV into medical care and subsequent treatment for substance use and mental health.

Screening for hepatitis, STDs, and TB are currently tracked for RW clients in the RW system of care, and follow CDC guidelines at entry to care and annually as part of routine HIV care. Historically, RW providers perform extremely well (over 90% compliant) in screening for STDs and hepatitis. However, TB screening rates have been suboptimal based on poor return rates for reading PPD skin tests. Based on this experience and as a strategy to increase TB diagnosis awareness, OAPP is in the process of implementing Quantiferon testing in all RW-funded medical outpatient sites.

Reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, community viral load, quality of care, and providing feedback of these results to providers and patients

Reporting of CD4 and viral load results to the HD- California HIV reporting laws require labs and health care facilities to report all CD4 count test results and HIV viral load tests to the local health officer within seven days of the completion of the 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.

Provisions of results to providers and consumers- At the conclusion of each monitoring site visit OAPP providers receive a monitoring report that indicates the provider's success in meeting performance measures (i.e. linkage to care, screening of co-morbidities, provision of referrals, etc.). The reports also compare the provider to all providers in that service category. In addition, linkage to care, retention in care, re-engagement in care, and positivity rates are presented in standard reports such as the annual Care Utilization and HIV Testing reports. These reports and other presentations are available to patients and to the public on OAPP's website.

Promote and Support the Provision of ART

Policies and Procedures for use of ART in Accordance with Treatment Guidelines- OAPP and LAC have policies and procedures in place in multiple forms to address HIV treatment in accordance with guidelines in LAC (See Appendix O).

Funding to Support ART Use in Accordance with Treatment Guidelines- OAPP's federal RW Part A grant is the primary funding source supporting treatment provision and adherence for LAC's poorest uninsured residents, and the state AIDS Drug Assistance Program (ADAP) provides ART for eligible PLWHA.

OAPP is currently reviewing community viral load and ART coverage rates to identify communities where community viral load is elevated, as well as to identify clinics and medical centers that may be having difficulty achieving viral load suppression among their patients on

ART, suggesting patient difficulty with adherence. Those sites will be prioritized for education and intensive monitoring activities in order to ensure reduction in viral burden.

Delivering all services in a culturally and linguistically appropriate manner

Please see response provided in *HIV Testing* section (see page 14).

Delivering all services in a manner consistent with applicable CDC and/or state/local guidelines and recommendations

Please see response provided in *HIV Testing* Section (see pages 15-16).

Condom Distribution

Prioritize and coordinate condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection

Nearly all new HIV infections in LAC are attributed to sexual contact (94%). More than (93%) of males living with HIV in LAC reported a risk factor of having sex with men, while nearly three out of four (73%) women acquired HIV through heterosexual contact²³. Because HIV incidence is influenced by so many different economic, social, environmental and cultural factors, a robust prevention portfolio that also includes availability of condoms is critical to reducing HIV infection and transmission in LAC.

OAPP will begin targeted condom distribution in 2012. The plan for the first phase of the targeted condom distribution campaign is to make available “1 million and 1 free condoms”. *Methods and data sources that will be used to identify settings that serves high risk populations and healthcare or non-healthcare facilities that will be recruited for condom distribution-* Given LAC’s immense population and vast geographic area, it would be cost-prohibitive and impractical to make condoms available to the entire population using public funds. Therefore OAPP will support increased condom availability in limited locations that optimally engage and

serve the highest-risk populations. OAPP plans to pilot the program by targeting two to three of the County's highest HIV burden areas, to include West Hollywood, Hollywood, and South Los Angeles. Specific blocks and intersections within these areas will be identified through the syndemic planning process and complex mapping activities. Detailed discussion of these methods and data sources are in the *Background and Need* section and Appendix B.

Proposed number of settings and types of settings (i.e. healthcare or non-healthcare setting) in which condom distribution activities will be supported- In 2012, condoms will be available in neighborhoods and non-healthcare settings that are densely populated with high risk individuals. Venues including clubs, bathhouses, sex clubs, and bars that primarily serve gay men will be targeted for condom distribution within each specified geographical area. Additionally, businesses like barber shops, clothing stores, and other retail outlets that serve high risk populations will also be asked to participate. Finally, condoms will be made available in County- funded clinics; hospitals; men's jails (including the unit for men who self identify as gay or TG); all sites offering HIV, STD, and/or viral hepatitis screening; and RW medical care sites.

State or local laws or regulations regarding condom distribution

There is no state or local laws regulating the distribution of condoms.

Expected condom distribution outcomes

It is expected that it will take the County approximately one year to coordinate, implement, and publicize LAC's condom distribution program. The program should be fully operational by September 2012. Specific program outcomes are included in *Program Goals and SMART Objectives* (Appendix H).

Condom distribution strategy and NHAS

Increase in scale of this intervention strategy will assist in reducing new infections, reduce health disparities, and improve health outcomes for PLWHA by preventing further STD infection. This strategy is directly tied to goals of the NHAS.

Policy Initiatives

Efforts to align structures, policies, and regulation in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts

To achieve the NHAS goals, a number of existing structures, policies, and regulations must be changed or enhanced to successfully implement the activities proposed in LAC's future Comprehensive Program Plan, and to create an enabling environment for optimal HIV prevention, care, and treatment. For example, OAPP successfully pursued legislation to remove the requirement of written consent for HIV testing in healthcare settings. However the requirement still remains for non-healthcare settings. Legislation, policies, and regulations that do not support or are not aligned with current service delivery models, client needs, or medical technology are barriers to public health. California laws and local regulations state that sexual activity in prison or jail settings is unlawful; therefore condom distribution in LAC jails is highly restrictive. One nonprofit organization is allowed to distribute a single condom (per week) to each gay identified inmate housed in a separate unit. Laws and regulations need to be relaxed or eliminated to allow condom distribution in all California prisons and LAC jails, increase the amount of condoms distributed, and to make condoms available for all male and TG inmates (gay and non-gay identified).

Proposed strategies and collaborators/partners that will address the proposed change or enhancement to existing structures, policies, and regulations- OAPP, LAC DPH programs, local governments (Cities of West Hollywood and Los Angeles), local HDs (Cities of Pasadena and

Long Beach), local MAC, State OA, public and private hospital administrators, substance abuse prevention and treatment providers, local community planning groups, consumers, advocates, law enforcement, academic and research partners, and local political leaders will collaborate to address the necessary changes and enhancements to existing structures, policies, and regulations. The proposed policy agenda is in Appendix P.

Expected policy outcomes- Successfully changing or eliminating barriers to any one of the structures, policies, or regulations previously identified will help LAC optimize HIV prevention, care, and treatment, thereby achieving the NHAS goals to reduce the number of new infections by 25%, increase the proportion of newly diagnosed HIV-positive clients linked to care within 90 days from 65% to 85%, and increase the proportion of HIV-positive African-American or Latino gay or bisexual men with undetectable viral loads by 20% by 2015. Many of the strategies listed above will assist in identifying HIV-positive persons who are unaware of their HIV status; tracking disease burden (i.e., community viral load), service delivery, service utilization, linkage to care, retention in care, and ART adherence; facilitate and streamline service delivery; mapping and syndemic planning activities; providing more comprehensive medical care to ensure the wellness of LAC residents; and will help LAC and State OA to accurately measure and report the number of HIV and AIDS cases thus impacting eligibility and funding opportunities for additional prevention services. Additional information regarding policy goals and objectives is located in the *Program Goals and SMART Objectives* (Appendix H).

Evidence-based HIV Prevention Interventions for HIV-negative persons

OAPP proposes to provide two out of the three recommended HIV program components: behavioral risk screening followed by individual and group-level evidence-based interventions

for HIV-negative persons at highest risk of acquiring HIV. In LAC, CLIs are embedded in evidence-based interventions (e.g., Community Promise) and other locally-developed HE/RR programs, condom distribution program, and social marketing. Category A funding will not directly support syringe services programs (SSPs).

Individual and group-level evidence-based interventions for HIV-negative persons

Strategy for recruiting and providing behavioral risk screening followed by individual and group-level evidence-based interventions to high risk negative and serodiscordant couples-

Procedures to identify populations and communities at greatest risk were based on the strategies outlined in the 2009-2013 HIV Prevention Plan (see Appendix Q). Table 6 (Appendix F) lists all interventions, target populations, and contractors for all 2012 HE/RR interventions for high risk HIV-negative individuals.

Description of expected intervention outcomes- All IDI and IDG programs implement a risk assessment at the first session, last session, and 30 days after the last session with each client, per contract requirements. Expected intervention outcomes include: increase in HIV knowledge; increase in perceived severity of HIV; increase in perceived self-efficacy; increase in consistent condom use; decrease in number of sexual partners; decrease in STD incidence; increase in reported HIV incidence; and increase in the proportion of clients successfully linked to a substance abuse program, mental health services, housing, safety/domestic violence services, legal protections, employment, or other social services. OAPP anticipates that the interventions will result in an increase in reported HIV incidence because all HE/RR programs link clients with unknown HIV status at baseline to HTS. Process measures collected include: number of participants in each intervention (rate of enrollment); proportion of participants who completed

all sessions of the intervention (completion rate); client satisfaction; and number of clients referred to the range of health and social services described above.

OAPP has also established performance measures at the agency-level. Some of these measures include providing culturally and linguistically appropriate services and materials, accurate and timely data submission, and submission of an evaluation and quality management plan. Starting in 2012, OAPP will also measure awareness and knowledge of nPEP and other biomedical and bio-behavioral interventions among contracted providers.

Future directions for HE/RR programs for HIV-negative persons- It is not possible to articulate the scale, scope, reach (areas to be served), or specific target populations of HE/RR programs in 2013-2016 until the ECHPP related RAND modeling and jurisdictional prevention planning activities are completed. However, preliminary findings indicate that behavioral risk screening followed by behavioral risk reduction interventions for high risk HIV-negative persons alone are unlikely to impact the transmission of HIV in LAC. Given the paucity of published evidence regarding the long term effectiveness of behavioral interventions and their relatively high cost, it is important for LAC to expand the prevention portfolio to include biomedical and co-factor interventions such as substance use treatment, mental health treatment, STD treatment, PS, housing services, stigma, and homophobia reduction efforts to effectively prevent forward transmission of HIV.

HIV-negative MSM, TG, and meth using MSM will be priority target populations in 2012. Community mobilization strategies such as SNT programs and POL interventions will be scaled-up to increase testing, reduce risk taking behaviors, and to reach the priority populations. Screening of HIV and other STDs is recommended at all points of care (e.g., substance addiction treatment, mental health treatment, primary care) for MSM, TG, and meth using MSM. OAPP is

currently researching ways to integrate behavioral interventions, health education, and biomedical interventions to create effective and innovative bio-behavioral interventions. For example, OAPP's Crystal Meth-PEP program includes STD screening, education, and intensive behavioral risk reduction counseling.

MSM who use meth will be able to access HE/RR services through redesigned, comprehensive risk screening and substance use treatment programs that address mental health issues that are concomitant with substance use and HIV risk.

Community evidence-based interventions

CLIs serving high risk HIV-negative individuals were solicited through the LAC DPH Request for Proposals process in 2008. A total of six contracts that provide services to Native American gay men and transgenders, Latino non-gay identified men, young women, and adult women will be in place through December 2012. A synopsis of information provided in contractor MOUs/MOAs is provided in table 7 (Appendix F).

Future directions for evidence-based CLI programs for HIV-negative persons- The extent of active outreach and condom distribution scale-up will depend on modeling activities and will be influenced by the extent to which condom availability and access is a barrier currently, the cost to saturate the zip codes where transmission is highest and when condom access is a problem, the potential reach and effectiveness of the strategy and the likelihood of success of this strategy given local community norms tied to condom use.

Procedure for identifying populations and communities at greatest risk for acquiring HIV to conduct outreach and condom distribution

All current HE/RR contracts have a line item in their budget for the purchase of condoms and the majority of HE/RR programs include outreach (distribution of educational materials

and/or safe sex kits including condoms) services as part of their scope of work. Although the location of the currently funded IDI and IDG interventions are based on the “hot spot” analysis and are not likely to change in 2012, outreach and condom distribution sites will be re-evaluated following the completion of the syndemic mapping activity. The results of the syndemic mapping activity will provide specific neighborhoods, blocks, or street intersections to target outreach and condom distribution activities (see *Condom Distribution* section, p. 26).

Assurance of appropriate service delivery

OAPP provides technical assistance, training, and closely monitors all funded contractors to ensure that services are culturally and linguistically appropriate for the target population. See *Program Planning, Monitoring and Evaluation, and Quality Assurance* section for a detailed description of quality management of provider services.

Syringe Services Programs

The City of LA has funded syringe exchange programs (SEPs) since 1998. However in 2000, the LAC Board of Supervisors (BOS) authorized County-funded SEPs under the provisions of AB 136. In LAC this process was initiated but eventually abandoned, as the proposed regulations on SEPs were considered to be too restrictive by existing service providers. LAC BOS revisited this issue in 2006 and approved less restrictive SEP regulations. OAPP played a large role in traversing the local bureaucratic barriers that existed leading up to the implementation of SEP's. In addition to the change in SEP regulations, LAC BOS also provided approximately \$500,000 to fund SEPs. LAC DPH and Los Angeles City will continue to support five SEPs or Syringe Services Programs (SSPs) in 2012. OAPP will not directly support SSPs in 2012, but staff will continue to be active in educating law enforcement and LAC policy makers on the importance of providing sterile injection paraphernalia.

Social Marketing, Media, and Mobilization

Social Marketing

In 2012 OAPP will have two social marketing campaigns running concurrently (Erase Doubt and LA Condom) and will improve LAC's HIV online services resource (HIVLA.org). OAPP will continue to partner with KCBS Marketing to update, manage, and promote the Erasedoubt.org website, develop marketing materials, and a media campaign for LAC's new condom distribution program. OAPP will enhance the Erase Doubt campaign by promoting PEP services for high risk priority populations, linkage to care for all individuals recently diagnosed or out of care, and the one million and one LA Condom campaign. The Erase Doubt campaign will also support targeted HIV testing events throughout the County, Spanish translation of media, and enhanced electronic linkages to bilingual services. Another critical social marketing activity in 2012 is the printing and dissemination of a Clinic Based Communication Strategy to help educate, train, and develop collateral materials for clinicians in South Los Angeles.

Support and promote social marketing campaigns targeted to relevant audiences, including the use of campaign materials developed and tested by CDC- OAPP supports and promotes local and national social marketing campaigns (See Appendix R). The local Erase Doubt social marketing campaign targets African-American and Latino MSM and their female partners through strategic placement of media and promotional events in highly impacted neighborhoods. Scaling up social marketing in these catchment areas is one of the few vehicles to reach HIV-positive persons out of care (e.g., bus ads, billboards, participation in community events that are not advertised as an event for HTS). Another strategy is the use of a viral marketing campaign (e.g., Facebook, You Tube, Twitter). These strategies or types of media technology were selected for their allowance of anonymity and their synergies with new technology.

Support and promote educational and information programs for the general population- OAPP's Erase Doubt social marketing campaign promotes educational programs and provides information for the general population in addition to targeted audiences. The Erasedoubt.org provides information on where to obtain testing and treatment for HIV, as well as events where HIV prevention activities occur (e.g., testing events, informational workshops, health fairs, etc.). The website hosts links to other informational sites, such as Greater than AIDS, Act Against AIDS, and HIVTest.org. And finally, Erasedoubt.org provides links to the State AIDS hotline and to local hotlines (i.e., 211 system for information on all County and health services, including HIV).

Detail and explain rationale for selecting health issues addressed in marketing campaign- The health issues that are addressed in the Erase Doubt marketing campaign are knowledge of HIV status, HIV testing, treatment, and care. The rationale for a pervasive focus on testing is the need to promote awareness and erase doubt about HIV status and ultimately reduce the 13,250 undiagnosed cases of HIV in LAC. The Erase Doubt campaign contains other HIV prevention messages such as Erase Doubt-know where to get tested and Erase Doubt-know your partner's status. Availability of treatment and care are also an important part of the messaging to reduce the annual number of new HIV infections by 25% and reduce the HIV transmission rate by 30%.

Media

Support and promote media technology for HIV prevention messaging to targeted populations and communities- OAPP uses media technology for HIV prevention messaging by maintaining a dedicated website (Erasedoubt.org), in both English and Spanish, where residents can go to get information on HIV and HIV services in the LAC area; building a viral marketing campaign to promote local events, provide quick facts about HIV in LAC, and interact with the community;

and by utilizing a smart phone dating application, Grindr, to promote the use of condoms and HIV testing. In 2012, OAPP plans to create an Erase Doubt HIV service search engine that will help find locations for every type of HIV service offered in LAC.

Community Mobilization

Encourage community mobilization to create an environment that supports HIV prevention-

OAPP will utilize 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 family, friends, and neighbors. The five main strategies that will be employed in 2012 are 1) engage community planning groups and coalitions to address community mobilization, 2) engage the MAC, 3) scale-up social marketing, 4) increase HIV awareness via faith based activities, and 5) increase HIV awareness via SNT and POL interventions.

Detail and explain rationale for community mobilization strategies- HIV prevention and care community planning is based on the principle that planning should be an open, candid, and participatory process in which differences in cultural, sexual, and ethnic background, perspective, and experience are essential and valued. Although the two main planning bodies, Prevention Planning Committee (PPC) and Commission on HIV (COH), are charged with planning, they provide a platform 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 will liaise with community members to provide educational forums to raise awareness regarding services, policies, new prevention and treatment interventions, and other critical topics.

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 services via the MAC. The MAC creates the opportunity to enhance HIV services and OAPP operations. In 2012, MAC will continue to advise OAPP in the development and implementation of HIV care and related quality assurance and management policies.

OAPP recognizes that institutions and communities of faith are trusted sources of information, mediators of social change and cultural norms, and influence 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 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.

Other community mobilization strategies that will aid in identifying the 13,250 undiagnosed cases of HIV are SNT and POL interventions. Both programs rely on peers or key opinion leaders to influence the behavior of others. OAPP currently funds one SNT program that serves gay and non-gay identified men who use meth. POL is an intervention that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. OAPP currently funds four POL programs targeting young and adult gay men. In 2012, OAPP plans to increase the number of SNT and POL programs. However the exact number, target population, and location of services cannot be determined until all modeling activities are concluded.

LAC is also currently assessing the influence and reach of various local community mobilization activities (see *Community Mobilization* section, p.36). Once this assessment is

complete (2011), OAPP will determine how best to invest limited human and financial resources. The broad aim of this strategy is to 1) challenge community norms, mores, stigma, homophobia, and transphobia especially in communities of color; 2) create an environment for open dialogue about sexual health; and 3) reduce barriers for utilization of HIV prevention and care services.

Social marketing campaign, media, and community mobilization strategies evaluation

Visibility, awareness, investment, and motivation to test are the primary evaluation measures for social marketing, media, and community mobilization strategies. Visibility will be measured by the frequency of website hits, time on the website, pages visited, and location of printed ads versus volume of traffic. OAPP will be able to track increase in web activity during a media push. Reports from media buys with online dating sites will be able to reveal if people are clicking through to check out the Erase Doubt website. Awareness will be measured throughout the year on various survey tools and risk assessments. Motivation to test as influenced by other social marketing, media, or community mobilization activities will be collected throughout the year in one-on-one interviews, focus groups, self-administered questionnaires/risk assessments, and internet based surveys. These data collection methods and monitoring of social media sites will also be used to measure acceptance of campaign/materials/events.

For the LA Condom Campaign, performance measures will include volume of condoms distributed, product popularity, and condom use. Data collection methods will include posting a survey on Erase Doubt website, entering condom distribution data into a database, conducting one-on-one interviews, and distributing a self-administered survey.

Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis Services

Pre-Exposure Prophylaxis (PrEP) for MSM populations at high risk for HIV

Currently OAPP does not support any PrEP programs in LAC. However, based on recent data²⁴ outlining the effectiveness of PrEP among MSM, OAPP's Medical Director, the MAC, local community planning groups, and other researchers are initiating discussions on possible public health service delivery models for PrEP. Preliminary assessments determined that clients who receive multiple nPEP interventions are ideal candidates for this intervention, but all other factors related to service provision are not developed. At this time, it is not possible to estimate when PrEP will be implemented in LAC or determine the scope of the program.

Non-Occupational post-Exposure Prophylaxis (nPEP) to populations at greatest risk

Biomedical interventions like nPEP are necessary for high risk groups who have not been successful in reducing their risk behaviors through traditional HIV prevention activities and programming. OAPP estimates the cost of a nPEP service delivery program to be approximately \$2,200/person if a two drug regimen is used.

Based on the success of a pilot nPEP project implemented by OAPP, in collaboration with UCLA and two HIV care clinics (LAGLC and Oasis Clinic), the nPEP pilot was transitioned into a service delivery program and implemented within one clinic site during ECHPP phase I. NPEP services to HIV- negative individuals at highest risk for sexual and intravenous exposure will be continued and scaled up with two additional healthcare settings in 2012 through ECHPP phase II. OAPP-funded PEP programs will collect the same process and outcome measures as IDI programs for HIV-negative persons (see pages 30-31). In addition, PEP programs will measure treatment adherence and seroconversion rates. OAPP is currently working on and will continue to develop a referral network for PEP service delivery, including the LAC sexual assault response team, community clinics serving patient populations with high rates of STDs and risk behavior, local EDs and Urgent Care Clinics, HIV providers, and

providers of services to MSM, meth using MSM, TG, and youth ages 18-24. OAPP must also identify a public health service delivery model for nPEP that is sustainable and integrated with other HIV prevention interventions.

Jurisdictional HIV Planning

As the jurisdiction with the second largest number of PLWHA in the U.S., LAC has been a pioneer in community planning since the beginning of the epidemic. Community engagement is central to the County's vision and approach in creating a comprehensive continuum of HIV prevention and care services to respond to the epidemic. Through active participation of community members including PLWHA, service providers, public health officials, government representatives, faith communities, and other stakeholders, LAC has established a system of HIV prevention and care services to reach a broad cross-section of its 9.8 million residents, including an estimated 61,700 PLWHA.

Plans to develop the jurisdictional HIV prevention plan

OAPP in collaboration with a consultant, the internal ECHPP workgroup, and the new HIV Prevention Planning Group (PPG) will develop and implement an engagement plan to create the new Jurisdictional HIV Prevention Plan (JHPP) that aligns with the NHAS. LAC's JHPP will be based on the current ECHPP plan and will include all required elements outlined in the PS12-1201 FOA guidance and the new Prevention Planning Guidance (release date pending). The new JHPP will also be a user friendly document that is a synthesis of all ECHPP documents (Workbook 1, Workbook 2, ECHPP at-a-glance, the ECHPP executive summary), and the findings from the RAND modeling activities and syndemic mapping analysis (see Appendix B and C). Upon receipt of the CDC Prevention Planning Guidance, LAC will begin restructuring the community planning body, develop an engagement plan, and develop a JHPP workplan. The

JHPP will be submitted to CDC with the PPG's letter of concurrence within six months after the start of the new funding cycle. Subsequently, a letter of concurrence will be provided to CDC on an annual basis.

Plans to facilitate a collaborative HIV prevention planning process

Group composition of HIV prevention planning group- The current composition of the PPC membership reflects the diversity and experiences of the HIV epidemic in LAC. The broad areas of expertise and perspectives brought to the table by PPC members have contributed to strategies put in place to reduce the number of new infections in LAC. Following the release of the new CDC Prevention Planning Guidance, OAPP will evaluate the current group composition and structure of the PPC and determine the best arrangement to carry out the new planning activities.

Proposed strategies that will increase coordination- The new PPG will retain and recruit individuals that represent local HDs (Long Beach, Pasadena, and LAC), Cities of West Hollywood and Los Angeles, State OA, research and academic institutions, public and private healthcare settings, and persons who are affected or impacted by HIV/AIDS to help coordinate HIV prevention activities within LAC. The collaboration and coordination between various State and local government representatives will provide opportunities to strategize and share data to implement efficient and effective prevention programs in LAC and across the State.

Ultimately, these efforts should result in making progress towards achieving NHAS goals by 2015.

Plans to ensure that the HIV Prevention Planning Group participates in the development of the Engagement Plan- The PPG in LAC will assist OAPP in the development of an Engagement Plan. The purpose of this plan is to identify strategies to increase coordination between prevention, care, and treatment services across State, local HDs, and tribal and local

governments and to reduce rates of new HIV infection and achieve NHAS goals. PPG participants will make recommendations regarding who should participate in the planning process, identify key partners, assist in developing engagement and retention strategies for previous and new prevention planning partners, provide recommendations on the prioritization of engagement activities, assist in the creation of the implementation plan, and evaluate the engagement process.

Capacity Building and Technical Assistance

Plans to conduct or update the capacity building needs assessment

As part of ECHPP, OAPP is collaborating with other LAC DPH partners, and RAND Corporation researchers on several modeling activities (see Appendix C) to determine the optimal use of prevention strategies to achieve the highest impact in addressing the NHAS goals and objectives. The results from the modeling activities will be used to help inform the scope and direction of LAC's prevention portfolio and identify any service gaps. OAPP will engage the PPG and use the results to: determine what services are needed, which prevention activities to scale-up, what populations should be targeted, where services should be provided, staffing resources needed to provide services, staffing resources to monitor and evaluate service provision, capacity building needs for service providers and HD staff, how to effectively coordinate services, what systems and processes need to be developed, what structural challenges need to be addressed, and to determine what collaborations and partnerships need to be formed. OAPP will collect additional information through key informant interviews, surveys, or focus groups. Once LAC's capacity building needs are identified, OAPP will develop a capacity building and training plan and will conduct "Plan, Do, Study, Act" activities to ensure continuous quality improvement.

Plans to provide or collaborate with partners within or external to the health department to offer capacity building assistance

OAPP will continue to collaborate with CDC's directly-funded capacity building assistance (CBA) providers; local academic and research institutions (RAND, USC, UCLA's Center for HIV Identification, Prevention and Treatment Services (CHIPTS)); AIDS Education Training Center (AETC); other DPH programs (i.e., HEP, LAC GIS users group); and consultants to meet the capacity building needs of OAPP-funded providers, PPG, and HD staff. Appendix R provides an overview of potential capacity building/technical assistance needs, capacity/technical assistance providers, topic areas, and tracking process/data sources.

Training plan for Health Department staff

OAPP will develop a training plan based on the results of the modeling exercise and capacity building needs assessment to ensure that staff is properly trained to provide direct or support services to one or more required or recommended activities under CDC PS12-1201. Preliminary training activities for HD staff are listed in Appendix S.

Identification and provision of training and technical assistance for providers and staff (HD, participating healthcare facilities, CBOs, or other service organizations)

Preliminary training activities for HD, participating healthcare facilities, CBOs, or other service organizations staff are listed in Appendix S. Description of activities to identify training needs is provided in the *Plans to conduct or update the capacity building needs assessment* section (p. 43). CBA and technical assistance are provided to individuals and groups in many different formats (i.e., in class training, one-on-one technical assistance sessions, email helpdesk, warmline, manuals and templates, and web-based training courses).

Tracking process for training and technical assistance activities

Data sources and processes for tracking training and technical assistance activities are provided in Appendix S.

Plans to facilitate exchange of information and peer-to-peer consultation and technical assistance among service providers

OAPP will convene bi-annual meetings with agencies funded under this FOA to facilitate exchange of information and peer to peer consultation among sites, and address any other issues for each required and recommended activity. Additionally, OAPP will continue to collaborate with medical administrators/providers who request assistance to implement routine HIV screening and/or to transition to a rapid testing model by conducting a series of planning meetings. These meetings will address strategies and specific objectives and activities to integrate routine HTS into the facility's current clinic flow consistent with the CDC's 2006 recommendations for HIV testing in healthcare settings.

C. Program Planning, Monitoring and Evaluation, and Quality Assurance

Current Epidemiologic and Surveillance Data for Program Planning and Evaluation

Access to real-time surveillance, testing, care, and laboratory data is critical to effectively target interventions and allocate resources that will reduce HIV transmission to individuals at highest risk. OAPP is currently working towards implementing the use of HIV and STD surveillance data for PS as outlined in CDC's 2008 Partner Services guidance and in accordance with AB 2541, as well as utilizing surveillance data to identify and track linkage to care for out of care populations, measure community viral load, identify sexual networks, and identify highly impacted areas. NHBS data in conjunction with testing, HE\RR, STD surveillance, and data from annual risk assessments will provide valuable information on emerging populations, risk behaviors, co-factors of HIV disease, awareness of HIV services, and barriers to service

utilization. Current epidemiologic and surveillance data will be used to measure and evaluate progress towards OAPP performance targets, NHAS goals, provision of services to target populations, service utilization, service effectiveness, gaps in services, and identify training and capacity building needs.

OAPP will ascertain where to focus efforts to make the largest impact with available resources using syndemic planning. Syndemic planning is rooted in examining the connections between health-related problems and offers a broader framework for understanding how multiple health problems interact in particular settings²⁵. This model utilizes population based data such as census and HIV/STD surveillance data, and other epidemiologic data (i.e., addiction, mental illness, poverty, homelessness, hepatitis B and C, meth use). Various statistical tests can be used to identify and measure the strength of the connections between diseases and co-factors. OAPP uses geospatial analysis as an effective tool for identifying areas in the County that have the highest disease burden (see Appendix B). OAPP has made the use of geospatial analysis a core component of planning and evaluating HIV and STD services and plans to significantly expand these efforts to include mapping community viral load (see Appendix B). Starting in 2012, OAPP will house a new geographic information systems (GIS) unit that will consist of a GIS coordinator and two GIS analysts.

Cities/MSAs with at least 30% of the HIV epidemic in Los Angeles County- As previously indicated in the *Background and Need* section (pages 1-7), only SPA 4 comprises at least 30% of the HIV epidemic (based on living cases of HIV/AIDS) in LAC. In 2012, GIS staff will continue to analyze HIV and STD surveillance data to determine if 1) new infection clusters vary from prevalent case clusters, and 2) if any prevalent clusters contain at least 30% of the HIV

epidemic. All clusters with at least 30% of the HIV epidemic will be reported to CDC as required.

Coordinated data collection and reporting to state and local surveillance programs for incidence and surveillance efforts- Strategies and protocols to facilitate coordinated data collection, matching, and reporting are currently being implemented. OAPP has recently revised HTS data collection forms to include all required fields for HIV case reporting and partner elicitation. All HIV-positive cases identified by an OAPP-funded contractor must be reported within a 72 hour period. This streamlined process will help ensure that the reporting of data to state and local surveillance programs is expeditious. In addition, OAPP and HEP will continue to conduct semi-annual data matches between HIV testing, HIV care services, and the HIV surveillance data to ensure accurate reporting of HIV cases.

California HIV reporting laws require labs and other health care facilities to report all CD4 count test results and HIV viral load tests to the local health officer within seven days of the completion of the 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. This also enables LAC DPH to continuously monitor trends and rates of new infections within communities across LAC. All OAPP-funded HIV prevention and care contractors including LAC PHL receive an annual monitoring site visit which includes review of HIV documentation for accuracy of data entry.

Collaboration with local NHBS staff to assess exposure to, utilization of, and effect of HIV prevention programs- LAC has been an NHBS site since 2003. HEP staff are responsible for implementing the national standardized survey on an annual basis. In sequential years, one of three rotating target populations (MSM, IDU, and heterosexuals) are surveyed between July and

November. MSM are being surveyed in 2011; IDU in 2012; and heterosexuals in 2013. This cycle will repeat in 2014-2016. NHBS data have been highlighted in the current HIV Epidemiologic Profile (see Appendix T), used to develop the 2009-2013 HIV Prevention Plan and ECHPP response, and are currently used in the RAND modeling activities.

OAPP will collaborate with HEP's staff to identify the variables that measure access or exposure to, utilization of, and effect of HIV prevention programs. OAPP and HEP staff will develop a data analysis plan to identify populations at high risk of HIV transmission; effective and ineffective prevention and care interventions; emerging issues and changes in the epidemic; estimate the prevalence of hepatitis B and C infection; and measure the strength of association between co-factors, co-morbidities, hepatitis, STDs, and HIV. By the end of the five year PS12-1201 grant period, data will have been collected at two additional time points for each population since 2008, which will provide an opportunity to conduct a trend analysis for three survey periods per population. The trend analysis will estimate whether there have been temporal changes in any of the variables or factors of interest. If changes are identified, OAPP will be able to realign prevention and care resources to ensure that NHAS goals are achieved.

Brief Program Description with Program Goals and Objectives

The developed goals and SMART objectives are provided in Appendix H.

Brief Description for Data Collection, Entry, Management, and Submission; Procedures for Data Security and Confidentiality; and Ability to Collect and Submit Data for Performance Measures

As described in the *HIV Testing* section and Appendix I, beginning July 2011, OAPP migrated from the HIRS data collection system to the HTS data system. HTS includes two primary data collection modalities. Providers who have electronic medical records (EMR) enter data directly into their EMR and electronically transfer their data to OAPP. Providers who do

not have an EMR collect data on standardized hard copy forms, scan at the provider site (see figure 2, Appendix F), and electronically transfer data to OAPP where data are read using Teleform scanning software. About 40% of all HIV tests are collected using an EMR. All data are submitted electronically over secure file transfer protocol (SFTP) using secure socket layering (SSL) authentication as well as 256-bit encryption of both the data and the transfer session. All HTS data must be entered or received by OAPP Research & Evaluation staff (data management team) within seven days from the test date and all forms for HIV-positive cases must be reported to OAPP within 72 hours from the test date. HE/RR data are submitted to OAPP on a monthly basis. All HTS required data will be exported to CDC as XML files. Client-level non-CT (non-HTS) data will be entered into CPEMS by HE/RR providers and all other non-HTS data will be entered by OAPP staff. Descriptive data and summary statistics will be included in APR and IPR reports and submitted as required by CDC.

OAPP employs a comprehensive data QA protocol to ensure that the most accurate and valid data are obtained from contracted programs. This plan includes data verification and validation procedures and is outlined in figure 2 (Appendix F).

Data verification procedures include automated validation checks of data elements including the identification of missing or inaccurate data. Data verification begins once OAPP receives the data or after the data are scanned on-site. In addition to data verification, a random sample of data records will be selected for data validation. This validation includes matching and checking for discrepancies between data within the database record to the original data collection form.

To support OAPP's data driven planning process a data management and a data analysis team will be created in 2012. The data management team will consist of a data manager who will be responsible for overall data processing, conversion, and reporting/submitting data to

CDC. Data processors and research analysts with the primary responsibility of cleaning, constructing datasets, and generating standard reports will also be a part of the data management team. Research analysts and epidemiologists in the data analysis team will be responsible for conducting specific analysis to inform program planning and special studies. For example, one data analyst will focus solely on analyzing match data from multiple data sources including HIV surveillance data for the purposes of informing TLC+ program activities described in this application.

Data security and client confidentiality are critical components of program monitoring and quality assurance. Security measures include: Password-protected data entry applications, data encryption, SSL and SFTP for secure data transmission, limited access to data, and regular monitoring and quality assurance checks. OAPP will adhere to CDC's Data Security and Confidentiality protocol and will follow the Rules of Behavior for Data Systems. Within six months after the start of the project period, OAPP will submit signed copies of the Assurance of Confidentiality, Memorandum of Understanding-CPEMS System Administrator, Memorandum of Understanding-Non-CPEMS System Administrator, and Rules of Behavior for Data Systems.

OAPP has both the capacity to collect and report required performance measures. To date, OAPP is compliant with submitting all federal and State data. OAPP will submit all required performance measures and program indicators as requested by CDC.

Plans to Develop the Comprehensive Program Plan

Within six months after the start of the project period (January 1, 2012), OAPP will submit a comprehensive program plan. This plan will include the following: 1) Program Description that outlines the annual and five year program goals for each required core component and activity, annual and five-year targets for assuring that newly diagnosed HIV-

positive persons are linked to medical care within three months of diagnosis, proposed annual and five-year targets for assuring that newly diagnosed HIV-positive persons are referred to and provided with PS within three months of diagnosis, description of the activities that will be conducted to meet the objectives, and capacity building needs; 2) Monitoring & Evaluation (M&E) Plan that describes a program monitoring and evaluation, qualitative and quantitative measures, description of data systems, and procedures in place for data security and confidentiality; and 3) QA Plan that outlines the QA measures to improve program quality and accountability, describes processes to ensure services are provided in a technically competent manner, describes services that are culturally and linguistically appropriate and that staff are trained accordingly, describes staff training, proper reporting of test results, appropriate laboratory QA procedures, and that QA policies and procedures are available and accessible to all staff working at OAPP.

D. Staffing and Management

The Management and Staffing Plan is provided in Appendix U.

Appendix A: Social Determinants of Health

Homelessness

Los Angeles City and County have the highest homeless count of any major U.S. city or county (Homeless Counts, National Alliance to End Homelessness, January 2009). The 2009 Greater Los Angeles Homeless Count projected an annual estimate of 96,169 homeless in Los Angeles County (LAC). African-Americans represented the largest racial group of the homeless population (47%), followed by Latino(a)s (29%), Whites (21%), and Native Americans (2%). Twenty-four percent of LAC's homeless were chronically homeless, 2% had HIV/AIDS, 24% were mentally ill, 41% had a substance abuse disorder, 2% were youth, 15% were veterans, and 9% were victims of domestic violence¹. In LAC, homelessness also disproportionately affects Persons living with HIV or AIDS (PLWHA). Homeless individuals represent less than 1% of the County's population, but account for 10% of the diagnosed cases of HIV/AIDS. Estimated HIV seroprevalence for this population is 3.5 times greater than the overall seroprevalence in the County (1.0%).

Low socioeconomic status

Low socioeconomic status is a powerful determinant of individual risk for HIV infection, mental health, substance addiction, health care access, and poor health outcomes. Poverty is particularly associated with increased morbidity and premature mortality. Unemployment, poverty, and illiteracy are correlated with poor access to health education, preventive services, and medical care resulting in an increased risk for HIV infection and faster progression to AIDS. Twenty-one percent of LAC residents lived below federal poverty level (FPL) compared to the state-wide rate of 16%². Nearly 55% of LAC residents lived at or below 300% FPL.

Substance Addiction

Unlike other parts of the country, the connection between substance use and HIV in LAC centers on unsafe sex while under the influence of alcohol or other drugs, rather than needle sharing. Substance abuse interferes with both adherence to medication regimens and treatment efficacy. Crystal methamphetamine (meth) was the most frequently reported primary drug used among all persons admitted to drug treatment in LAC followed by cocaine/crack³.

Mental Illness

Mental illness can affect the progression of HIV disease, medication adherence, and the likelihood of engaging in high-risk behaviors that may result in HIV transmission. The 2007 CHIS (California Health Interview Survey) found that 10.3% of LAC respondents saw a healthcare provider for emotional/mental health issues in the last 12 months. Twenty-seven percent of Ryan White (RW) clients receiving services in FY 2009 reported a recent history of mental illness.

Multiple Co-factors

Research findings and local data support the strong correlation between HIV incidence, HIV viral load, high sexual risk, and sexually transmitted diseases (STDs). Approximately 25% of all HIV-positive tests conducted at an OAPP HIV testing site came from a public health STD clinic⁴. Twenty-eight percent of the clients who accepted an HIV test through partner services (PS) were newly diagnosed⁵. In 2009, 7% of gonorrhea and 39.5% of syphilis cases were co-infected with HIV⁶. However, it is highly likely that the number of cases is underreported. STD data must be matched with HIV surveillance data to measure the true proportion of co-infection. PLWHA who have co-morbid illnesses had poorer access to primary medical care compared to the general population. Only 69% of PLWHA who indicated using substances and reported

mental health problems in 2009 received medical outpatient care compared to 80% of RW clients without addiction issues or mental illnesses.

¹ Inter-University Consortium Against Homelessness. Ending Homelessness in Los Angeles. January 2007. Available at: <http://www.unitedwayla.org/getinformed/rr/research/basic/Pages/Ending.aspx> .

² CHIS 2007

³ Substance Abuse Prevention and Control, Los Angeles County Department of Public Health. Fact Sheet: Drug Use and Misuse in Los Angeles County.

⁴ Office of AIDS Programs and Policy, Los Angeles County Department of Public Health, HIV Counseling and Testing Annual Report 2009, 2010: 1-53.

⁵ LAC 2010 PS10-1001 Annual Progress Report FY 2010

⁶ Janson M. et. al. Enhancing Comprehensive HIV Prevention Planning A Syndemic Spatial Analysis of HIV and STI Burden Presentation at the 2011 National HIV Prevention Conference; August 16, 2011.

Appendix B: Re-assessing the HIV Epidemic in Los Angeles County: A Syndemic Approach

The Office of AIDS Programs and Policy (OAPP) in collaboration with Los Angeles County, Department of Public Health (DPH), HIV Epidemiology Program (HEP), and the local prevention planning group recognized the importance of behavior, identity, and geography in identifying the priority populations, types of interventions/testing modalities, and “hot spot” or highly impacted geographic areas for the 2009-2013 HIV Prevention Plan. In determining which of these factors would serve as the primary lens through which Los Angeles County (LAC) would view its epidemic, five key questions were discussed¹.

1. “Who are the populations at risk for HIV/AIDS?”
2. “What are the behaviors that put an individual at risk?”
3. “What are the cofactors that heighten a person’s risk for HIV/AIDS?”
4. “Where are the people at risk for HIV/AIDS (i.e., live, work, play, seek services)?”
5. “How do identity issues influence a person’s perception of risk, actual risk for HIV, and access to prevention and testing services?”

In 2007, LAC HIV prevention planners wanted to use robust, valid population-based data upon which to make evidence-based decisions. However at that time, the uses of surveillance data and data sharing were limited. For example, transgender identity or gender was not captured in a majority of population-based datasets including surveillance. HIV names based reporting was only recently adopted and the HIV surveillance system was still in its infancy stage and reliable (stable and complete) data were unavailable. Routine screening of hepatitis, tuberculosis (TB), addiction, mental health disorders, and sexually transmitted infections (STIs) was not conducted at all publicly-funded service sites and across LAC DPH programs. Thus it was difficult to measure the association between co-morbidities.

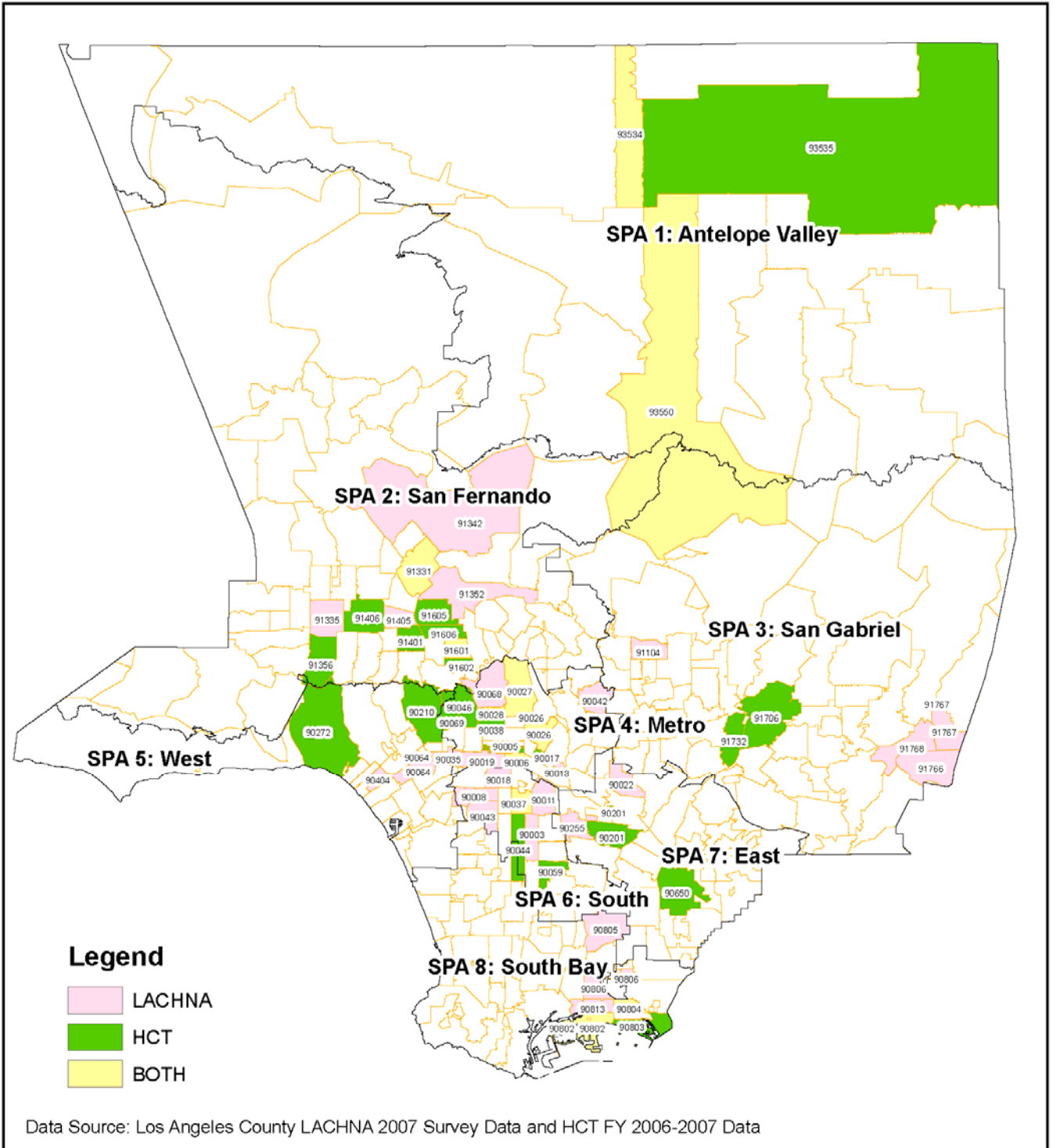
Despite these challenges, LAC prevention planners utilized four primary data sources for the 2009-2013 planning model. Data sources included: AIDS surveillance data, OAPP counseling and testing data, STD surveillance data, and a local needs assessment (Los Angeles Coordinated HIV Needs Assessment). The following factors were used to develop the planning model²:

1. AIDS Incidence
2. AIDS Prevalence
3. HIV Incidence Estimates
4. Estimated Population Size (potential target populations)
5. Gonorrhea, Chlamydia, and Primary and Secondary Syphilis rates
6. Substance Use Rates
7. Inconsistent Condom Use
8. Use of methamphetamine, crack, cocaine, or heroin
9. Sex Exchange: exchanged sex for money, drugs, or to meet some other need
10. Resident Zip Code of high-risk negative LACHNA participants
11. Resident Zip Code of HIV-positive OAPP counseling and testing clients

The first geographic assessment of HIV risk and service needs was conducted for the 2009-2013 HIV Prevention Plan. This analysis was based on the prevalence of high risk behavior and HIV status. Frequency counts were assessed rather than rates by zip code because it is difficult to estimate the size of the high risk population in each given geographic area. However the first “hot spot” map

identifying high-risk areas in LAC by zip code (see figure 1) was a good starting point to understand where target populations live and where some HIV prevention services may be directed³.

Figure 1. High-Risk Areas in Los Angeles County by Zip Code



Although the 2009-2013 HIV planning model is not referenced as a syndemic planning model, the HIV prevention planners did examine connections between health-related problems thus utilizing a syndemic orientation.

Syndemic planning is rooted in examining the connections between health-related problems and it offers a broader framework for understanding how multiple health problems interact in particular settings⁴. OAPP needed to re-assess where it should focus efforts to make the largest impact with available resources. Beginning in 2010, a syndemic planning model was used to focus on connections among cofactors of disease. These connections will then be considered when prioritizing and targeting future HIV prevention services in LAC. This planning model also aligns with other avenues of social change to assure the conditions in which all people can be healthy. The syndemic planning model utilizes population based data such as HIV/STD surveillance, census, and other epidemiologic data (i.e., addiction, mental illness, poverty, homelessness, hepatitis B and C, meth use). Various statistical tests can be used to identify and measure the strength of the connections between diseases and co-factors and OAPP uses geospatial analysis to investigate the distribution of multiple co-occurring epidemics. DPH has historically prioritized and provided services over its 4,000 square mile jurisdiction through SPAs. However, disease burden geographical differences are not explained by SPA boundaries and the variation of disease burden within a given SPA can be dramatic. Data sharing with DPH HIV Epidemiology, Sexually Transmitted Diseases Programs (STDP), and OAPP provided an opportunity to examine disease burden without regard to arbitrary boundaries.

Beginning in 2011, OAPP used syndemic geospatial analysis to analyze spatial relationships between multiple co-occurring epidemics in HIV, syphilis, and gonorrhea. In order to assess spatial distributions of HIV and STD cases the Average Nearest Neighbor (ANN) statistic was used. The ANN calculates actual mean distance between cases and compares that mean to a hypothetical random distribution. If the ANN (z-score) is statistically significant ($p \leq 0.1$) then the spatial distribution of cases could not be explained by random chance, and a cluster effect truly exists. Once it was determined that HIV and STD cases are clustered and that the clusters cannot be explained by chance, Nearest Neighbor Hierarchical Clustering (Nnh)⁵ analysis was performed to describe the variation in spatial data and exact geographic location of the clusters.

Using case data with address information that could be geo-coded to the exact location, the following table and figures show the syndemic cluster analysis for newly identified HIV cases, syphilis and gonorrhea infections (2009 data). Additional geospatial analysis will be conducted with prevalent cases as well as new infections for recent years to compare differences and identify trends.

Table 1. 2009 HIV, syphilis, and gonorrhea infection geo-coded data used in the syndemic data analysis.

Data Source	N
Newly identified HIV Cases	1,858
Syphilis	2,641
Gonorrhea	7,198

Figure 2 shows five distinct clusters identified within the County. These five clusters represent 82.3% of all newly identified HIV cases (2009 HIV Surveillance Data) within LAC. Table 2 shows the disease burden within each cluster, and figure 3 depicts the layering of HIV and STI clusters.

Figure 2: Cluster Areas, Los Angeles County, 2011

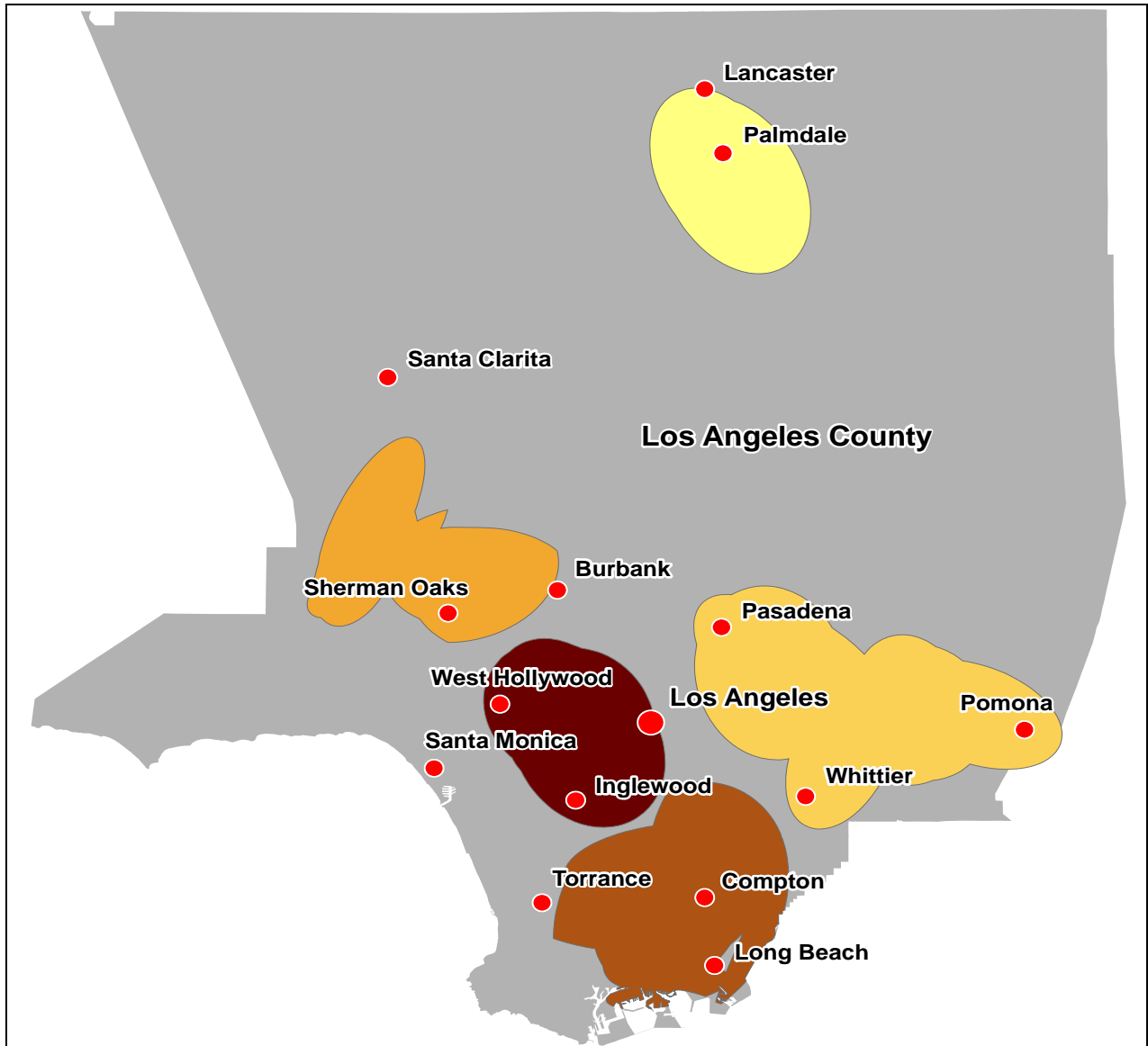


Table 2. Disease Burden within the Five Syndemic Clusters (2009)

Disease Burden Cluster Location					
	Central	South	Northwest	East	North
	N %	N %	N %	N %	N %
Newly Identified HIV Cases	861 46.3%	318 18.4%	159 9.2%	114 6.6%	22 1.3%
Syphilis + HIV	642 58.5%	94 9.0%	90 8.6%	61 5.8%	<5 -%
Syphilis no HIV	712 44.6%	222 13.9%	191 12.0%	118 7.4%	14 1.0%
Gonorrhea	3,330 42.1%	1,613 20.4%	637 8.0%	439 5.5%	237 3.0%

Data source: 2009 HIV Surveillance and 2009 STD surveillance data

Figure 3: Nearest Neighbor Hierarchical Clustering Summary

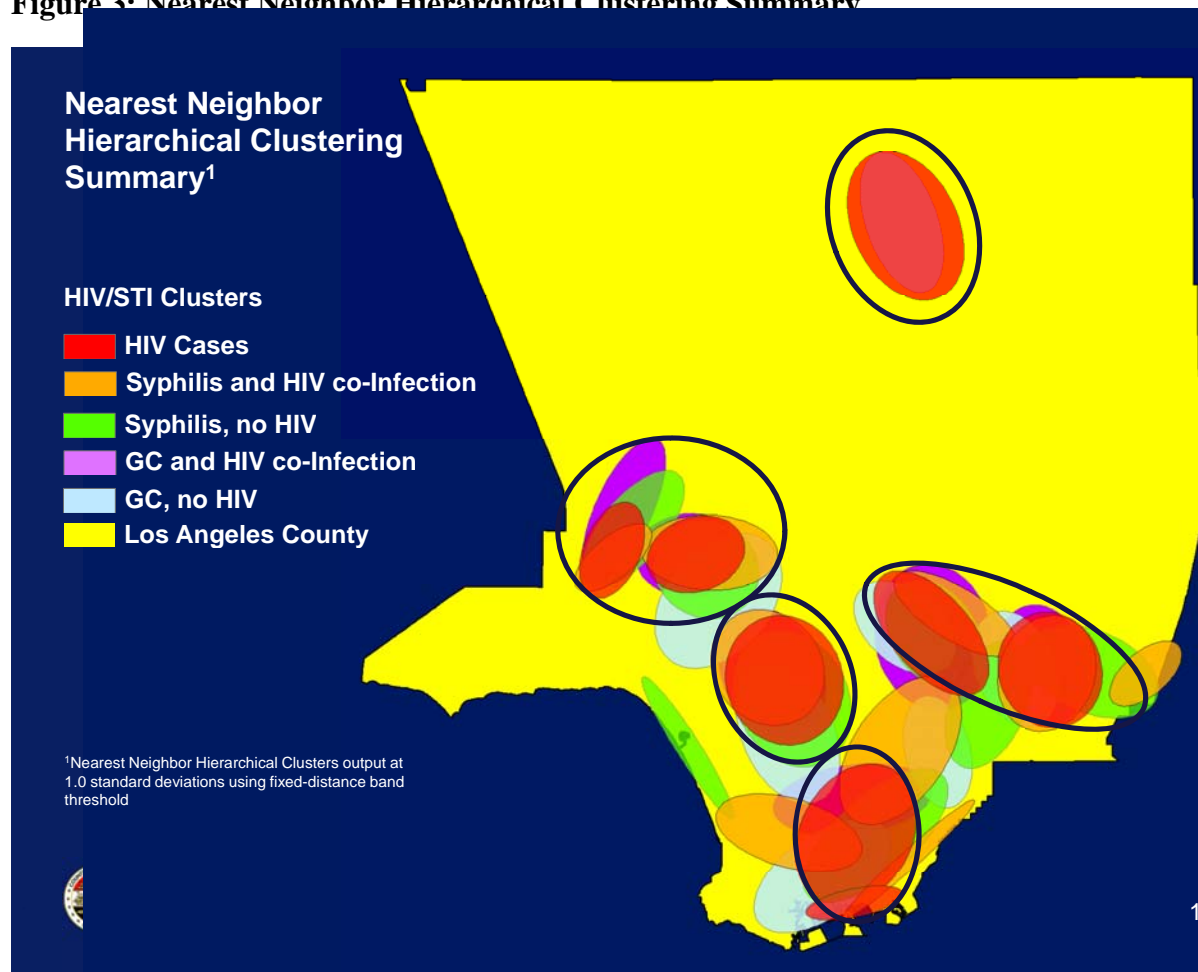


Figure 4 provides an overall perspective of current HIV Testing Services (HTS) in the County with respect to the five cluster areas⁶. Figures 5 – 9 provide a view of current HTS available within each of the cluster areas (central, south, northwest, east, and north).

Figure 4: HIV Services and Five Cluster Areas, Los Angeles County, 2011

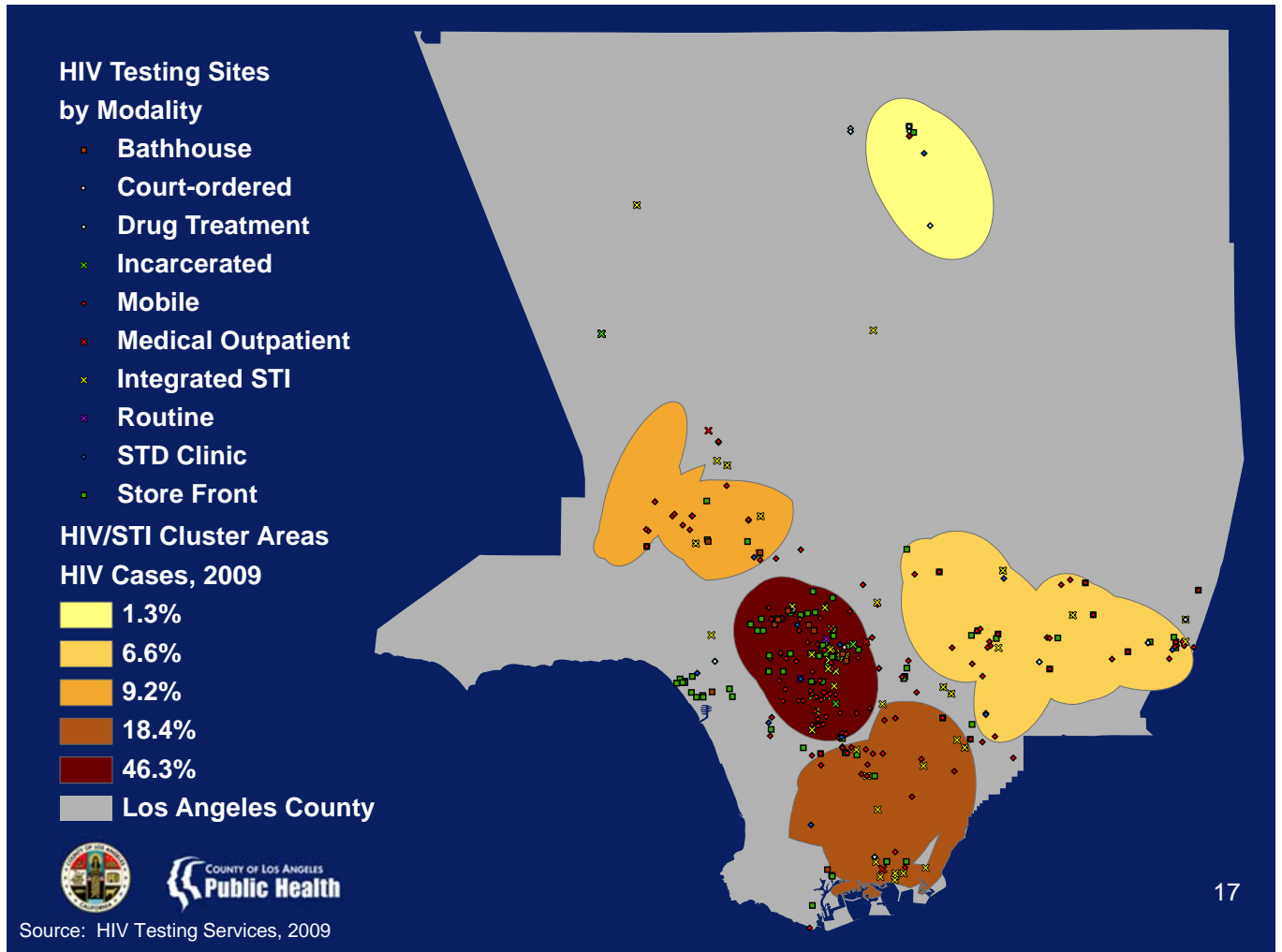


Figure 5:

Central Cluster Area and HIV Services, Los Angeles County, 2011

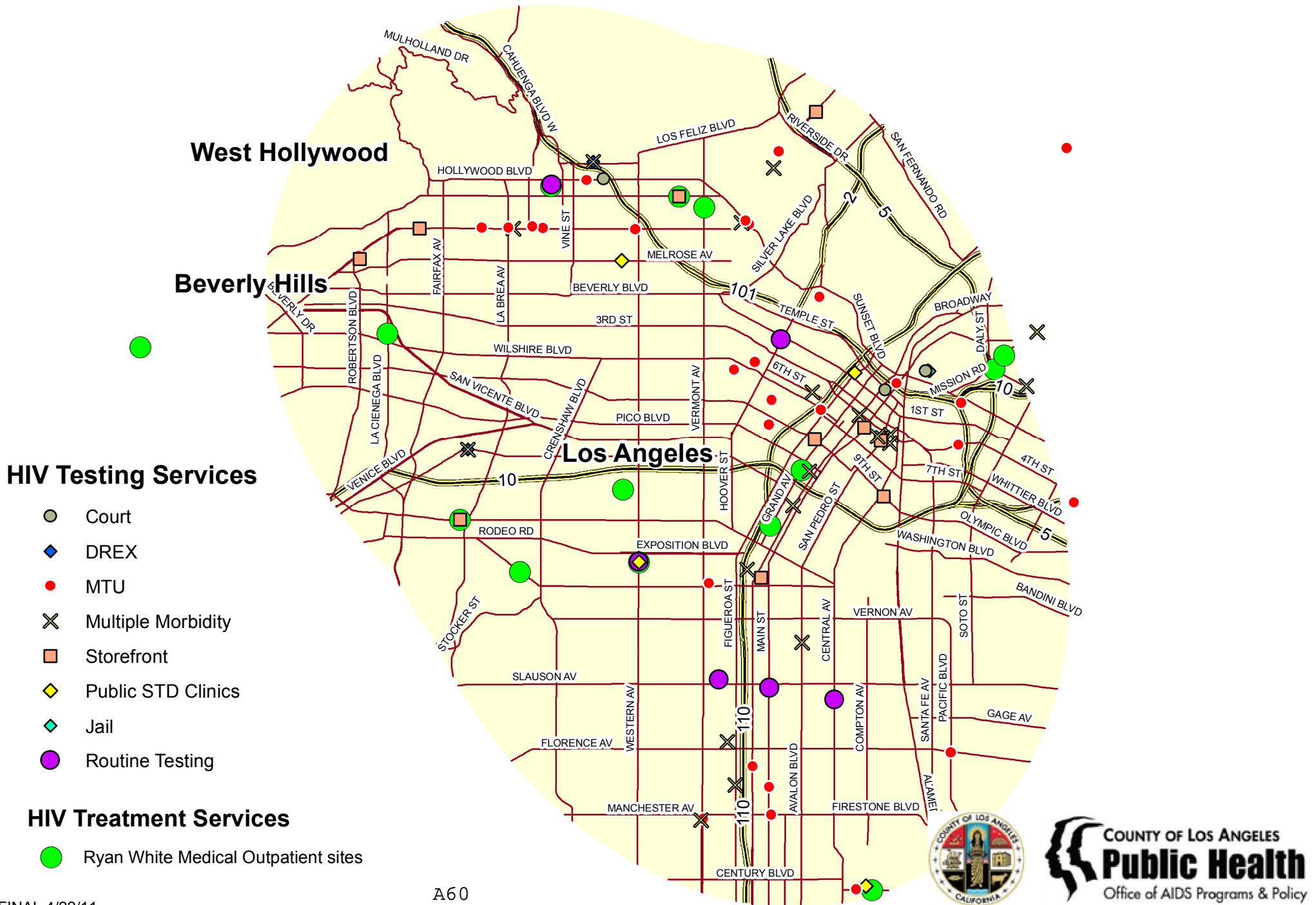


Figure 6:

South Cluster Area and HIV Services, Los Angeles County, 2011

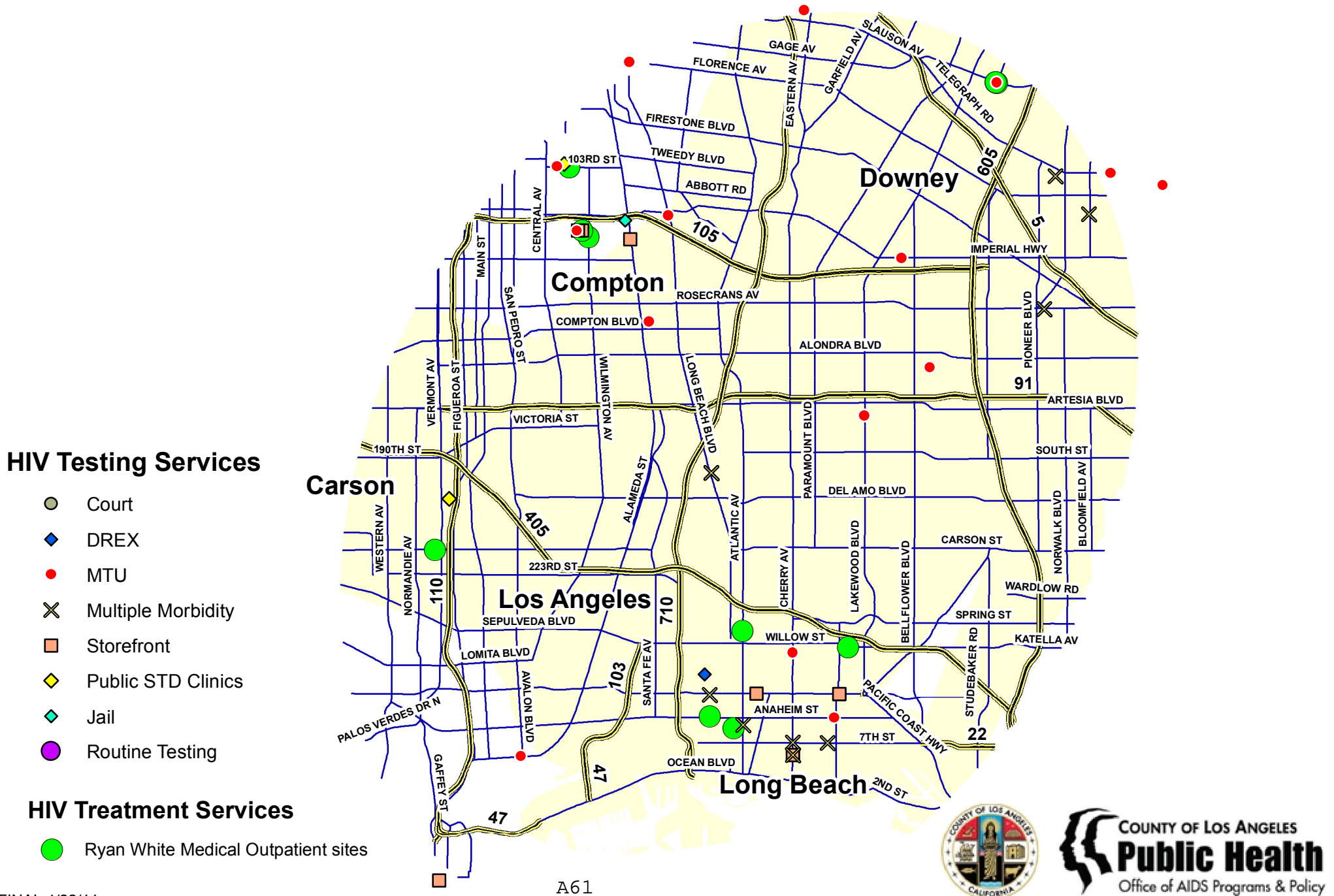


Figure 7:

Northwest Cluster Area and HIV Services, Los Angeles County, 2011

HIV Testing Services

- Court
- ◆ DREX
- MTU
- ✕ Multiple Morbidity
- Storefront
- ◆ Public STD Clinics
- ◆ Jail
- Routine Testing

HIV Treatment Services

- Ryan White Medical Outpatient sites

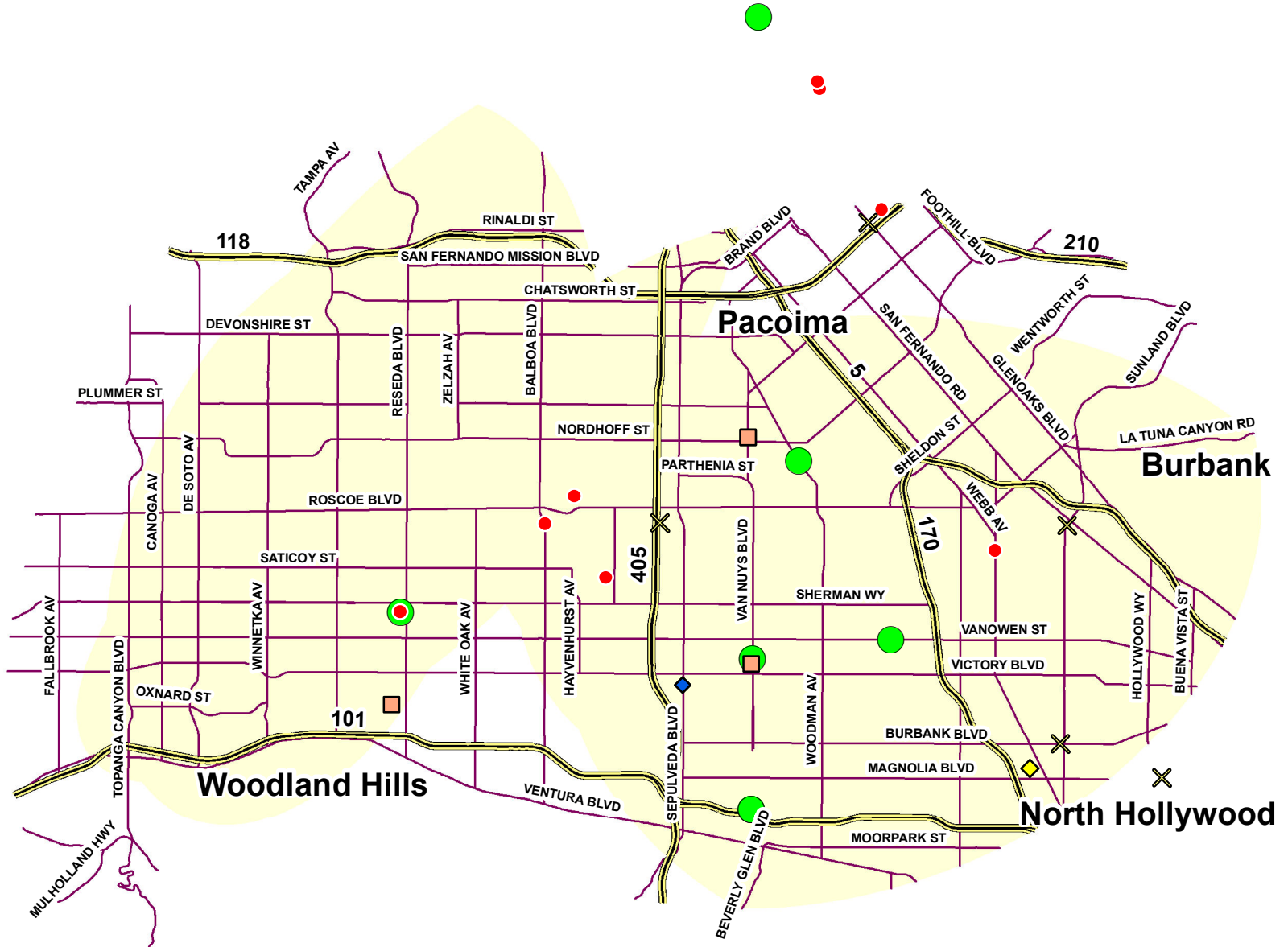


Figure 8:

East Cluster Area and HIV Services, Los Angeles County, 2011

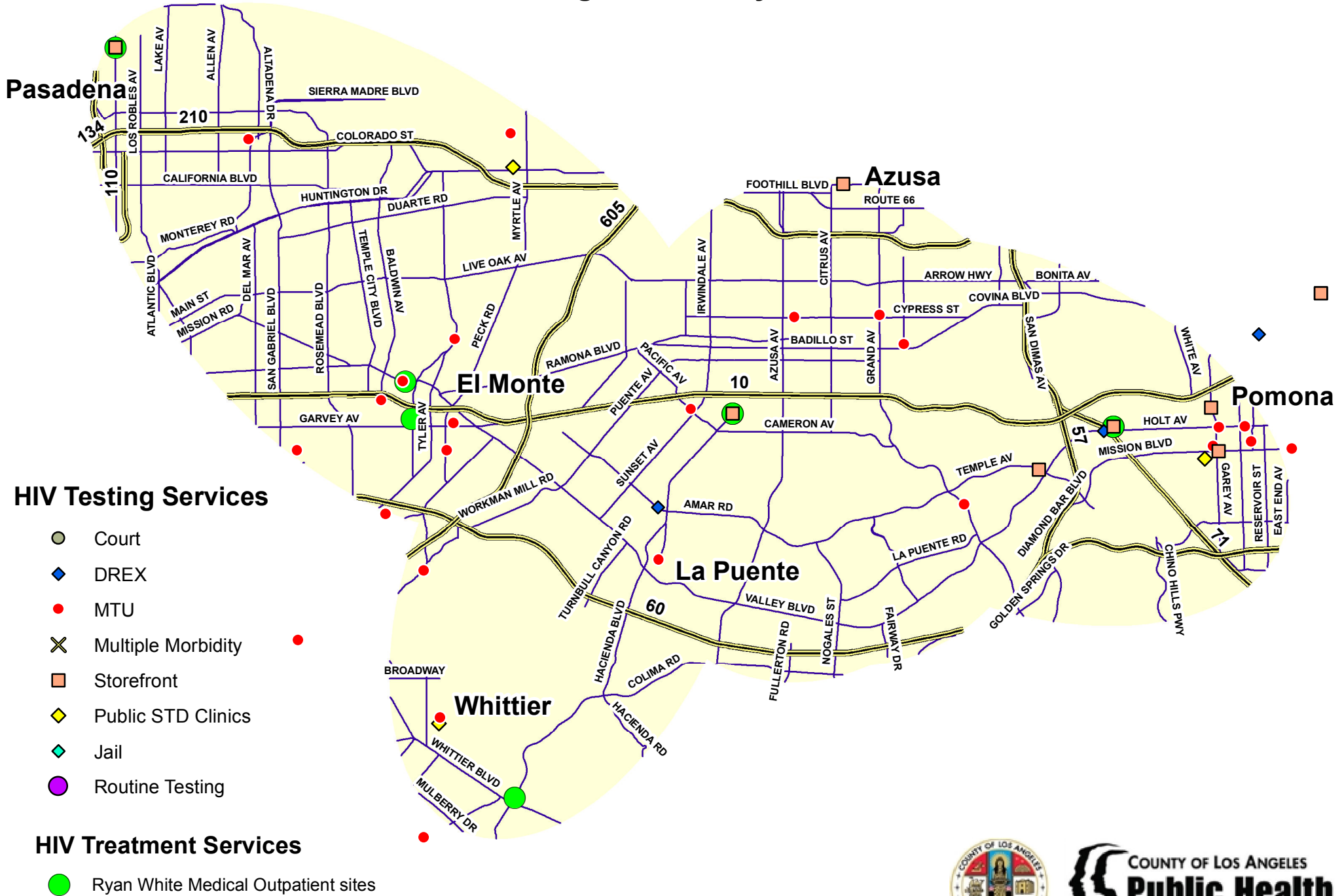
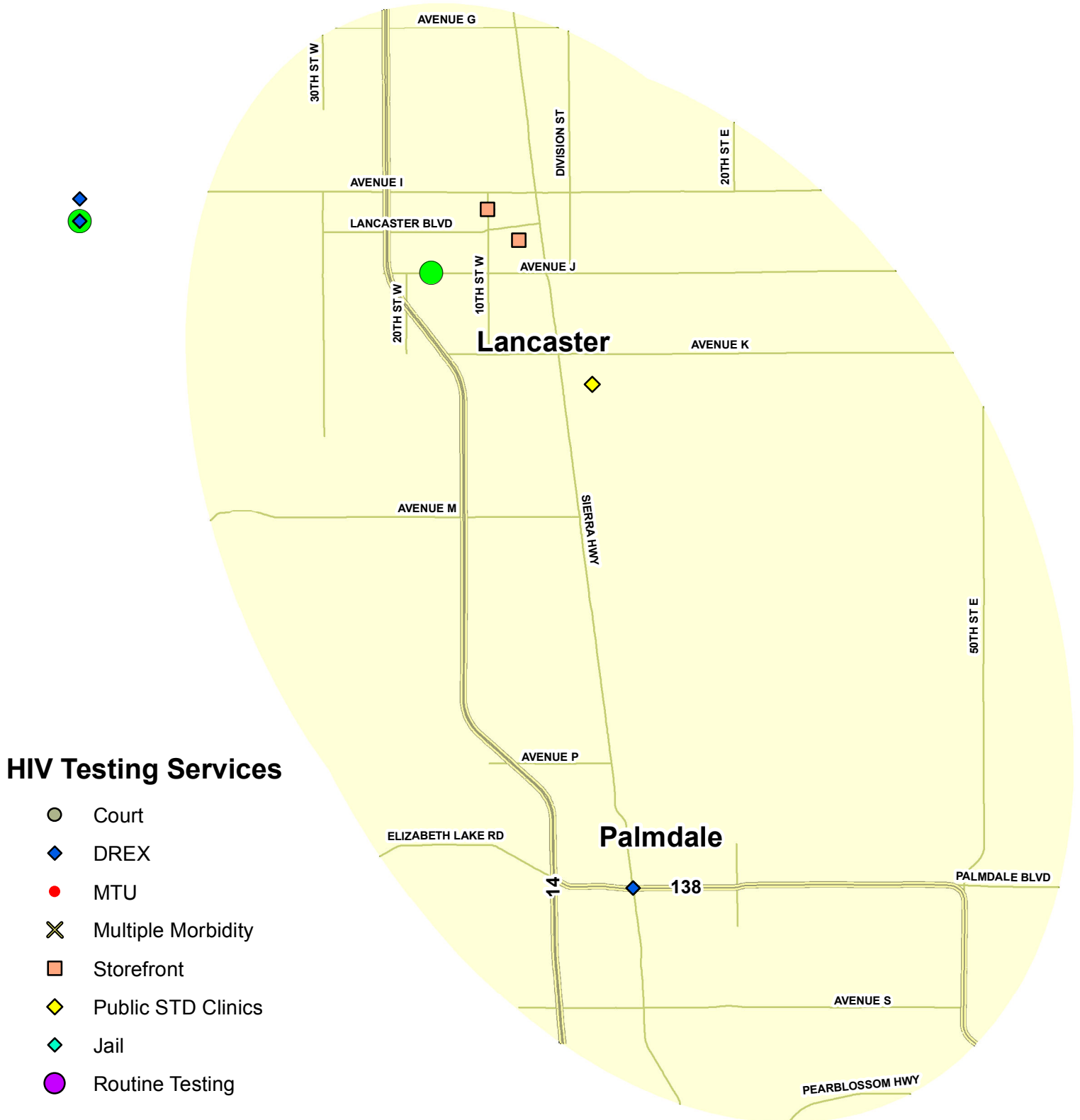


Figure 9:

North Cluster Area and HIV Services, Los Angeles County, 2011



Preliminary Conclusions

Newly diagnosed cases of HIV are statistically significantly ($p < 0.01$) distributed in clusters within LAC. This is also true of syphilis and gonorrhea/Chlamydia (GC) cases. The five cluster groups represent more than 80% of all HIV/STI cases and less than 33% of LAC land area. Central and south cluster have the highest HIV disease burden in the County (46.3% and 18.4% of all HIV cases respectively). Based on the preliminary analysis of these co-occurring epidemics, current HIV testing resources are mostly in line with HIV/STI syndemic with the exception of the south cluster where the proportion of testing effort was less than the proportion disease burden. However, there were some limitations such as an undercount of co-infection due to unmatched surveillance data and data do not fully include homeless populations.

Syndemic planning through the use of geospatial analysis is a powerful tool for prioritizing and identifying the most highly impacted areas. It has the capacity to map disease burden block-by-block and identify single- or multi-level clusters (clusters within clusters). This analysis included the largest-level clusters. Future syndemic geospatial analyses will include prevalence cases, multi-year data to assess trends, and community viral load. Additional analyses will also examine relationships of upstream determinants of health (mental health, addiction, poverty, violence, etc.) with HIV/STIs. Another analytic tool that will be utilized is spatial regression. This type of analysis will determine how much of each co-factor is contributing to the spatial pattern of HIV/STI cases⁷. Geospatial analysis is a critical planning and evaluation tool and efforts in this area must be scaled-up.

¹ Los Angeles County, Department of Public Health. 2009-2013 HIV Prevention Plan. Available at: [Hhttp://www.publichealth.lacounty.gov/aids/PreventionPlan.htm](http://www.publichealth.lacounty.gov/aids/PreventionPlan.htm)

² Los Angeles County, Department of Public Health. 2009-2013 HIV Prevention Plan. Available at: [Hhttp://www.publichealth.lacounty.gov/aids/PreventionPlan.htm](http://www.publichealth.lacounty.gov/aids/PreventionPlan.htm)

³ Los Angeles County, Department of Public Health. 2009-2013 HIV Prevention Plan. Available at: [Hhttp://www.publichealth.lacounty.gov/aids/PreventionPlan.htm](http://www.publichealth.lacounty.gov/aids/PreventionPlan.htm)

⁴ Syndemic Overview-What Principles Characterize a Syndemic Orientation? [Hhttp://www.cdc.gov/syndemics/overview-principles.htm](http://www.cdc.gov/syndemics/overview-principles.htm) accessed August 25, 2011

⁵ Smith, Goodchild, Longley, 2011

⁶ Enhancing comprehensive HIV prevention planning: A syndemic spatial analysis of HIV and STI burden. Janson, M., Hu, V. Cheng, K, Frye, D., Kerndt, P., and Sayles, J. Presentation at the 2011 National HIV Prevention Conference; August 16, 2011.

⁷ Enhancing comprehensive HIV prevention planning: A syndemic spatial analysis of HIV and STI burden. Janson, M., Hu, V. Cheng, K, Frye, D., Kerndt, P., and Sayles, J. Presentation at the 2011 National HIV Prevention Conference; August 16, 2011.

Appendix C: RAND Modeling Overview

LAC Department of Public Health Additional ECHPP Activities

Modeling Activities

The Office of AIDS Programs and Policy (OAPP) as part of the ECHPP process is collaborating with other LAC Department of Public Health partners, and RAND researchers on several modeling activities to determine the optimal use of prevention strategies to achieve the highest impact in addressing the National HIV/AIDS Strategy (NHAS) goals and objectives. OAPP will use the

1. Maximizing the Benefit of Prevention Interventions – this was a tool developed by RAND in 2004 to assist prevention programs in prioritizing prevention strategies. OAPP is updating this tool in order to estimate the cost effectiveness of LAC’s HIV prevention strategies. Additional information about the tool is available at:

http://www.rand.org/health/surveys_tools/maximizing_benefit.html

2. Preventable Burden of Disease – adopted from the LAC Department of Public Health Office of Health Assessment to prioritize prevention strategies (originally used for tobacco and diabetes). This tool uses a quantitative and qualitative approach to understanding preventable burden for major intervention strategies to aid in priority setting. Preventable burden is the total (fraction) disability-adjusted years of life (DALYs) that could be gained if the preventive intervention were delivered as recommended.

3. Return on Investment – a collaboration with RAND and OAPP in developing robust decision-support tools that can be used to more explicitly recognize the trade-offs among different resource allocation options. This collaboration will be carried out as a three-step process.

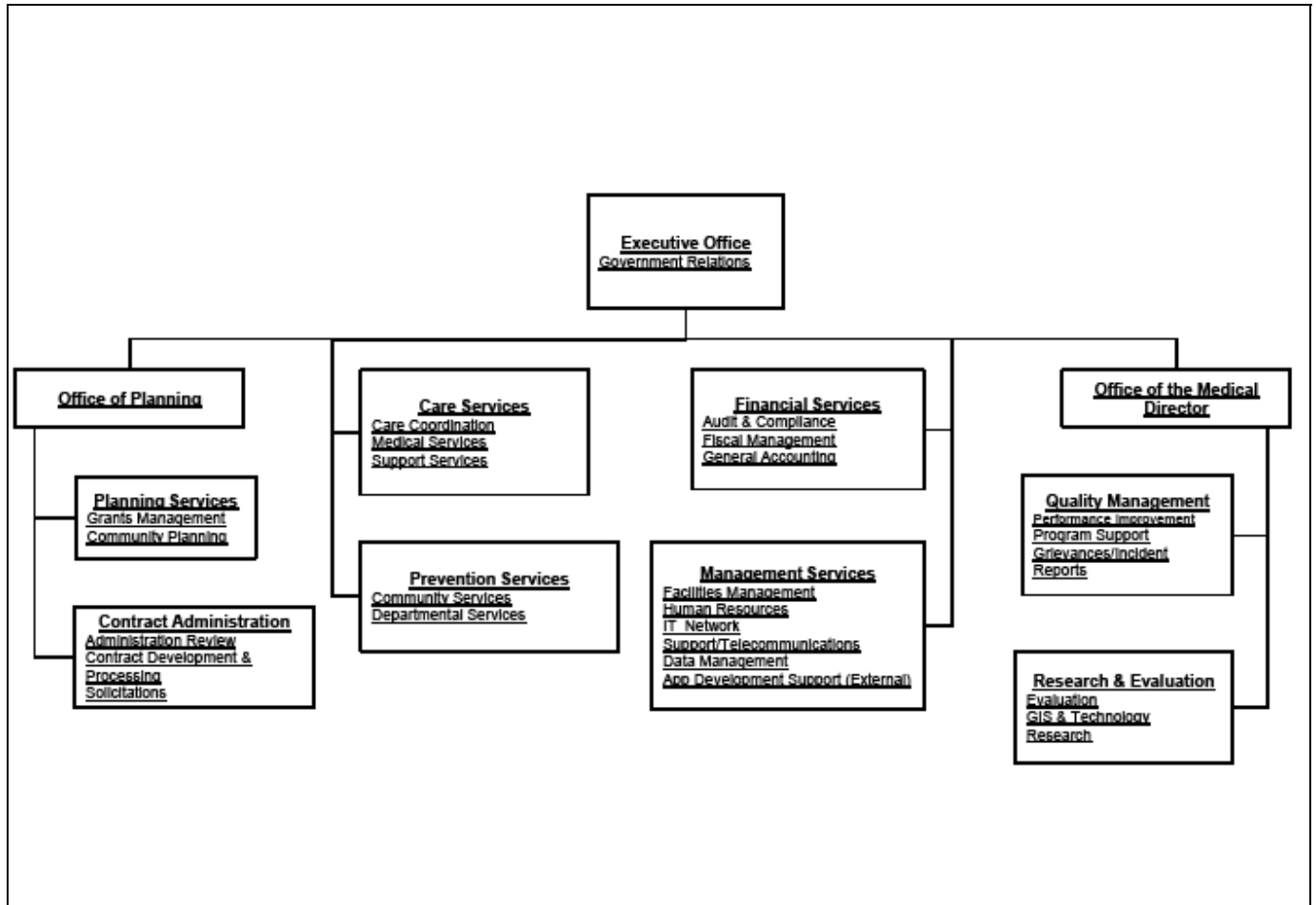
First, RAND will collaborate with the Los Angeles OAPP to develop a overarching conceptual framework that: (a) describes the multiple pathways along which people move through prevention-care continuum; and (b) notes the roles that various intervention strategies

might play in reducing flows along undesired pathways and increasing flows along desired pathways.

Second, RAND will work with the OAPP to develop an explicit Return-On-Investment (ROI) framework. Drawing on this conceptual framework, the ROI framework will: (a) identify a common outcome that can be used to compare across all interventions (e.g., reduction of new incidences, people in continuous care, or decreases in community viral loads, etc.); and (b) logically map how different interventions along the prevention-care continuum may contribute to the common outcome.

Finally, RAND will develop a set of preliminary computer simulation tools that will allow the OAPP to begin the process of making direct ROI comparisons across competing resource allocation options. We will use the conceptual and ROI frameworks to build a set of robust decisions models and populate the parameter estimates from the literature and the OAPP's own experiences.

Appendix D: OAPP Organizational Chart



Operating under OAPP’s Executive Office are the: 1) Office of Planning, which supports grants management and reporting, program planning, program evaluation, and HIV social marketing activities, and whose subsection Contract Administration, oversees solicitation and procurement; 2) Care Services Division, which provides contract and program monitoring of core medical and supportive services; 3) Prevention Services Division, which provides contract and program monitoring of prevention services including HIV testing; 4) Financial Services Division, which performs accounting, fiscal management and auditing and compliance functions; 5) Management Services Division, which oversees human resources and information technology; 6) Office of the

Medical Director, which includes the Research and Evaluation and Quality Management Divisions that are responsible for clinical oversight, quality assurance and improvement, training, and research; and 7) Government Relations which is responsible for policy analysis and external communications.

Appendix E: Modeling of HIV Testing 2011-15 Methodology

A. Determining Baseline

- The **62,803** baseline for people living with HIV/AIDS was taken from surveillance data from the LAC HIV Epidemiology Program.
 - 49,300 known HIV cases
 - 4,150 Pending HIV cases
 - 4,500 Coded living HIV
 - 16,000 Named living HIV
 - 24,650 Reported living with AIDS
 - 13,503 unknown HIV cases based on modified CDC estimate of 21.5% of HIV+ are unaware of their status ($49,300/0.785 = 62,803$)

B. Methodology in Setting Goal of 90% Knowledge of HIV Status in all of Los Angeles County in 2015

- A 'stock and flow' model is employed where the 'stock' is the PLWHA and the flow in the system are the new cases and the cases that die due to HIV/AIDS
- 2,500 new cases per year based on $2,000/0.785\% = 2,548$ (0.785% known cases based on CDC estimated), corresponding with numbers provided in HIV Epidemiologic Profile 2009 (2,000 – 2,500 new cases per year)
- 4/100,000 is the Mortality Rate due to HIV/AIDS in 2007 according to the Office of Health Assessment of Los Angeles County
- There is an estimated 60% (or 1,200 tests among 2,000) number of cases identified by private (non OAPP-funded) sites. Estimated 40% (800) identified by OAPP-funded sites.
- Total cases for a given year was determined by:
 - Taking previous year's total cases (starting with baseline)
 - Adding 2,500 new cases
 - Multiplying 4/100,000 and previous year's total and subtracting this number from the new total
- Unknown cases for a given year was determined by:
 - Taking newly calculated total cases for that year
 - Subtracting known cases from previous year (starting with baseline)
 - Subtracting cases identified by private, non-OAPP funded agencies (ex. 1,200) in that year
 - Subtracting cases identified by public, OAPP funded agencies (ex. 800) in that year
- Known cases for a given year was determined by:
 - Taking total cases for that year
 - Subtracting unknown cases for that year
- Repeat until five year cycle is completed (adjusting the number of cases identified by OAPP-funded sites, the percentage of known cases in Los Angeles County should be no less than 90%)

C. Model for Allocation of Testing Efforts in order to Determine Necessary Number of Tests

- An estimate of new (preliminary) positivity rates of four different modalities/programs (targeted, STD, routine and social network testing) was determined using data from September 30, 2009 through September 29, 2010
- Overall new (preliminary) positivity rate for the year was determined by:
 - Taking estimated positivity rate (estimate from 09/30/09 – 9/29/10) of each modality/program
 - Multiplying by the estimated proportion of total tests from each modality/program for the year (proportions should add up to 1) and multiplying by 4 (for each of the four programs)
 - Adding each product together
 - Taking total sum and dividing by 4
- Total number of tests for the year was determined by:
 - Taking number of cases identified by OAPP for that year (this number was determined in section by B when setting a goal of 90% known HIV status)
 - Dividing by the overall new (preliminary) positivity rate

Year	New Cases per Year**1	Mortality Rate Due to HIV/AIDS (4/100,000)**	Persons Living with HIV/AIDS***	Number of Cases Identified per Year (private)**2	Number of Cases Identified per Year (OAPP-funded)*	Do Not Know Status	Know Status	% Know Status
Baseline			62,803			13,503	49,300	78.5%
2011	2,500	0.00004	65,300	1,200	1,100	13,700	51,600	79.0%
2012	2,500	0.00004	67,798	1,200	1,800	13,198	54,600	80.5%
2013	2,500	0.00004	70,295	1,200	2,700	11,795	58,500	83.2%
2014	2,500	0.00004	72,792	1,200	3,100	9,992	62,800	86.3%
2015	2,500	0.00004	75,289	1,200	3,400	7,889	67,400	89.5%

This number should reach 90% in order to achieve goal set in NHAS

Year	Number of Cases Identified per Year (OAPP-funded)*	Testing Effort Targeted		Testing Effort % Routine		Testing Effort % STD Public Health		Testing Effort % Social Network		Overall New (Preliminary) Positivity Rate	Number of Tests to be Conducted
		at rate ³ : 1.03%		at rate ³ : 0.90%		at rate ³ : 0.88%		at rate ³ : 7.02%			
2011	1,100	0.40	0.39	0.39	0.20	0.01		1.01%	108,997		
2012	1,800	0.39	0.39	0.19	0.03		1.13%	159,222			
2013	2,700	0.38	0.40	0.17	0.05		1.25%	215,655			
2014	3,100	0.37	0.41	0.15	0.07		1.37%	225,701			
2015	3,400	0.37	0.41	0.14	0.08		1.43%	236,950			
Overall	12,100	0.38	0.40	0.17	0.05		1.24%	946,525			
Overall Tests Per Modality:		361,572	378,610	160,909	45,433						

*Ranges for both New Cases per year (2,000-2,500) and Number of Cases Identified (2,000-3,000) based on personal contact with Virginia Hu, HIV Epidemiology Program on 2/24/10

¹2,500 was calculated from 2,000/0.785% (the estimated known percentage of cases) = 2,548 or approximately 2,500 tests.

²Estimated 60% (or 1,200 tests among 2,000) number of cases identified by private (non OAPP-funded) sites. Estimated 40% (800) identified by OAPP-funded sites.

³Based on New (Preliminary) Positivity Rates from Sep 30, 2009 through Sep 29, 2010 data in HIRS, teleform, and from STD program. CSV (Targeted Testing) Data based on CY2009.

**Data Source: Office of Health Assessment Los Angeles County; Department of Public Health. Mortality in Los Angeles County 2007

***2009 estimate of 62,803 provided by HIV Epidemiology Program, Department of Public Health (based on 49,300 known cases and 21.5% estimate of unknown cases)

Appendix F: Tables and Figures

Table 1: Clinic Sites

Venue Name	Type	Target Population	Routine HIV Screening Experience	Rationale for Selection	Opt-in; Opt-out	Testing Technology
LAGLC Sexual Health Program	HIV/STD Clinic	Primarily MSM, Transgender individuals	2.5 years	Located in high HIV prevalence area and high risk population	Opt-out rapid HIV testing	-Clearview Complete -OraQuick -Uni-Gold
LAC+USC Medical Center	Emergency Dept.	Latinos and African Americans	2+years	Located in high HIV prevalence area	Opt-out	-Clearview Complete -OraQuick
HHHCHC	Urgent Care	African Americans and Latinos	8 months	Located in high HIV prevalence area	Opt-out	OraQuick
St. John's	Community Health Center	African Americans and Latinos	8 months	Located in high HIV prevalence area	Opt-out	-OraQuick -INSTI
T.H.E. Clinic	Community Health Center	African Americans and Latinos	3+years	Located in high HIV prevalence area	Opt-out	OraQuick
To be Determined	Community Health Center	Latinos	Implementation date – 2012/2013	Located in high HIV prevalence area	Opt-out	To be Determined
To be Determined	Community Health Center	African Americans and Latinos	Implementation date – 2012/2013	Located in high HIV prevalence area	Opt-out	To be Determined
Clinica Romero	Community Health Center	Latinos	2 years +	Located in high HIV prevalence	Opt-out	Clearview Complete

Venue Name	Type	Target Population	Routine HIV Screening Experience	Rationale for Selection	Opt-in; Opt-out	Testing Technology
				area		
Central City	Community Health Center	African Americans and Latinos	2 years +	Located in high HIV prevalence area	Opt-out	-Clearview Complete -OraQuick
To be Determined	County operated Hospital	Latinos	Implementation date – 2012/2013	Located in high HIV prevalence area	Opt-out	To be Determined
To be Determined	Urgent care	African Americans and Latinos	Implementation date – 2012/2013	Located in high HIV prevalence area	Opt-out	To be Determined

Table 2: Correctional Sites

Venue Name	Type	Target Population	Routine HIV Screening Experience	Rationale for Selection	Opt-in; Opt-out	Testing Technology
Twin Towers, Men's Inmate Reception Center, Medical Unit	Correctional Facility	African Americans and Latinos	1 year	High risk populations	Opt-out	-Clearview Complete -OraQuick
Pitches Detention Center South*	Correctional Facility	African Americans and Latinos	2 years	High risk populations	Opt-out	OraQuick
Pitches Detention Center East*	Correctional Facility	African Americans and Latinos	2 years	High risk populations	Opt-out	OraQuick
North County Correctional Facility*	Correctional Facility	African Americans and Latinos	2 years	High risk populations	Opt-out	OraQuick
Century Regional Women's Jail	Correctional Facility	African Americans and Latinos	2 years	High risk populations	Opt-out	OraQuick
Twin Towers, Men's Inmate Reception Center	Correctional Facility	African Americans and Latinos	< 1 year	High risk populations	Opt-out	OraQuick

* It is proposed that these locations will be phased out by December 2012 and all testing will eventually be centralized into two (2 sites) locations: 1) Women will be tested at the Century Regional Women's Jail and 2) Men will be tested when they come through the Men's Inmate Reception Center.

Table 3: STD Clinics

Venue Name	Type	Target Population	Routine HIV Screening Experience	Rationale for Selection	Opt-in; Opt-out	Testing Technology
Antelope Valley Health Center	STD Clinic	African Americans and Latinos	5+ years	Access to clients not normally seen in community-based	Opt-out	Conventional

Venue Name	Type	Target Population	Routine HIV Screening Experience	Rationale for Selection	Opt-in; Opt-out	Testing Technology
				programs. Reach clients who prefer “bundled” testing that includes HIV		
Central Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
Hollywood-Wilshire Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
Monrovia Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
North Hollywood Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
Pomona Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-in	Conventional
Simms/Mann/Burke Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
South Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
Ruth Temple Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
Torrance Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional

Venue Name	Type	Target Population	Routine HIV Screening Experience	Rationale for Selection	Opt-in; Opt-out	Testing Technology
Curtis Tucker Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional
Whittier Health Center	STD Clinic	African Americans and Latinos	5+ years	Same as above	Opt-out	Conventional

Table 4: HIV New and Overall Positivity Rate by Type of OAPP-funded Testing Program, 2010

Type of Testing Program	Number of HIV Tests	HIV Overall Positivity Rate		HIV New Positivity Rate	
	N	n	(%)	n	(%)
Grand Total	100,788	1,249	1.24%	1,031	1.04%²
Public Health STD Clinics	24,831	239	0.96%	198	0.80%
Routine Testing	17,802	347	1.95%	341	1.92%
Testing within Jail Settings	12,933	73	0.56%	25	0.19%
Targeted Testing	45,222	590	1.30%	467	1.08%
OAPP Subcontracted Agencies					
Storefront	27,695	332	1.20%	283	1.02% ²
MTU Program	9,486	93	0.98%	82	0.86%
Multiple Morbidity MTU Program	3,511	44	1.25%	35	1.00%
Social Network Testing Program	707	55	7.78%	44	6.22%
Bath Houses and Sex Clubs¹	1,991	30	1.51%	N/A	N/A
Court Ordered & Drug Expansion Testing Programs	1,832	36	1.97%	23	1.26%

Data Source: HIV Testing System as of 080511

¹Total test numbers are approximate and obtained from provider monthly reports. Data on number of new positives are not available.

² The denominator for HIV new positivity rate does not include the number of HIV tests from CSVs

Table 5: Current HE/RR Prevention Interventions/Programs for HIV-Positive Persons

2011-2012 Interventions/Programs	Target Population Served	2012 Providers
Healthy Relationships	Gay Identified Men	El Proyecto Del Barrio and Bienestar
Options	Gay Identified Men	AIDS Project Los Angeles
Project AIM	Young Gay Identified Men	Children's Hospital of Los Angeles
Outreach	Gay Identified Men	AIDS Project Los Angeles, Being Alive, Bienestar, El Proyecto Del Barrio, and Los Angeles Gay and Lesbian Center
Interventions Delivered to Individuals (IDI)	Gay Identified Men	Being Alive and Los Angeles Gay and Lesbian Services Center
Interventions Delivered to Groups (IDG)	Gay Identified Men	Being Alive, Bienestar, and El Proyecto Del Barrio
Comprehensive Risk Counseling Services (CRCS)	Gay Identified Men	AIDS Project Los Angeles, Bienestar, Friends Research Institute, Special Services for Groups, and Watts Healthcare Center

Table 6: 2012 HE/RR Interventions for High Risk HIV-negative Individuals

2011-2012 Interventions/Program Models	Target Population	Service Provider
Mpowerment	Gay Identified Men	El Proyecto Del Barrio
Mpowerment	Young Gay Identified Men	Whittier Rio Hondo AIDS Project
Safety Counts	People Who Share Needles/Works	Asian American Drug Abuse Program and California Drug Counseling, Inc.
SISTA	Women	Asian American Drug Abuse Program and Whittier Rio Hondo AIDS Project
SISTA	Transgenders	East Valley Community Health Center, Minority AIDS Project, and Special Services for Groups
Many Men, Many Voices (3MV)	Gay Identified Men	AIDS Project Los Angeles and Los Angeles Center for Alcohol and Drug Abuse
Popular Opinion Leader (POL)	Gay Identified Men	AIDS Healthcare Foundation, Asian Pacific AIDS Intervention Team, and Westside Family Health Center

2011-2012 Interventions/Program Models	Target Population	Service Provider
POL	Young Transgender	Childrens Hospital Los Angeles
POL	Young Women	Valley Community Clinic
D-Up	Non-Gay Identified Men Who Have Sex with Men, Transgender or Multiple Genders	Minority AIDS Project
Community Promise	Native American Gay Men and Transgenders	AIDS Project Los Angeles
Community Promise	Residents in SPA 1	AIDS Project Los Angeles
Community Promise	Gay Identified Men	Los Angeles Center for Alcohol and Drug Abuse
MIP	People Who Share Needles/Works	East Valley Community Health Center
SHIELD	Residents in SPA 1	Tarzana Treatment Center
Outreach	Gay Identified Men	AIDS Project Los Angeles, Bienestar, Friends Research Institute, Los Angeles Center for Alcohol and Drug Abuse, and Westside Family Health Center
Outreach	Non-Gay Identified Men Who Have Sex with Men, Transgender or Multiple Genders	Friends Research Institute, Los Angeles Center for Alcohol and Drug Abuse, and Minority AIDS Project
Outreach	Young Gay Identified Men	In the Meantime Men's Group, Special Services for Groups, and Whittier Rio Hondo AIDS Project
Outreach	Transgender	Bienestar, East Valley Community Health Center, Friends Research Institute, Minority AIDS Project, and Special Services for Groups
Outreach	People Who Share Needles/Works	Asian American Drug Abuse Program, California Drug Counseling, Inc., El Centro Del Pueblo, and Tarzana Treatment Center
Outreach	Women	Asian American Drug Abuse Program, City of Long Beach Health Department, Common Ground, East Los Angeles Womens Center, JWCH Institute, Inc., and Whittier Rio Hondo AIDS Project
Outreach	Young Women	City of Long Beach Health Department and Valley Community Clinic
Outreach	Native Americans	AIDS Project Los Angeles
Interventions Designed for Individuals (IDI)	Gay Identified Men	Bienestar and Friends Research Institute

2011-2012 Interventions/Program Models	Target Population	Service Provider
IDI	Young Gay Identified Men	No providers
IDI	Non-Gay Identified Men Who Have Sex with Men, Transgender or Multiple Genders	Friends Research Institute
IDI	Transgender	Bienestar and Friends Research Institute
IDI	People Who Share Needles/Works	Asian American Drug Abuse Program, California Drug Counseling, Inc., East Valley Community Health Center, and El Centro Del Pueblo
IDI	Women	City of Long Beach Health Department, Greater Los Angeles Agency on Deafness, Inc., and JWCH Institute, Inc.
IDI	Young Women	City of Long Beach Health Department
IDI	Native Americans	No providers
IDI	Jail Based	Center for Health Justice
Interventions Designed for Groups (IDG)	Gay Identified Men	AIDS Healthcare Foundation, AIDS Project Los Angeles, Bienestar, El Proyecto Del Barrio, Friends Research Institute, Los Angeles Center for Alcohol and Drug Abuse, Minority AIDS Project, and Westside Family Health Center
IDG	Young Gay Identified Men	In the Meantime Men’s Group, Special Services for Groups, and Whittier Rio Hondo AIDs Project
IDG	Transgender	AIDS Project Los Angeles, Bienestar , East Valley Community Health Center, Friends Research Institute, Minority AIDS Project, and Special Services for Groups
IDG	Youth Transgender	Children’s Hospital of Los Angeles
IDG	People Who Share Needles/Works	Asian American Drug Abuse Program, California Drug Counseling, Inc., and Tarzana Treatment Center
IDG	Women	Asian American Drug Abuse Program, City of Long Beach Health Department, Common Ground, East Los Angeles Womens Center, Greater Los Angeles Agency on Deafness, Inc., JWCH Institute, Inc., and

2011-2012 Interventions/Program Models	Target Population	Service Provider
		Whittier Rio Hondo AIDS Project
IDG	Young Women	City of Long Beach Health Department, Valley Community Clinic
IDG	Native Americans	AIDS Project Los Angeles
IDG	Jail Based	Center for Health Justice
CRCS	Gay Identified Men	AIDS Project Los Angeles, Bienestar, Friends Research Institute, Special Services for Groups, and The Wall Las Memorias
CRCS	Transgender	Bienestar and Special Services for Groups

Table 7: 2012 Community-level Interventions for High Risk HIV-negative Individuals

2011-2012 CLI for High Risk HIV-negative Individuals (Provider)	Target Population Served (Service Planning Area)	Expected Outcomes for 2012
Community Promise (AIDS Project Los Angeles)	Native American Gay Men and Transgenders (SPAs 1-8)	104 Native American Gay Men will participate in a community identification process focus group or complete a client survey 35 Native TG will participate in a community identification process focus group or complete a client survey
Community Promise (AIDS Project Los Angeles)	Residents in SPA 1 (SPA 1)	150 Latino Non-gay identified MSM or TG will participate in a community identification process focus group
Community Promise (Los Angeles Alcohol and Drug Program)	Latino Non-gay identified MSM or TG (SPAs 3 and 7)	101 Latino Non-gay identified MSM or TG will participate in a community identification process focus group
CLI (City of Long Beach Department of Health)	Young Women at Sexual Risk (SPA 8)	At least one CLI presentation will be conducted to promote and recruit young women into the young women's program (IDI/IDG). At least 149 young women will commit to reducing at least one risk behavior following the CLI.
CLI (City of Long Beach Department of Health)	Women at sexual risk (SPAs 7 and 8)	At least one CLI presentation will be conducted to promote and recruit women into the young women's program (IDI/IDG). At least 160 women will commit to reducing at least one risk behavior

2011-2012 CLI for High Risk HIV-negative Individuals (Provider)	Target Population Served (Service Planning Area)	Expected Outcomes for 2012
		following the CLI.
CLI (East Los Angeles Womens Center)	Latina Women at sexual risk (SPAs 4 and 7)	250 women will attend a Community Presentation lead by Promotoras. 213 women will increase their knowledge by 15% between pre- and post-test 181 women will commit to reducing at least one risk behavior following the presentation.

Figure 1: HIV-positive Individuals Linked to Care

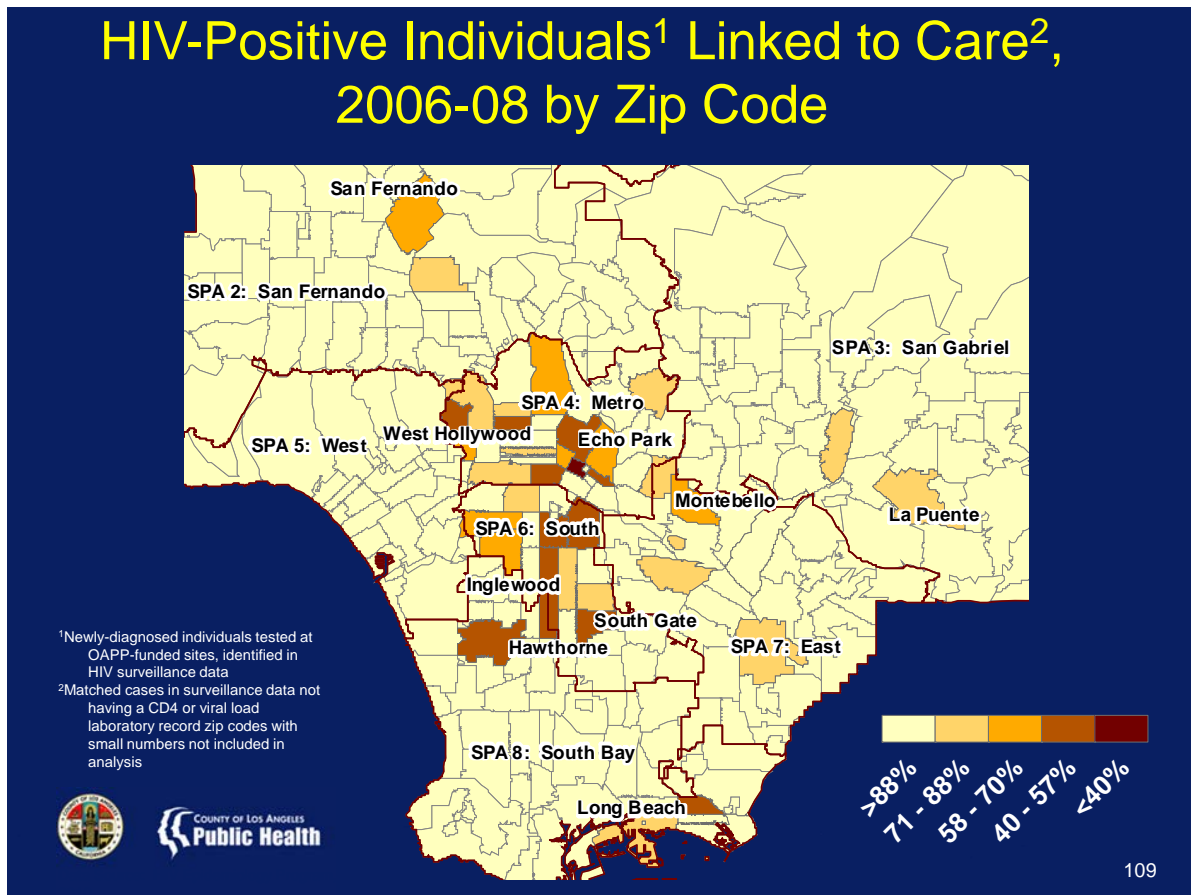
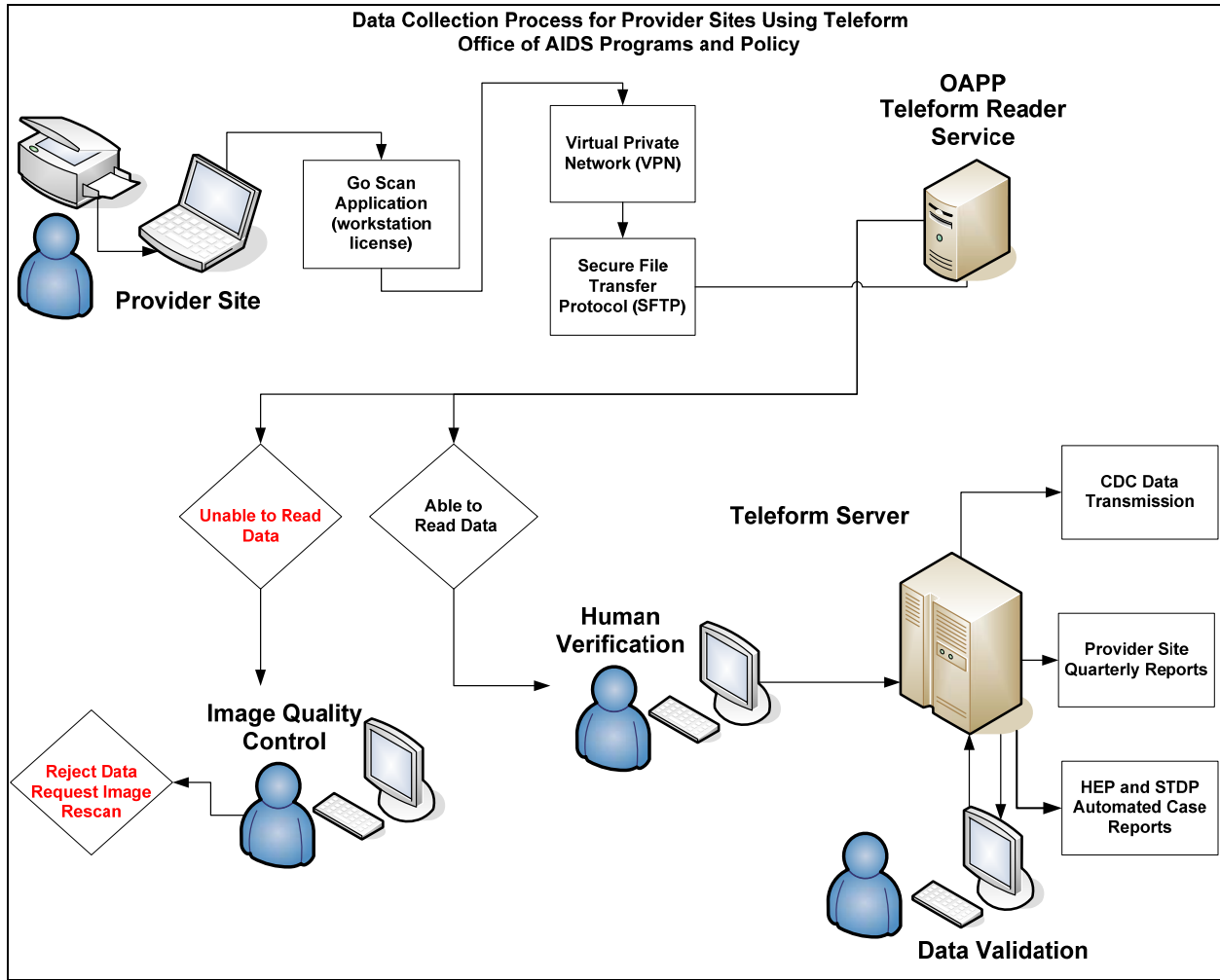


Figure 2: Data Collection Process for Provider Sites Using Teleform



Appendix G: Description of Non-clinical or Targeted Testing Modalities in Los Angeles County

Storefront testing- Storefront testing includes CBOs, non-clinical testing sites within high-risk areas identified in the Los Angeles County HIV Prevention Plan 2009-2013¹, and substance use treatment settings. Based on 2010 preliminary findings, 283 new positives (out of 27,695 tests) were diagnosed at a storefront site (1.02%). OAPP will fund 15 storefront testing sites in 2012 (see table 4 in Appendix F).

Mobile Testing Units (MTUs)- MTUs offer an opportunity to provide HTS in targeted high-risk areas that may not have access to storefront sites or healthcare facilities (i.e., skid row, bridges and underpasses, parks), testing events and health fairs, and at venues such as bars and clubs where HTS are offered during non-traditional testing hours (from about 8pm – 1am). Almost 10,000 (n=9,486) tests were conducted in a MTU last year with a new positivity rate of 0.86%. Six mobile testing programs provide services in SPAs 2 through 8 (see table 4 in attachment E).

Multiple Morbidity (MM) Testing Units- Since 2000, OAPP has partnered with contracted agencies to provide MM testing services on MTUs that provide services in all eight SPAs. The MM testing services provide screenings for hepatitis A, acute and chronic hepatitis B and C, syphilis, Chlamydia, gonorrhea, and HIV all within one visit. Over 3,500 tests were conducted by three OAPP-funded MM testing units that achieved the jurisdictional new positivity rate (1.0%) in 2010. Based on the increased need for integrated testing services and the need to test hard to reach populations, OAPP plans on doubling this investment to a total of six MM testing units in 2012.

Commercial Sex Venues (CSV)- The CSV testing program was established by County Ordinance No.2004-0050 in May 2005 to provide HIV and STD testing to patrons of CSVs (bath houses and sex clubs). Through a collaborative agreement with CSV owners, integrated HIV and STD testing services are provided at 11 CSV testing sites throughout LAC. In 2010, OAPP provided test kits for approximately 2,000 tests and a 0.9% overall positivity rate was attained².

Courts/Drug Expansion (DREX) program- The court-ordered testing program is a long-standing partnership between OAPP and the LAC County courts in order to achieve compliance with California Penal Code Sections 1202.1 and 1202.6, which mandate HIV/AIDS testing for all persons convicted of prostitution and other specified sex crimes. OAPP community services counselors provide delivery of HTS, education, and referral services at court sites throughout the County. DREX was established in 1989 to meet the HIV/AIDS testing and educational needs of the clients accessing drug treatment services. OAPP community services counselors provide HTS, and individual and group education of inpatient and outpatient clients and their social affiliates in drug treatment, sober living houses, and methadone clinics. Court ordered testing combined with DREX HTS had the second highest new positivity rate (1.26%) compared to other non-clinical or targeted testing modalities in 2010. OAPP will continue to support HTS services provided through the court-ordered testing program throughout 2012.

Social Network Testing (SNT)- In 2010, the SNT program yielded the highest new positivity rate (6.22%) among all of the targeted testing programs. This finding is comparable to the 7.1% new positivity rate from the pilot SNT project supported by CDC PS10-1001 Supplemental Funding³. These data provide a convincing argument for expanding the SNT strategy to other high risk or hard to reach populations in 2012.

HIV Testing Events- OAPP collaborates with private and public community partners to combine HIV social marketing campaigns and community events (e.g. health fairs, HIV counseling and testing week initiatives, and other HIV testing events) with the goal of normalizing HIV testing while increasing community-wide access to testing services. In 2012, OAPP will plan, coordinate and implement expanded HTS and prevention-related activities at a number of county-wide events (e.g., HIV Testing Week 2012) and other OAPP and agency sponsored events.

¹ Los Angeles County, Department of Public Health. 2009-2013 HIV Prevention Plan. Available at: <http://www.publichealth.lacounty.gov/aids/PreventionPlan.htm>

² 2010 preliminary data from provider monthly reports and not OAPP HIV Testing System

³ Social network testing project (SNT): An effective method to diagnose HIV infection among young MSM. Kim, M., Ogata, P., Rivas, C., and Meta, J. Presentation at the 2011 National HIV Prevention Conference; August 16, 2011.

Appendix H: Program Goals and SMART Objectives

During 2012 OAPP will strive to achieve the goals, strategies, and objectives listed below:

Activity	Goal	Strategy	Objective
<p>Opt-out HIV testing in healthcare settings</p>	<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>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>	<ol style="list-style-type: none"> 1. By December 2012, implement at least 2 new routine opt out testing programs in an emergency department or urgent care center 2. By December 2012, conduct at least 15,000 HIV tests at emergency departments or urgent care centers. 3. By December 2012, provide at least 6 trainings/ technical assistance sessions for healthcare providers to enable implementation of a routine testing program and reimbursement.
<p>Testing in Non-clinical Settings</p>	<p>Goal 2: Increase the number of individuals who know their HIV status and normalize testing in health care settings.</p>	<p>Strategy 1: Increase the number of tests done through opt-out HIV testing in health care settings.</p>	<ol style="list-style-type: none"> 1. By December 2012, at least 60,000 individuals tested at OAPP supported routine HIV testing programs will know their HIV status. 2. By December 2012, identify at least 300 newly diagnosed HIV-positive individuals at OAPP supported routine HIV testing sites.
<p>Testing in Non-clinical Settings</p>	<p>Goal 1: Re-assess provision of non-clinical HIV testing services to better target the epicenters of disease burden.</p>	<p>Strategy 1: Use syndemic spatial analysis (mapping) to better target HIV testing in non-clinical settings</p>	<ol style="list-style-type: none"> 1. By December 2012, 85% of targeted HIV testing sites fall within the identified epicenters of disease burden.
<p>Testing in Non-clinical Settings</p>	<p>Goal 2: Identify new/innovative targeted testing strategies to identify new infections.</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 rapid testing sites.</p>	<ol style="list-style-type: none"> 1. By December 2012, implement at least one additional social network testing programs in Los Angeles County. 2. By December 2012, implement RTA at 75% of targeted HIV Counseling and Testing (HCT) sites. 3. By December 2012, identify at least 500 new HIV-positive testers across all targeted HCT programs.

Activity	Goal	Strategy	Objective
<p>Condom Distribution</p>	<p>Goal 1: Increase condom distribution to target priority populations.</p>	<p>Strategy 1: Increase condom distribution to all sites offering HIV, STD, and/or viral hepatitis screenings and Ryan White Medical care.</p> <p>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>1. To increase availability of condoms at 75% (53 of 70 total agencies) of HCT, HE/RR, and Ryan White medical sites by December 2012.</p> <p>2. By December 2012, work with the LASD to change policy on increasing number of condoms distributed to greater than 1/week/inmate (current standard).</p>
<p>PEP</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>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>1. Identify at least 50 community distribution sites by June 2012.</p> <p>2. By December 2012, identify at least 100 community distribution sites.</p> <p>3. By December 2012, begin distribution programs at 50 community sites.</p> <p>4. By December 2012, distribute at least 150,000 LA condoms</p>
<p>PEP</p>	<p>Goal 1: Identify a public health service delivery model</p>	<p>Strategy 1: 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>1. Complete a manual of procedures for nPEP service delivery by July 2012.</p> <p>2. Deliver nPEP services to at least 150 individuals by December 2012.</p> <p>3. Convene at least 2 meetings of the LAC nPEP workgroup by December 2012.</p> <p>4. Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2012.</p>
<p>Policy Initiatives</p>	<p>Goal 1: Implement effective syringe access program.</p>	<p>Strategy 1: Prevent disease and protect public safety through increased access to sterile syringes.</p>	<p>Objective 1: By December 2012, attend at least two meetings with County and City of Los Angeles SSP staff</p>
<p>A88</p>	<p>Goal 2: Improve data collection and tracking for HIV testing in medical settings to</p>	<p>Strategy 1: Work with LAC health care centers on accurately and consistently reporting HIV testing data to the Department of Public</p>	<p>Objective 1: By December 2012, identify and prioritize 3 non-OAPP funded clinics to work with on reporting their HIV testing data to LAC DPH.</p>

Activity	Goal	Strategy	Objective
Comprehensive Prevention for Positives	<p>facilitate measurement of HIV screening rates.</p> <p>Goal 1: Improve linkage to care among persons newly diagnosed with HIV.</p>	<p>Health.</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.</p> <p>Strategy 2: Convene a Testing, Linkage to Care+ (TLC+) workgroup among Los Angeles Department of Public Health programs.</p>	<p>1. By December 2012, 100% of persons who receive their HIV positive test results at OAPP funded testing agencies will be referred to medical care.</p> <p>2. By December 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.</p> <p>3. By December 2012, convene at least 4 TLC+ workgroup meetings.</p> <p>4. By March 2012, a protocol for integrating ARTAS into HIV partner services program will be completed.</p> <p>5. By December 2012, ARTAS partner services will be initiated at 2 testing sites</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>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.</p>	<p>1. Implement data matching every 3 months starting in January 2012.</p> <p>2. Starting April 2012, begin using data from matched data to identify newly diagnosed HIV positive individuals not in care</p>
	<p>Goal 3: Increase rates of retention in care in the Ryan White system of care.</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>Strategy 3: Implement new Retention Navigation Program</p>	<p>1. By December 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>2. By June 2012, finalize MCC model and assessment tools.</p> <p>3. By December 2012 enroll at least 50 clients in the Retention Navigation Program</p> <p>4. By April 2012, develop protocols for 2 pilot projects aimed out re-engagement and retention in care as part of TLC+ workgroup.</p>
	<p>Goal 4: Develop strategies to use existing public health/surveillance data to identify HIV-positive</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>1. Conduct data matching to identify RW and previous RW clients every 3 months starting in January 2012.</p> <p>2. Starting in August 2011, begin using data identifying HIV positive out of care to inform delivery of MCC services at Ryan White funded medical clinics and Retention Navigation Program by March 2012.</p>

Activity	Goal	Strategy	Objective
	<p>individuals not in care.</p> <p>Goal 5: 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>Strategy 1: Ensure high quality HIV medical care is available in the Ryan White system of care</p> <p>Strategy 2: Continue to monitor and promote ART for all people living with HIV/AIDS (PLWHA) who meet treatment guidelines</p>	<ol style="list-style-type: none"> 1. By December 2012, have HIV ART coverage rate of 90% in Ryan White system. 2. By December 2012, achieve viral load suppression levels of 75% or greater for patients receiving primary HIV care in Ryan White system. 3. By July 2012, monitor 100% of all Ryan White contracts to determine whether ARV use is consistent with treatment guidelines. 4. By July 2012, 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>Comprehensive Prevention for Positives</p>	<p>Goal 6: Minimize HIV transmission through viral load suppression among Ryan White medical care clients.</p>	<p>Strategy 1: Monitor community level viral load among Ryan White clients.</p> <p>Strategy 2: Deploy interventions for individuals with detectable viral load e.g. Prevention with Positives, treatment adherence programs.</p> <p>Strategy 3: Referral to substance use and mental health services through the Los Angeles County Ryan White Medical Care Coordination (MCC) program.</p>	<ol style="list-style-type: none"> 1. By December 2012, 90% of Ryan White clients are screened for HIV risk behavior at least twice a year. 2. By December 2012, achieve viral load suppression levels of 75% or greater for patients receiving primary HIV care in Ryan White system. 3. By December 2012, monitor 100% of all Ryan White contracts to determine whether ARV use is consistent with treatment guidelines. 4. By December 2012, implement at least one new social network testing program 5. By December 2012, increase the proportion of HIV-positive clients who accept partner services by 25%
	<p>Goal 7: Prevent perinatal transmission in HIV positive pregnant women in Los Angeles County.</p>	<p>Strategy 1: Increase HIV screening among pregnant women in Los Angeles County.</p> <p>Strategy 2: Ensure pregnant HIV-positive women in the Ryan White system of care are receiving appropriate HIV perinatal medical care and ART.</p>	<ol style="list-style-type: none"> 1. By April 2012, 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. 2. By July 2012, incorporate perinatal standards of HIV care into the Los Angeles County Commission on HIV Ryan White standards of care. 3. By December 2012, 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. 4. By December 2012, 100% of HIV positive pregnant women in Ryan White system of care received a referral to perinatal HIV specialty clinics. 5. By December 2012 complete chart abstraction to estimate missed perinatal prevention opportunities

Activity	Goal	Strategy	Objective
	<p>Goal 8: To increase HIV case finding through partner services</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>	<ol style="list-style-type: none"> 1. By January 2012, implement ongoing reporting of all new HIV positive cases in Los Angeles County HIV surveillance system to the HIV/STD partner services program. 2. By December 2012, 85% of eligible index patients will be interviewed for Partner Services. 3. By December 2012, 50% of newly diagnosed HIV positive clients will accept Partner Services. 4. By December 2012, 50% of notified partners, not previously HIV-positive, will receive an HIV test. 5. By December 2012, 95% of all HIV positive test results will be disclosed for those tested in the Partner Services program.
	<p>Goal 9: Reduce risk behavior among HIV positive persons (including HIV-discordant couples).</p>	<p>Strategy 1: Deliver Evidence Based Interventions (EBIs) to reduce risk behavior among HIV-positive persons.</p>	<ol style="list-style-type: none"> 1. By December 2012, 90% of Ryan White clients receive a risk behavior screening in clinical settings every 6 months. 2. By July 2012, begin tracking/monitoring referrals of Ryan White clients with high risk behavior screening to HE/RR interventions targeting HIV positive persons. 3. By December 2012, 75% of clients participating in an HE/RR prevention for positives program will complete all sessions of the intervention.
<p>Comprehensive Prevention for Positives</p>	<p>Goal 10: Improve access to mental health and substance use services for HIV positive individuals in Ryan White system of care.</p>	<p>Strategy 1: Provide comprehensive screening, referrals, and linkage to mental health and substance use services.</p>	<ol style="list-style-type: none"> 1. December 2012, 95% of all Ryan White clients should be screened for need of mental health and/or substance use services. 2. By December 2012, 90% of Ryan White clients screened received a referral. 3. By December 2012, 80% of Ryan White clients with a referral received a mental health and/or substance use service intake to initiate services.
	<p>Goal 11: Improve access to mental health and substance use services for HIV-positive individuals in OAPP funded HIV testing or HE/RR program</p>	<p>Strategy 1: Provide comprehensive screening, referrals, and linkage to mental health and substance use services.</p>	<ol style="list-style-type: none"> 1. December 2012, 95% of all HIV-positive prevention clients should be screened for need of mental health and/or substance use services. 2. By December 2012, 90% of HIV-positive prevention clients screened received a referral. 3. By December 2012, 100% of HIV-positive prevention clients with a referral received a mental health and/or substance use service intake to initiate services.

Activity	Goal	Strategy	Objective
Social Marketing	Goal 1: To increase the visibility of the Los Angeles County Erase Doubt campaign.	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)	1. Increase media purchase by 100% by December 2012 2. Increase hits on Erase Doubt website by 50% by December 2012 3. Increase visibility of Erase Doubt messaging through targeted media placement throughout geographic “hot spots” by December 2012
	Goal 2: To increase awareness of free testing and treatment services available throughout Los Angeles County.	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.	1. Increase media purchase by 100% by December 2012 2. Sponsor at least 2 community HIV testing events by December 2012 3. Participate in at least 2 Los Angeles County health fairs by December 2012
Community Level Interventions	Goal 1: To increase the visibility of the Los Angeles County Erase Doubt campaign.	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).	1. Increase media purchase by 100% by December 2012 2. Increase hits on Erase Doubt website by 50% by December 2012 3. Increase visibility of Erase Doubt messaging through targeted media placement throughout geographic “hot spots” by December 2012
	Goal 2: To increase awareness of free testing and treatment services available throughout Los Angeles County.	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	1. Increase media purchase by 100% by December 2012 2. Sponsor at least 2 community HIV testing events by December 2012 3. Participate in at least 2 Los Angeles County health fairs by December 2012

Activity	Goal	Strategy	Objective
HERR for High Risk Negatives	<p>Goal 1: Identify high risk HIV-negative persons (including those for HIV-discordant couples) at risk of acquiring HIV.</p> <p>Goal 2: Increase the availability of EBIs for high risk HIV-negative persons (including those for HIV-discordant couples) at risk of transmitting HIV.</p>	<p>Strategy 1: Increase partner services among HIV positive individuals.</p> <p>Strategy 1: Increase availability of biomedical interventions (PEP, PrEP, CM-PEP).</p> <p>Strategy 2: Develop provider education and client outreach materials.</p> <p>Strategy 3: Inventory effectiveness of current EBIs in place in Los Angeles County.</p>	<p>1. Implement 3.0 FTE ARTAS partner service Public Health Investigators in high disease burden areas within Los Angeles County by December 2012.</p> <p>2. Increase the number of embedded PHIs at clinics with high rates of STDs by 50% by December 2012.</p> <p>1. Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2012.</p> <p>2. Conduct 2 community forums with presentations to discuss PrEP by December 2012.</p> <p>3. Prioritize EBIs based on the results of the modeling exercises by July 2012.</p>
	<p>Goal 3: Increase integrated HIV, STD, and viral hepatitis screening sites in Los Angeles County.</p>	<p>Strategy 1: Increase the number of targeted HIV testing venues that provided integrated screening e.g. commercial sex venues and jails.</p> <p>Strategy 2: Increase Program Collaboration Service Integration (PCSI) opportunities within Los Angeles County Department of Public Health (DPH).</p>	<p>1. Convene quarterly DPH PCSI workgroup meetings by February 2012.</p> <p>2. Redefine the scope of work for the commercial sex venue testing initiative by December 2012.</p> <p>3. Purchase 2 additional multiple morbidity testing units by December 2012.</p>
	<p>Goal 4: Increase provider capacity to provide integrated prevention messages and services.</p>	<p>Strategy 1: Provide clinician and health care worker training to include prevention messages about HIV, STDs, and viral hepatitis.</p>	<p>1. Partner with AIDS Education Training Centers (AETC) to provide at least 2 clinician trainings with continuing education credits by December 2012</p> <p>2. Implement Hepatitis A and B vaccination protocols in multiple morbidity mobile testing units, and nPEP programs by December 2012.</p> <p>3. By June 2012, post updated list of local free hepatitis A and B vaccination sites, as well as STD and TB treatment sites at online resource: www.hiv1a.org website.</p>

Activity	Goal	Strategy	Objective
HERR for High Risk Negatives	Goal 5: Decrease social factors impacting HIV risk among HIV negative persons at highest risk of acquiring HIV.	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). Strategy 2: Increase awareness of biomedical and bio-behavioral programs (e.g. nPEP, CM-PEP, PrEP).	1. By December 2012, provide at least 2500 HIV tests at substance abuse clinics. 2. Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2012.
	Goal 6: Provide substance use treatment to HIV negative men who have sex with men and transgender individuals who also use crystal meth.	Strategy 1: Increase outreach activities to recruit and enroll individuals into substance use treatment services. Strategy 2: Increase awareness of biomedical and bio-behavioral programs.	1. By December 2012, enroll 60 HIV negative crystal meth using MSM and transgender individuals into substance use treatment services. 2. Circulate nPEP marketing materials to 100% of OAPP supported HIV prevention and care programs by December 2012.
Program Planning, Monitoring, and Evaluation, and QA	Goal 1: Use HIV and STD surveillance data to prioritize risk reduction counseling and partner services, and to evaluate linkage to care.	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.	1. Conduct data matching every 3 months starting in January 2012. 2. Develop and implement ARTAS partner services protocol for those newly diagnosed with HIV by March 2012.

Activity	Goal	Strategy	Objective
Community Mobilization	Goal 1: Engage community planning groups to address community mobilization.	Strategy 1: Continue working with the Prevention Planning group (PPG), the Commission on HIV (COH) Strategy 2: Implement Phase II of OAPP's Social Marketing campaign.	1. By December 2012, convene at least 12 community planning meetings. 2. Increase hits on Erase Doubt website by 50% by December 2012. 3. Increase visibility of Erase Doubt messaging through targeted media placement throughout geographic "hot spots" by December 2012.
	Goal 2: Increase HIV awareness via faith-based communities, social networks, and popular opinion leaders.	Strategy 1: Continue to fund Faith-based HIV prevention activities. Strategy 2: Implement additional social network testing programs in Los Angeles County.	1. By December 2012, support at least 1 HIV faith-based HE/RR program. 2. By December 2012, support at least 1 new Popular Opinion Leader intervention targeting gay men. 3. By December 2012, support at least 1 social network testing program for high risk negative and HIV positive individuals among African American, Latino, MSM, and crystal meth users.
Jurisdictional HIV Prevention Planning	Goal 1: Develop a Jurisdictional HIV Prevention Plan	Strategy 1: Re-assess the structure of the community planning group Strategy 2: Form the new Prevention Planning Group Strategy 3: Create an Engagement Plan	1. By January 2012, determine new structure of the Prevention Planning Group 2. By February 2012 develop Engagement Plan 3. By May 2012 develop the Jurisdictional HIV Prevention Plan 4. By June 2012, the HIV Prevention Planning Group will provide a letter of concurrence for the Comprehensive HIV Program Plan 5. By December 2012, at least two presentations or trainings on the Jurisdictional HIV Prevention Plan will be delivered
Capacity Building and Technical Assistance	To be Determined	To be Determined	To be Determined following modeling activities

Appendix I: New Directions in HIV Testing Services: Los Angeles County Testing Model

In 2011, the Office of AIDS Programs and Policy (OAPP) began the process of streamlining and improving HIV Testing Services (HTS) conducted by community partners. The intent of developing the new Los Angeles County (LAC) testing model and taking testing in new directions is to align services with the National HIV/AIDS Strategy (NHAS) and local goals. The three primary goals of NHAS are: 1) reducing the number of people who become infected with HIV; 2) increasing access to care and improving health outcomes for people living with HIV; and 3) reducing HIV-related health disparities. An analysis of HIV prevention and care programs showed that, to impact the aforementioned goals, the annual number of HIV tests conducted in Los Angeles County will need to nearly triple, and linkage to care and Partner Services activities will need to expand.

Data supports that approximately 21% of the estimated 61,700 people living with HIV/AIDS (PLWHA) in LAC are not aware of their HIV positive status. Studies show that approximately 50% of all new HIV infections each year are transmitted by PLWHA who are unaware of their HIV status. OAPP supports a variety of HIV testing modalities including: HIV counseling and testing services in storefronts, substance abuse clinics, courts, mobile units, and in commercial sex venues; social network; multiple morbidity testing; jail-based testing; and routine HIV screening in health care settings (e.g., clinics, STD clinics, emergency departments, substance abuse clinics, urgent care centers) to assist with identifying undiagnosed infection as well as counsel and educate those at elevated risk for acquiring HIV.

It is OAPP's goal to modernize the Los Angeles County HIV testing program to make it more effective and easier for people to test, get linked into care, and receive appropriate referrals while providing high quality services AND make it easier and more cost effective for community service partners to provide HIV testing services.

Los Angeles County New Testing Model

In order to increase the efficiency and effectiveness of HTS, OAPP implemented the following changes starting July 2011:

Program Area/Activity	Challenge	New Direction	Benefits
Reimbursement Restructuring and Pay-for-Performance	Reimbursement mainly focused on identifying risk, provision of confirmatory test disclosure, referrals to care linkage, and partner services and was not performance based	New reimbursement method focuses on documented linkage to care and partner services as well as positivity rate in addition to overall testing volume. The new reimbursement method is based on the following performance measures:	Should promote increased testing volume, increased positivity rate, and increased linkages to care and partner services

Program Area/Activity	Challenge	New Direction	Benefits
		<ul style="list-style-type: none"> • number of tests indicated by scope of work, • achieving or exceeding a 1.03% positivity rate, • 85% documented linkage to care for newly diagnosed HIV-positive testers, and • 100% of all HIV-positive testers will be offered/referred to partner services). 	
Rapid Testing Algorithm <i>New Testing Technology</i>	<p>Waiting for confirmatory test results resulted in loss to follow up, lower linkage to care rates, and increased levels of anxiety for the client. This was especially true for transient populations.</p>	<p>New HIV testing algorithm focuses on providing linkages to care and partner services after testing positive to two rapid tests (see pgs. 101-102)</p>	<p>Increase those aware of their status and increase linkages to care and partner services. Decrease agency staff time spent doing follow-up calls and paperwork for confirmatory disclosure. Staff can spend more time for direct service delivery.</p>
Rapid Testing Algorithm <i>New Counseling Messages</i>	<p>Clients were not told that they had HIV and should immediately access care until confirmatory results were available. This contributed to low disclosure rates and an increasing number of individuals unaware of their HIV status.</p>	<p>If two reactive results are obtained (two-step RTA), the client is told “since two of the rapid tests were reactive, this means your result is positive for HIV” The client will be linked to a medical provider (during the same counseling session)</p> <p>If only one rapid test is used and the result was reactive, the counselor will tell the client “your result was reactive. This very likely means you have HIV antibodies” (see p. 103 for more counseling messages)</p>	<p>This change in counseling messages will decrease the number of HIV-positive persons unaware of their HIV status, facilitate early linkage to care, improve patient health outcomes, may decrease community viral load and forward transmission of HIV.</p>

Program Area/Activity	Challenge	New Direction	Benefits
Linkages to Care and Partner Services	<p>HIV counselors focused on following-up with clients to disclose confirmatory HIV test results rather than assisting clients with setting up first medical appointment; partner services offered voluntarily by counselors</p> <p>All high risk clients had to receive HIV risk reduction counseling per contract requirements. For many repeat testers the counseling was not beneficial to the client and limited testing volume.</p>	<p>All clients referred to Public Health partner services through 3rd party notification. Counselor's main focus is to assist clients with first medical appointment and to verify completion with medical provider.</p> <p>The client with the counselor decides how much counseling is needed.</p>	<p>Increase successful linkages to care; should increase partner elicitation and testing of partners</p>
HIV Counseling Session <i>Optional Counseling</i>	<p>HIV testing contracts required that HTS staff complete continuing education units. Although all counselors must have current certifications to provide services; linkage to care, partner services, data submission, and disclosure rates could be improved.</p>	<p>OAPP's HIV counselor training program was revised to incorporate the New Directions in HIV testing services. Advanced Counselor Training (Basic II), Finger stick Proficiency, Partner Services, and Phlebotomy Certification (as directed by OAPP) are all required. All HIV testing service providers must attend at least 16 hours of OAPP-approved skills-building training annually.</p>	<p>HIV testing programs will be able to test more clients. This model supports true client-centered counseling</p>
HIV Counselor Training and Re-certification			<p>The revised counselor training program focuses on linkage to care, partner services, data collection and reporting, client-centered counseling, cultural competency, co-morbidities and co-factors of HIV, and competency.</p> <p>By routinely honing counseling and testing skills, a higher proportion of HIV-positive clients will be linked to care, screened for co-morbidities, and referred to partner services.</p> <p>The new directions will require a higher level of skills to implement services with fidelity to testing protocols and to achieve performance goals for reimbursement. Thus, HIV testing</p>

Program Area/Activity	Challenge	New Direction	Benefits
HIV/STD Integrated Testing	The necessity of blood draw/sample for other co-morbid screenings limited the number of service providers who could offer integrated testing. One of the biggest challenges was having phlebotomy certified staff on site.	OAPP now requires that sites have at least one phlebotomy certified staff available during normal testing hours. OAPP is also providing finger stick training to all HIV testing counselors. This is the direct result of the implementation of the two-step RTA model which requires a blood sample. OAPP is also developing a Multiple Morbidity Diagnostic Screening protocol which would standardize and normalize services.	service providers should be compensated and this may decrease agency staff turnover rates. Integrated testing will increase the number of newly diagnosed cases. Newly diagnosed clients who have co-morbid diseases will be linked into care, receive treatment, and will have better health outcomes. This will reduce the transmission of HIV and STIs in the community.
Laboratory Services Vendor	One challenge that impacts linkage rates, efficiency of partner service provision, and quality of HIV testing data and HIV surveillance data is the inconsistency in the delivery time of laboratory results. A significant amount of staff time is needed to follow-up and track lab results. Another limitation was the variance in lab fees across vendors.	OAPP strongly recommends that all contracted testing providers utilize the Los Angeles County Public Health Lab (PHL). OAPP and PHL have a MOU which allows OAPP to monitor the quality and timeliness of laboratory services (see Appendix J). OAPP will coordinate provision of results on behalf of the agency.	By transitioning services to the PHL, OAPP was able to negotiate a lower fee structure due to the high volume of tests. The turnaround time for test results should decrease and since OAPP is coordinating the service, HIV counselors will have more time for direct service delivery.
Laboratory Services Confirmatory Test	With new testing technology the Western Blot test is no longer necessary and is duplicative since	OAPP is recommending only the viral load test for reactive results from the two-test RTA	Cost savings since the viral load test would be covered by Ryan White or a third party payor.

Program Area/Activity	Challenge	New Direction	Benefits
	<p>HIV-positive clients get a viral load test when linked to care</p>		<p>Prevention resources could be redirected in purchasing more test kits, scaling up prevention services for HIV-positive individuals, or for a multitude of other prevention activities.</p>
<p>Data Collection and Reporting: <i>Data Collection Forms</i></p>	<p>Different data collection requirements for California Office of AIDS and CDC. Most data elements not being used to evaluate or improve programs. Data burden affected both HTS service providers and OAPP data management team.</p>	<p>OAPP transitioned away from the state's Two-Tier model for HIV testing and began collecting a limited set of data per test session to match the minimum CDC data collection requirements. Client-centered counseling will still be offered to individuals at high risk for HIV.</p>	<p>Cost and time savings for services providers. Providers can devote more time to direct services and focus on client-centered testing, improving quality of services, and collect more accurate and complete data. This is critical because data drive prevention planning and resource allocation in Los Angeles.</p>
<p>Data Collection and Reporting: <i>Data Submission</i></p>	<p>Data entry and submission was burdensome for HIV testing providers and negatively impacted testing volume. Completeness and validity of testing data was not optimal. Providers were required to submit data for negative clients on a monthly basis and case report forms should be submitted within 72 hours.</p>	<p>OAPP transitioned HTS sites from the HIV Information Resources System (HIRS) to Teleform – a scannable data collection system. Providers must submit HIV-positive case forms within 72 hours and screening forms for HIV-negative clients on a weekly basis.</p>	<p>Manual data entry is eliminated. Faster data reporting of tests and HIV cases by providers; improved HIV case finding; improved evaluation of HIV testing performance indicators; and increased inclusion of cases in the active surveillance system which will enhance LAC's ability to secure additional funding.</p>
<p>Data Collection and Reporting: <i>Case Reporting</i></p>	<p>Costly and overly complex data collection system, duplicative data elements reported for HIV testing and HIV case reporting. The case reporting process was also redundant. Service providers had to submit the case report forms to HIV Epidemiology Program (HEP) for active surveillance,</p>	<p>OAPP transitioned HTS sites from the HIV Information Resources System (HIRS) to Teleform – a scannable data collection system. OAPP integrated HIV testing data collection and the HIV case reporting form. Providers will only submit data to OAPP and OAPP will disseminate the</p>	<p>Faster data reporting of tests and HIV cases by providers; improved HIV case finding; improved evaluation of HIV testing performance indicators; and increased inclusion of cases in the active surveillance system which will enhance LAC's ability to secure additional funding.</p>

Program Area/Activity	Challenge	New Direction	Benefits
	OAPP, and to the Sexually Transmitted Diseases Program (STDP) for partner services.	information to HIV Epidemiology surveillance team and STDP partner services public health investigators.	

Figure 1: Two-Test RTA with a Blood Screening Test

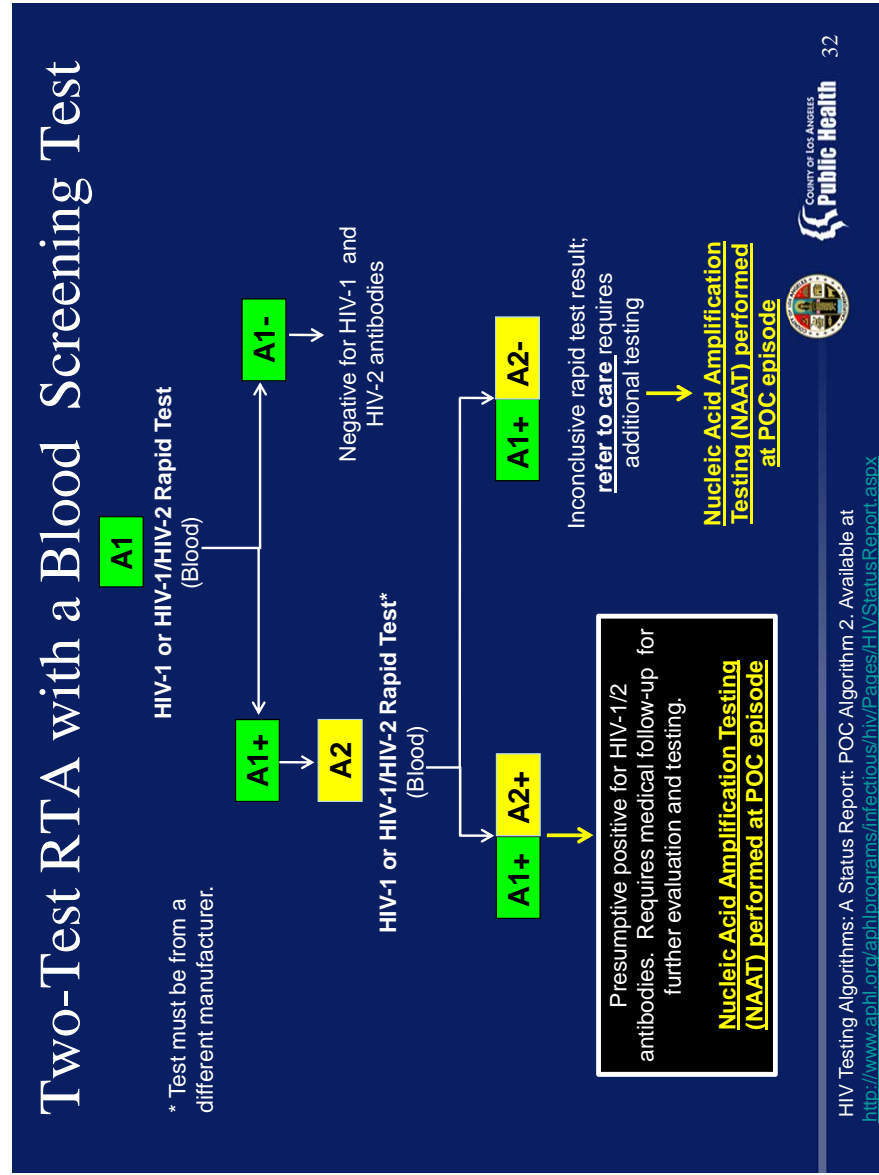
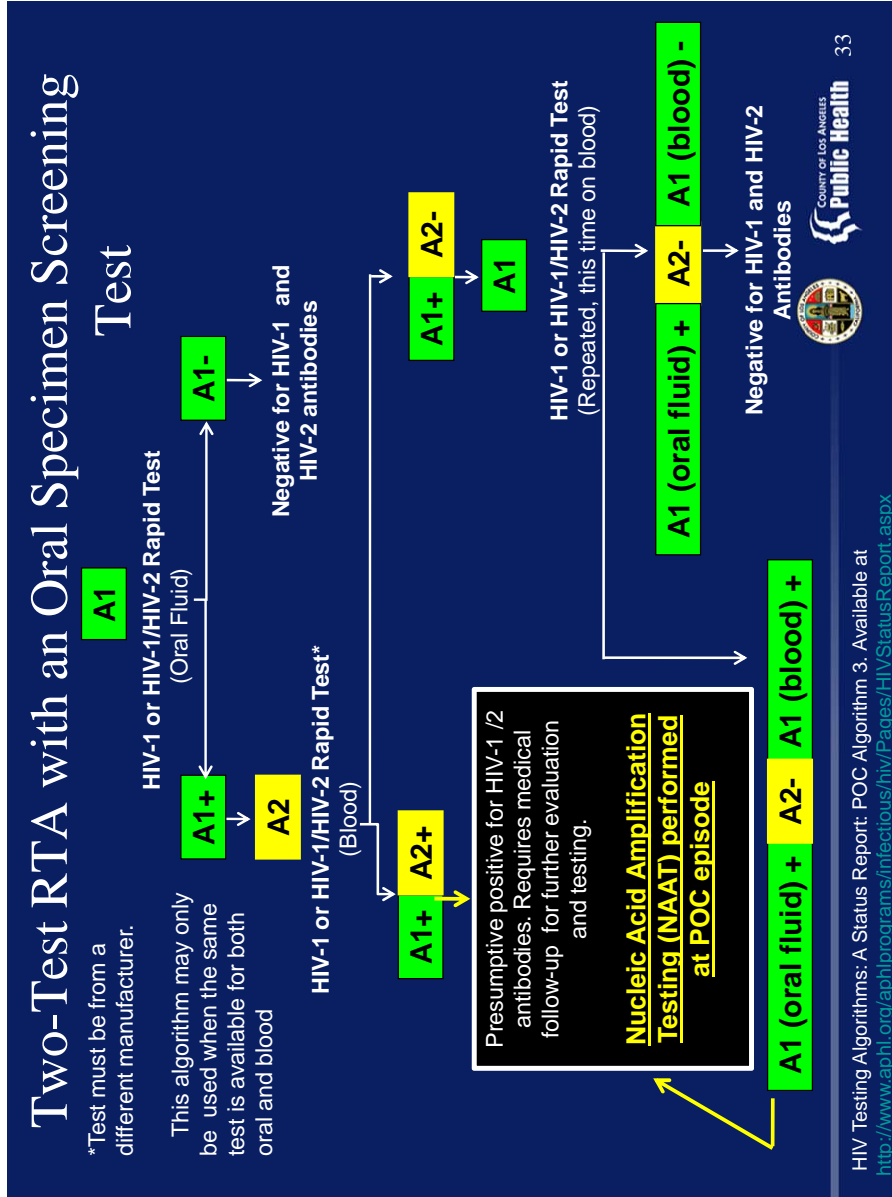


Figure 2: Two-test RTA with an Oral Specimen Screening Test



RTA Counseling Messages: Sample Scripts

Consent

What do you say about process? If your first test comes back reactive, we would want to do some further testing. We would run up to 2 additional rapid tests here, which could take up to a half hour. This would require a fingerstick or drawing blood. A specimen would then be sent to a lab for further testing to facilitate linkage to medical care. In any event, I will be able to give you some solid information about whether or not you have HIV today. Is this OK with you?

What do you say about contact information?

In case we need to contact you for any reason, we will use the information you provided on the form.

First Reactive (+)

What do you say? Your result was reactive. This very likely means you have HIV antibodies. We are going to run up to two more rapid tests using blood and we will also send a sample to the lab for further testing to facilitate linking you into care. This could take up to 30 more minutes. Before you leave today I should be able to give you some solid information about whether or not you have HIV. We can talk as much as you want while we wait.

Positive Result (+ +)

What do you say? Both rapid tests we ran today were reactive. Since two of the rapid tests were reactive, this means your result is positive for HIV. I want you to know that we can work together and know that you are not alone in any part of this. It is very important for you to be able to receive medical care. It is highly unlikely the test results of the specimen we are sending to the lab will be different than the tests we ran today; however, it will help start the process of you receiving medical care and other services. As part of the services we provide, we will be linking you to a medical provider and following up with you. Also, as part of our team, public health department staff will contact you and offer you partner services options to assist you with informing partners of possible exposure. They will also follow up with you about seeing a provider. Does that work for you? Do you have any questions? I have a few more questions to ask you. I want to make sure I have the right contact information.

Negative Result (+ - -)

What do you say?

Although the first rapid test we ran today was reactive, we ran two additional rapid tests and both were non-reactive. Based on this, you do NOT have HIV.

Inconclusive Result (+ -)

What do you say? Although the first rapid test ran today was reactive, we ran another blood test it was non-reactive, which means the result is inconclusive. We will still want to link to a medical provider for follow-up. In the meantime, the blood samples we have will be sent to a lab for further diagnostic testing.

2nd Test Non-Reactive and 3 Test Reactive, Positive Result (+ - +)

What do you say? The first test was reactive, and we ran a second rapid test, which was non-reactive. Since those two tests didn't agree, we ran a third test which was also reactive. Since two of the rapid tests were reactive this means your result is positive for HIV. I want you to know that we can work together and know that you are not alone in any part of this. It is very important for you to be able to receive medical care. It is highly unlikely the test results of the specimen we are sending to the lab will be different than the tests we ran today; however, it will help start the process of you receiving medical care and other services. As part of the services we provide, we will be linking you to a medical provider and following up with you. Also, as part of our team, public health department staff will contact you and offer you partner services options to assist you with informing partners of possible exposure. They will also follow up with you about seeing a provider. Does that work for you? Do you have any questions? I have a few more questions to ask you. I want to make sure I have the right contact information]. A103

Appendix J: MOA Between OAPP and Public Health Lab

Appendix pages A104-A115

Appendix K: Partner Services

As the health department grantee, OAPP is responsible for the provision of partner services (PS) to HIV infected persons and their partners within LAC. However, Sexually Transmitted Diseases Program (STDP) has the only legal authority to conduct partner notifications in the field for PS. Therefore, OAPP will utilize three methods to contract for PS which are: 1) Provision of PS through STDP Public Health Investigators (PHI), which includes maintaining systems to adhere to local policies requiring that all persons reported through various mechanisms are followed-up to ensure the provision of PS; 2) Community-Embedded Disease Intervention Specialist (CEDIS): STDP, in collaboration with OAPP, will operate a CEDIS model to conduct PS at two number high volume HIV/AIDS testing and treatment facilities in 2012. CEDIS are staff who provide PS to newly-identified syphilis and HIV cases, are employed directly by a community based organization, and are also jointly supervised by a STDP PHI; 3) HTS and HE/RR staff at OAPP-funded provider sites will refer all HIV-positive testers directly to PS within 72 hours of disclosures as well as provide partner elicitation services.

Appendix L: Data Sharing Plan

On a routine basis, OAPP, HIV Epidemiology Program (HEP), and Sexually Transmitted Disease Program (STDP) will share and provide HIV surveillance and testing data to facilitate increased linkages to care and partner services for clients testing positive at OAPP-supported testing sites in LAC. In addition, an agreement will be established to share and provide data necessary to effectively track linkage to care, partner services, and viral load. To achieve these goals, the following key activities will be conducted: a) Matching of HIV surveillance data with HIV testing data and the re-disclosure of laboratory results for confirmatory HIV tests as well as viral load, and CD4 results to identify individuals out of care and provide linkage follow-up and partner services (PS), and monitor overall linkage and retention to care and viral load; b) Matching of HIV surveillance data and STD and TB data to monitor co-morbid infection; c) Matching of HIV surveillance data and Ryan White (RW) Care data to provide comprehensive case finding.

These activities have the support of the CDC and the California Department of Public Health, Office of AIDS. Further, these activities are consistent with AB2541 which on January 1, 2011, revised Sections 120130, 121022, and 121025 of the California Health and Safety Code to allow for the re-disclosure of HIV surveillance data for public health purposes.

To increase HIV case finding through PS, LAC will utilize HIV surveillance data to increase delivery of PS. LAC's revised HIV testing plan (which began August 1, 2011) requires that all positive tests at OAPP-contracted sites are reported to OAPP within a 72 hour window period. Once OAPP receives the testing form, staff will generate a case report which will be sent simultaneously to surveillance and the PHIs at STDP for further follow-up with index cases.

Because the case report form is integrated with OAPP's data collection form, service providers are contractually obligated to submit data in a timely manner. OAPP's data management team; quality assurance, provider support services, and Financial Services Division staff; and prevention contract program managers work with agencies to ensure timely submission, completeness, and validity of data. This will expedite the inclusion of these cases in both HEP and STDP surveillance systems. HEP surveillance data will be reviewed to determine whether or not the index case is a new positive and STDP surveillance data will determine if the client is dually-diagnosed with STI(s). Both data matches will help PHIs determine if partner services should be initiated, the priority of the case, and will assist with locating the client and verifying client information.

Appendix M: List of Los Angeles Area HIV Specialty Clinics

Los Angeles Area HIV Specialty Clinics

offering comprehensive HIV services for women, infants, children, adolescents and their families

PERINATAL HIV CLINIC	CONTACT PERSON(S)	TELEPHONE NUMBER
<p>Children's Hospital Los Angeles (CHLA) 4650 Sunset Blvd, Los Angeles, CA 90027 Note: *This is not a birth/delivery hospital</p>	<p>Physician: Dr. Joseph A Church Division of Allergy-Clinical Immunology E-mail: JChurch@chla.usc.edu</p>	<p>(323) 361-2501</p>
<p>LAC-USC Maternal Child Clinic 1640 Marengo Street, HRA BLDG., 2nd Floor Los Angeles, CA 90033</p>	<p>Clinic and Answering Service</p> <p>Administrative: Rosie, NP Judy, PA</p> <p>Pediatrics: Marthia, FNP Cynthia, RN</p> <p>OB/Adults: Dr. Alice Stek (OB/GYN), E-mail: stek@usc.edu Dr. Francoise Kramer (Adult ID) Dr. Andrea Kovacs (Peds ID) Dr. James Homans (Peds and Adult ID) Dr. Lashonda Spencer (Peds & Adult ID) Dr. Michael Neely (Peds ID) Dr. Leslie Carmichael (Adult ID)</p>	<p>(323) 226-2200 (323) 226-5068 (323) 226-2200 (323) 226-2200 (323) 226-2200</p>
<p>Memorial Medical Center of Long Beach (LBMMC) 501 East 27th Street, Suite #103 Long Beach, CA 90806</p>	<p>Administrative- Pua Fineanganofa Physician: Dr. Deveikis E-mail: adeveikis@memorialcare.org</p>	<p>(562) 933-8590</p>

<p>Mattel Childrens Hospital at UCLA- CARE 4 Families Clinic 10833 Le Conte Avenue Room 22-442 MDCC Los Angeles, CA 90095</p>	<p>Administrative Assistant: Ruth A. Mares-Arons E-mail: rmares@mednet.ucla.edu</p> <p>Nicki Falgout, RN E-mail: nfalgout@mednet.ucla.edu</p> <p>Terri Sayama, LCSW E-mail: tsayama@mednet.ucla.edu</p> <p>Physician(s): Dr. Karen Nielson Dr. Jaime Deville Dr. Yvonne Bryson</p>	<p>(310) 206-6369</p> <p>(310) 206-3536</p>
<p>Cedars-Sinai Medical Center (CSMC) - Pediatric Infectious Diseases Clinic 8700 Beverly Blvd - North Tower, 4th Floor, Room 4220 Los Angeles, CA 90048</p>	<p>Administrative: Silvia Guzman E-mail: Silvia.Guzman@cshs.org</p> <p>Physician: Dr. Deborah Lehman Associate Director of Pediatric Infectious Diseases E-mail: Debbie.Lehman@cshs.org</p>	<p>(310) 423-4471</p>
<p>Harbor-UCLA Medical Center 1000 W. Carson Street Torrance, CA 90509</p>	<p>Spring Wettgen, PNP E-mail: swettgen@labiomed.org</p> <p>Physician: Dr. Margaret Keller Chief, Pediatric Infectious Diseases E-mail: keller@labiomed.org</p>	<p>(310) 781-3656</p> <p>(310) 222-4175</p>
<p>Kaiser-Bellower HIV Clinic 9449 East Imperial Hwy Downey, CA 90242</p>	<p>Physician: Dr. Victor K. Wong E-mail: Victor.K.Wong@kp.org</p>	<p>(562) 803-2310</p>

For any questions or concerns about Pediatric HIV/AIDS Reporting, please contact:
Azita Naghdi, MPH
HIV Epidemiology Program - 600 S. Commonwealth Avenue, Ste. 1260, Los Angeles, CA 90005
Tel: (213) 351-8153 Email: anaghdi@ph.lacounty.gov

Appendix N: List of Prevention Services Subcontractors 2011

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
OFFICE OF AIDS PROGRAMS AND POLICY

PREVENTION SERVICES SUBCONTRACTORS (2011)

SUB-CONTRACTOR	SITE ADDRESS (Main)	Target P Population	HIV COUNSELING AND TESTING	OUTREACH (1)	ILI (2)	GLI (3)	PCM (4)	CLI (5)	HC/PI (6)	OTHER (7)	EVIDENCE BASIS FOR HE/R PROGRAMS		
AIDS Healthcare Foundation	6255 West Sunset Blvd, # 2100 Los Angeles, CA 90028	Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0			
		Men, Women, Transgender, Youth	Storefront West Hollywood	0	0	0	0	0	0	0			
		Men, Women, Transgender, Youth	Storefront Long Beach	0	0	0	0	0	0	0	0		
		Men, Women, Transgender, Youth	Storefront SPA 5	0	0	0	0	0	0	0	0		
AIDS Project Los Angeles	611 South Kingsley Drive, Los Angeles, CA 90005	HIV-positive Men		*	*	*	*	*	*	*	HERR		
		African-American Gay Identified Men		*	*	*	*	*	*	*	Many Men Many Voices		
		Crystal Meth Using Gay Identified Men		*	*	*	*	*	*	*	HERR		
		General Population in SPA 1		*	*	*	*	*	*	*	Community Promise		
		Native Americans		*	*	*	*	*	*	*	HERR/Red Circle Project		
		Gay Identified Men		*	*	*	*	*	*	*	CRCS		
		Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0			
		Men, Women, Transgender, Youth	Storefront SPA 1	0	0	0	0	0	0	0	0		
		Women		*	*	*	*	*	*	*	*	HERR	
		People who Share Needles/works		*	*	*	*	*	*	*	*	Safety Counts	
Asian American Drug Abuse Program	5318 S. Crenshaw Blvd, Los Angeles, CA 90043	HIV-positive Gay Identified Men		*	*	*	*	*	*	*	HERR		
		HIV-positive Gay Identified Men		*	*	*	*	*	*	*	Healthy Relationships		
		Gay Identified Men		*	*	*	*	*	*	*	Hermanos de Sol y Luna		
		Transgender		*	*	*	*	*	*	*	Hermanas de Sol y Luna		
		Transgender		*	*	*	*	*	*	*	CRCS		
		Gay Identified Men		*	*	*	*	*	*	*	CRCS		
		Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	0		
		Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0	0		
		Being Alive/People with HIV/AIDS Action Coalition	7531 Santa Monica Blvd Los Angeles, CA 90046	HIV-positive Gay Identified Men		*	*	*	*	*	*	*	HERR
				HIV-positive Gay Identified Men		*	*	*	*	*	*	*	Healthy Relationships
Gay Identified Men				*	*	*	*	*	*	*	Hermanos de Sol y Luna		
Transgender				*	*	*	*	*	*	*	Hermanas de Sol y Luna		
Transgender				*	*	*	*	*	*	*	CRCS		
Gay Identified Men				*	*	*	*	*	*	*	CRCS		
Benestar Human Services	5326 East Beverly Blvd, Los Angeles, CA 90022	HIV-positive Gay Identified Men		*	*	*	*	*	*	*	Healthy Relationships		
		HIV-positive Gay Identified Men		*	*	*	*	*	*	*	Hermanos de Sol y Luna		
		Gay Identified Men		*	*	*	*	*	*	*	Hermanas de Sol y Luna		
		Transgender		*	*	*	*	*	*	*	CRCS		
Being Alive/People with HIV/AIDS Action Coalition	5326 East Beverly Blvd, Los Angeles, CA 90022	Gay Identified Men		*	*	*	*	*	*	*	CRCS		
		Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0			
Benestar Human Services	5326 East Beverly Blvd, Los Angeles, CA 90022	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0			
		Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0			

SUB-CONTRACTOR	SITE ADDRESS (Main)	Target Population	COUNSELING AND TESTING	OUTREACH (1)	ILI (2)	GLI (3)	PCM (4)	CLI (5)	HC/PI (6)	OTHER (7)	EVIDENCE BASIS FOR HERR PROGRAMS
California Drug Consultants	11751 Davis Street Moreno Valley, CA 92557	People who Share Needles/works		*	*	*	*	*	*	*	Safety Counts
California State University, Long Beach	6300 State University Drive, Long Beach, CA 90815	Men, Women, Transgender, Youth	Multiple Morbidity	0	0	0	0	0	0	0	
Center for Health Justice	8235 Santa Monica Blvd #214 West Hollywood, CA 90046	Jail-population		*	*	*	*	*	*	*	HERR
Central City Community Health Center	5230 East Beverly Blvd Los Angeles, CA 90022	Clinic Patients	Routine Testing	0	0	0	0	0	0	0	
Charles Drew University/Oasis Clinic	1731 East 120th Street Los Angeles, CA 90059	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
Childrens Hospital Los Angeles	4650 Sunset Blvd, Mailstop #1 Los Angeles, CA 90027	Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0	
	4650 Sunset Blvd, Mailstop #1 Los Angeles, CA 90027	Young Gay-identified Men		*	*	*	*	*	*	*	HERR
	4650 Sunset Blvd, Mailstop #1 Los Angeles, CA 90027	Young Transgenderers		*	*	*	*	*	*	*	HERR
City of Long Beach	4650 Sunset Blvd, Mailstop #1 Los Angeles, CA 90027	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	4650 Sunset Blvd, Mailstop #1 Los Angeles, CA 90027	Young Women		*	*	*	*	*	*	*	HERR
City of Pasadena Health Department	4650 Sunset Blvd, Mailstop #1 Los Angeles, CA 90027	Women		*	*	*	*	*	*	*	HERR
	1845 North Fair Oaks Avenue Pasadena, CA 91103	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
Clinica Monsenor Oscar Romero	123 South Alvarado Street Los Angeles, CA 90057	Clinic Patients	Routine Testing	0	0	0	0	0	0	0	
Common Ground	2112 Lincoln Blvd, Ste 190 Santa Monica, CA 90405	Women		*	*	*	*	*	*	*	HERR
	2112 Lincoln Blvd, Ste 190 Santa Monica, CA 90405	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
East Los Angeles Women's Center	1255 South Atlantic Boulevard Los Angeles, CA 90022	Women		*	*	*	*	*	*	*	Promotoras
	420 South Glendora Avenue West Covina, CA 91790	Transgender		*	*	*	*	*	*	*	HERR
East Valley Comm Health Center	420 South Glendora Avenue West Covina, CA 91790	People who Share Needles/works		*	*	*	*	*	*	*	PIM
	420 South Glendora Avenue West Covina, CA 91790	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	420 South Glendora Avenue West Covina, CA 91790	Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0	
	1157 Lemonnyne Street Los Angeles, CA 90026	People who Share Needles/works		*	*	*	*	*	*	*	HERR
El Proyecto Del Barrio	8902 Woodman Avenue Arliea, CA 91331	HIV-positive Gay Identified Men		*	*	*	*	*	*	*	Healthy Relationships
	8902 Woodman Avenue Arliea, CA 91331	Gay Identified Men		*	*	*	*	*	*	*	Empowerment
	8902 Woodman Avenue Arliea, CA 91331	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	

SUB-CONTRACTOR	SITE ADDRESS (Main)	Target Population	COUNSELING AND TESTING	OUTREACH (1)	ILI (2)	GLI (3)	PCM (4)	CLI (5)	HC/PI (6)	OTHER (7)	EVIDENCE BASIS FOR HERR PROGRAMS
Friends Research Institute	1419 North La Brea Los Angeles, CA 90028	Non-Gay Identified Men		*	*	*	*	*	*	*	HERR
	1419 North La Brea Los Angeles, CA 90028	Gay Identified Men		*	*	*	*	*	*	*	HERR
	1419 North La Brea Los Angeles, CA 90028	Crystal Meth Using Gay Identified Men		*	*	*	*	*	*	*	HERR
	1419 North La Brea Los Angeles, CA 90028	Transgender		*	*	*	*	*	*	*	HERR
	1419 North La Brea Los Angeles, CA 90028	Gay Identified Men		*	*	*	*	*	*	*	CRCS
	1419 North La Brea Los Angeles, CA 90028	Men, Women, Transgender, Youth	Social Network	0	0	0	0	0	0	0	0
Greater Los Angeles Agency on Deathness	2222 Laverna Avenue Los Angeles, CA 90041	Women		*	*	*	*	*	*	*	HERR
In The Meantime	407475 West Pico Blvd. Los Angeles, CA 90019	Young Gay-identified Men		*	*	*	*	*	*	*	HERR
JWCH Institute, Inc.	1910 West Sunset Blvd. #650 Los Angeles, CA 90026	Women		*	*	*	*	*	*	*	HERR
	1910 West Sunset Blvd. #650 Los Angeles, CA 90026	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	1910 West Sunset Blvd. #650 Los Angeles, CA 90026	Men, Women, Transgender, Youth	Multiple Morbidity	0	0	0	0	0	0	0	
	11015 Bloomfield Avenue Santa Fe Springs, CA 90670	People who Share Needles/works		*	*	*	*	*	*	*	Community Promise
	11015 Bloomfield Avenue Santa Fe Springs, CA 90670	Gay Identified Men		*	*	*	*	*	*	*	3MV
Los Angeles County/University of Southern California Hospital	1200 North State Street, #101 Los Angeles, CA 90033	ER Patients	Routine Testing	0	0	0	0	0	0	0	
Los Angeles Gay and Lesbian Center	1625 North Schrader Avenue Los Angeles, CA 90028	HIV-positive Gay Identified Men		*	*	*	*	*	*	*	HERR
	1625 North Schrader Avenue Los Angeles, CA 90028	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	1625 North Schrader Avenue Los Angeles, CA 90028	Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0	
	1625 North Schrader Avenue Los Angeles, CA 90028	Clinic Patients	Routine Testing	0	0	0	0	0	0	0	

SUB-CONTRACTOR	SITE ADDRESS (Main)	Target Population	COUNSELING AND TESTING	OUTREACH (1)	ILI (2)	GLI (3)	PCM (4)	CLI (5)	HC/PI (6)	OTHER (7)	EVIDENCE BASIS FOR HE/RR PROGRAMS
Minority AIDS Project	5149 West Jefferson Blvd. Los Angeles, CA 90016	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	5149 West Jefferson Blvd. Los Angeles, CA 90016	Non-Gay Identified Men		*	*	*	*	*	*	*	DUP
	5149 West Jefferson Blvd. Los Angeles, CA 90016	Transgender		*	*	*	*	*	*	*	SISTA
Special Services for Groups	605 W. Olympic Blvd. # 600 Los Angeles, CA 90015	Young Gay-identified Men		*	*	*	*	*	*	*	HERR
	605 W. Olympic Blvd. # 600 Los Angeles, CA 90015	Transgender		*	*	*	*	*	*	*	HERR
	605 W. Olympic Blvd. # 600 Los Angeles, CA 90015	Gay Identified Men & Transgenders		*	*	*	*	*	*	*	CRCS
	605 W. Olympic Blvd. # 600 Los Angeles, CA 90015	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	5101 Hoover Street Los Angeles, CA 90037	Clinic Patients	Routine Testing	0	0	0	0	0	0	0	0
Tazana Treatment Center	18646 Oxnard Street Tazana, CA 91356	Men, Women, Transgender, Youth	MTU	0	0	0	0	0	0	0	
	18646 Oxnard Street Tazana, CA 91356	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
	18646 Oxnard Street Tazana, CA 91356	People who Share Needles/works		*	*	*	*	*	*	*	HHRP
	18646 Oxnard Street Tazana, CA 91356	General Population in SPA 1		*	*	*	*	*	*	*	SHIELD
The Catalyst Foundation	44758 Elm Avenue Lancaster, CA 93534	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
The Center Long Beach (One in Long Beach)	2017 East 4th Street Long Beach, CA 90814	Men, Women, Transgender, Youth	Storefront	0	0	0	0	0	0	0	
To Help Everyone (T.H.E.) Clinic	3834 South Wester Avenue Los Angeles, CA 90062	Clinic Patients	Routine Testing	0	0	0	0	0	0	0	
The Well - Las Memorias	111 North Avenue 56 Los Angeles, CA 90042	Gay Identified Men		*	*	*	*	*	*	*	CRCS
	111 North Avenue 56 Los Angeles, CA 90042	Faith Leaders		*	*	*	*	*	*	*	Faith Based
Valley Community Clinic	6801 Coldwater Canyon Ave North Hollywood, CA 91605	Young Women		*	*	*	*	*	*	*	POL
	6801 Coldwater Canyon Ave North Hollywood, CA 91605	Men, Women, Transgender, Youth	Multiple Morbidity	0	0	0	0	0	0	0	
Watts Health Care Corporation	10300 South Compton Avenue Los Angeles, CA 90002	Transgender		*	*	*	*	*	*	*	CRCS
Westside Family Health Center	1711 Ocean Park Boulevard Santa Monica, CA 90405	Gay identified Men		*	*	*	*	*	*	*	HERR
Whittier Rio Hondo AIDS Project	9200 Colima Road, # 104 Whittier, CA 90065	Young Gay-identified Men		*	*	*	*	*	*	*	Empowerment
	9200 Colima Road, # 104 Whittier, CA 90065	Women		*	*	*	*	*	*	*	SISTA

***HERR Contracts under negotiation**

SUMMARY

- 38 Agencies
- 14 HERR + HCT Agencies
- 7 HCT Only Agencies
- 14 HERR Only Agencies
- 53 HERR Programs
- 34 HCT Programs

*Includes new routine testing sites

Appendix O: Policies and Procedures for use of ART in Los Angeles County

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 (U.S. Department of Health and Human Services. [*Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*](#). January 10, 2011. Available at <http://aidsinfo.nih.gov/Guidelines/GuidelineDetail>) 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 (RW) services, including HIV treatment in accordance with current guidelines for HIV medical care.
3. The OAPP Medical Advisory Committee (MAC), 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 RW system of care.

Appendix P: OAPP Policy Agenda

Starting in 2012, the following LAC strategies are proposed: Continue to engage in meetings and conversations with local, state, and federal legislators and policy makers; continue participation in UCHAPS and other bodies that influence policy; support and pursue statewide legislation such as AB 491 to remove written informed consent in community testing venues which will eliminate one barrier to HIV testing and screening; develop a strategic plan with and assist local Emergency Departments and Urgent Care Clinics in areas with a high density of HIV, gonorrhea, and syphilis to implement opt-out routine HIV testing; promote and help facilitate HIV, STD, substance abuse, and mental health screening in all treatment and care services; identify ways to provide continuing education and promote early linkage to care and partner services for all new positives in public and private healthcare settings; develop and execute an action plan for prevention services to prevent perinatal transmission of HIV; promote accurate and timely reporting of HIV laboratory results (i.e., CD4) and HIV case reports at all public and private healthcare facilities; review and revise current standards of care; remove existing barriers which limit access to sterile 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; support LAC DPH and City of Los Angeles in scaling-up the number of syringe services programs (SSP); develop policies, procedures, and MOUs/MOAs that will facilitate data sharing among public and private healthcare facilities and DPH programs in order to accurately track the level of routine screening, linkage to care, retention in care, measure the level of co-morbidities, and conduct syndemic planning based on accurate and robust data in HIV-positive patients; and review and revise current Institutional Review Board, Protection of Human Subjects Protocol Submission requirements to allow for systematic chart reviews of vulnerable populations in order to accurately measure HIV perinatal screening rates.

Appendix Q: HIV Prevention Priorities and Planning

The 2009-2013 HIV Prevention Plan¹ identified six priority populations, 14 critical target populations, and a list of co-factors that contribute to a person's risk for acquiring or transmitting HIV. The priority and critical populations were selected based on available local data (e.g., STD surveillance, HIV surveillance, poverty, HIV testing, local needs assessment, and substance use data).

A composite HIV risk profile was developed which included HIV prevalence as well as a number of high-risk drug and sexual behaviors. The composite risk profile was analyzed by zip code, and those zip codes with the highest person count within each Service Planning Area (SPA) were identified as a "hot-spot" zip code. This "hot-spot" analysis was the precursor to the syndemic planning model used today.

All Health Education Risk Reduction (HE/RR) interventions for high risk HIV-negative individuals were solicited through the LAC DPH Request for Proposals process in 2008. Prospective HE/RR service providers were required to provide services to one or more target populations in one or more of the "hot-spot" zip codes. OAPP also stipulated that each proposed intervention must be evidence-based (e.g., proven effective in well-designed, and preferably randomized controlled trials) or based on theory from scientific literature.

¹ Los Angeles County, Department of Public Health. 2009-2013 HIV Prevention Plan. Available at: <http://www.publichealth.lacounty.gov/aids/PreventionPlan.htm>

Appendix R: Promotion of Local and National Social Marketing Campaigns

- 1) OAPP has its own social marketing campaign, Erase Doubt, which includes messages targeted to high-risk populations and communities. Media include bus ads, placement of posters in bars and clubs, messaging on gas pumps in high burden areas, messaging on gay male dating sites such as Grindr, etc. OAPP will adapt the Erase Doubt brand to include a targeted condom distribution campaign, a targeted informational Post Exposure Prophylaxis (PEP) campaign, etc. in 2012.
- 2) OAPP will continue to support, promote, and partner with other agencies and organizations (e.g. Los Angeles Gay and Lesbian Center, AIDS Healthcare Foundation, STDP, etc.) who have developed social marketing campaigns by promoting their campaigns on the Erase Doubt website (erasedoubt.org). The Erase Doubt logo will also be provided to agencies that want to co-brand it with their marketing. OAPP will also continue to support and promote agency events tied to other campaigns. These collaborations will provide consistent messaging about HIV risk, testing, stigma reduction, and availability of free care and treatment throughout LAC beginning in 2012.
- 3) Links to CDC developed campaigns will continue to be posted on Erasedoubt.org website. OAPP will supplement Erase Doubt materials with CDC printed materials and OAPP staff will participate in events sponsored by CDC.

Appendix S: Capacity Building Activities 2012

Appendix S: Capacity Building Activities 2012

Topic Area Requested or Provided	CBA/TA Recipient	CBA/TA Provider	Data Source/Tracking Process
Client Recruitment	OAPP-funded providers	OAPP Provider Support Services and Prevention Services Division staff, STDP PHIs CDC CBA for CBOs	OAPP program manager agency contact log and CRIS system
Client Retention	OAPP-funded providers	OAPP Provider Support Services, Prevention Services Division staff, Office of the Medical Director, Care Services Division, Office of Planning, Research and Evaluation Division, QM Division; HEP; STDP; Medical Advisory Committee; other CDC-funded jurisdictions; CDC CBA for HD; and CDC CBA for CBOs	Meeting sign in sheets, meeting agendas, TA logs, training database, and CRIS system
Staff Retention	OAPP-funded providers	OAPP Provider Support Services, Prevention Services Division staff, and Office of the Medical Director	Meeting sign in sheets, meeting agendas, TA logs, and training database
Evidence-based Interventions (i.e., Biomedical interventions)	OAPP staff, OAPP-funded providers, and PPG	OAPP Provider Support Services, Prevention Services Division staff, Office of the Medical Director, Office of Planning, Research and Evaluation Division; HEP; RAND; UCLA CHIPTS; UCHAPS; CDC CBA for HD; CDC CBA for CBOs	Meeting sign in sheets, meeting agendas, TA logs, training database, and CRIS system

Topic Area Requested or Provided	CBA/TA Recipient	CBA/TA Provider	Data Source/Tracking Process
Adaptation of EB1 or PHS (i.e., ARTAS ALCM)	OAPP staff, OAPP-funded providers, HEP, STDP PHIs, and care planning body	OAPP Office of the Medical Director, Office of Planning, Prevention Services Division, Care Services; HEP; STDP PHIs; other funded jurisdictions; CDC CBA for HD	Meeting sign in sheets, meeting agendas, TA logs, training database, and CRIS system
Organizational Infrastructure and Program Sustainability (i.e., third party payor sources, collaboration, data sharing, etc.)	OAPP, OAPP-funded Providers, Healthcare settings in partnership with OAPP to provide routine testing services	OAPP Office of the Medical Director, Office of Planning, Prevention Services Division, Executive Office; RAND; and CDC CBA for CBOs	Meeting sign in sheets, meeting agendas, TA logs, and CRIS system
Data Collection and Data Submission (i.e. training on new data system, completion of forms, how to submit data for positive cases, etc.)	OAPP staff and OAPP-funded Providers	OAPP Data management team, Provider Support Services, Prevention Services Division, Quality management Division and CDC National Monitoring and Evaluation Team	Meeting sign in sheets, meeting agendas, TA logs, training database, and emails to CDC project officer
Utilization of Data (i.e., prevention planning, program evaluation, syndemic modeling, geospatial analysis, continuous quality improvement, etc.)	OAPP staff, OAPP-funded providers, and PPC	OAPP Research & Evaluation, Office of Planning, Prevention Services Division, QM Division, HEP, STDP, RAND, other LAC DPH programs, and CDC CBA for CBOs	Meeting sign in sheets, meeting agendas, TA logs, and CRIS system
Information Systems and Data Management	OAPP staff and OAPP-funded providers	OAPP Data management team, Provider Support Services, Prevention Services Division, Quality management Division, experts in GIS, and CDC PERB	Meeting sign in sheets, meeting agendas, TA logs, training database, and emails to CDC project officer
Client Centered Services (i.e., disclosure, counseling, offering PS, provision of referrals, motivational interviewing, etc.)	OAPP-funded providers	Provider Support Services, Prevention Services Division, Office of the Medical	Meeting sign in sheets, meeting agendas, TA logs, training database, and CRIS system

Topic Area Requested or Provided	CBA/TA Recipient	CBA/TA Provider	Data Source/Tracking Process
ABC's of Hepatitis	OAPP, STDP, HEP staff; OAPP-funded providers; and PPG	Director, and CDC CBA for CBOs Other LAC DPH Programs, OAPP Hepatitis Prevention Coordinator, Provider Support Services	Meeting sign in sheets and meeting agendas
HIV, STD, hepatitis, and TB 101	OAPP, STDP, HEP staff; OAPP-funded providers; and PPG	Other LAC DPH Programs, OAPP Hepatitis Prevention Coordinator, Provider Support Services, and Office of the Medical Director	Meeting sign in sheets, meeting agendas, TA logs, and training database
Partner Services	OAPP, STDP, HEP staff; OAPP-funded providers; and PPG	OAPP Office of the Medical Director, Office of Planning, Prevention Services Division, Care Services; HEP; STDP PHIs; other funded jurisdictions; CDC CBA for HD	Meeting sign in sheets, meeting agendas, TA logs, training database, and CRIS system
Quality Management	OAPP staff and OAPP-funded providers	OAPP Office of the Medical Director, Office of Planning, Prevention Services Division; LAC DPH Quality Improvement Team; CDC CBA for CBOs; and protocols and templates for QM and QA contract requirements	Meeting sign in sheets, meeting agendas, TA logs, and CRIS system
Program Evaluation (i.e., evaluation plans and logic models)	OAPP staff and OAPP-funded providers	Office of Planning, HEP, consultants, UCLA CHIPTS, and CDC CBA for CBOs	Meeting sign in sheets, meeting agendas, TA logs, and CRIS system
Promotion of Routine Testing	All Healthcare administrators and providers in high disease burdened areas	OAPP Office of the Medical Director, Quality Management Division, LAC Medical Advisory Committee, and AIDS Education Training	TA logs and request forms

Topic Area Requested or Provided	CBA/TA Recipient	CBA/TA Provider	Data Source/Tracking Process
Cultural Competency (i.e., delivering services in a culturally and linguistically appropriate manner)	OAPP-funded providers	Center OAPP Prevention Services and Provider Support Services Divisions, UCLA CHIPTS, and CDC CIBA for CBOs	Meeting sign in sheets, meeting agendas, TA logs, and CRIS system
Contract Monitoring (i.e., Contract Management 101, Coordinated Contract Monitoring, Program Manager Training, and New Leadership Orientation)	OAPP staff	OAPP Provider Support Services Staff	Training database
New Directions HIV Testing (i.e., Rapid testing implementation, two-step RTA, use of rapid test kits, finger stick training, consent procedures, disclosure script, partner services, linkage to care, development of a QA plan, etc.)	OAPP staff and OAPP-funded service providers	OAPP Provider Support Services, Research and Evaluation Division, and Prevention Services staff and test kit companies	Training database and training calendar
HIPAA, data security, and other public health required trainings	OAPP-staff	LAC DPH/DHS staff and web-based trainings	LAC DPH Learning Net
HIV Jurisdictional Prevention Planning (i.e., Development of the Jurisdictional HIV Prevention Plan, syndemic planning, development of the engagement plan, overview of the new community planning guidance (not yet released) etc.)	OAPP-staff, PPG, and care planning body	OAPP governmental co-chairs, UCHAPS, CDC's community planning guidance, CDC CBA for HD, and consultants	Meeting sign in sheets, meeting agendas, emails, meeting minutes/summary, and CRIS system

Appendix T: An Epidemiologic Profile

The 2009 edition of *An Epidemiologic Profile of HIV and AIDS in Los Angeles County* can be downloaded at www.ph.lacounty.gov/hiv/ by clicking “HIV Statistics and Reports”.

Appendix pages A133-A298

Appendix U: Management and Staffing Plan

How the Program will be Planned, Managed, and Overseen

Within LAC DPH, HEP, STDP, and OAPP were operating as independent programs. Consistent with CDC's 2009 recommendations and guidance for health department program coordination and service integration (PCSI), effective February 2011 the LAC DPH began the integration of OAPP, STDP, and HEP into one consolidated public health program. The newly formed program will coordinate the County's response to HIV and all STDs using an integrated prevention and treatment approach that combines surveillance, planning, data collection and analysis, and geographic mapping to design and implement data-driven programming in the areas with highest disease morbidity. Administrative functions are being consolidated and streamlined, followed by integration of research and evaluation activities, program planning, and direct service delivery to enable a seamless County response that treats the individual holistically to promote overall sexual health and wellness.

Key personnel from OAPP will be actively involved in overseeing the implementation of the seven required and three recommended activities described in this application. These key personnel are responsible for directing the activities of over 47 FTE who will contribute towards the activities funded under this FOA.

Collaborations with Other Programs (e.g., surveillance, STD, laboratory)

OAPP could not adequately respond to the epidemic without meaningful coordination and collaboration efforts. OAPP continually strives to strengthen collaboration and coordination of HIV prevention activities with internal and external partners to provide integrated services that address co-factors of HIV and overall wellness of LAC residents, and to improve systems of

care by streamlining service delivery. These efforts include multiple morbidity screening and testing, uniform laboratory services, training of staff and providers, data matching, using surveillance data for prevention planning and service delivery, integrated educational messages, partner services, linkage to care, retention in care, integration of care and prevention activities, and identifying and addressing structural barriers.

OAPP's collaboration with other DPH programs is critical in halting the progression of HIV within LAC. OAPP collaborates and coordinates activities with DPH (syringe exchange); LAC Sheriff's Department (testing and HE/RR in jails); LAC Substance Abuse Prevention and Control (SAPC) program (substance use data and methamphetamine interventions); LAC TB program (improve screening and identification of latent and active TB among HIV-positive clients in RW Part C funded clinics); LAC Department of Mental Health (routine screening of HIV among clients with mental health disorders and identification of appropriate standards of care and prevention services); STDP (PS, multiple morbidity testing, data matching/sharing, and development of educational materials); HEP (care and prevention planning, data matching/sharing, evaluation of linkage to care and retention in care, and development of the Epidemiologic Profile); LAC Immunization program (evaluation of perinatal HIV screening rates); and PHL (provision of lab results and identification of effective and efficient lab reporting processes).

Proposed staff, staff experience and background, and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation

Mario J. Pérez, MPH, Director, is responsible for managing, planning and guiding the annual investment of more than \$90 million in local, state and federal resources that support a responsive and comprehensive local HIV/AIDS service delivery system for LAC residents. Mr.

Pérez is overseeing the integration of OAPP, STDP, and HEP into one consolidated public health program, the Division of HIV and STD Programs, under his leadership.

Michael Green Ph.D., MHSA, Chief of Planning, oversees the planning and procurement of HIV prevention and care services, community planning and social marketing. He serves as one of the two governmental Co-Chairs of the HIV Prevention Planning Committee (PPC), and has over ten years experience in coordinating HIV, STD, and surveillance programs.

Jennifer Sayles, M.D., MPH, Medical Director and Assistant Professor of Medicine at UCLA, provides county-wide leadership in the clinical management of HIV/AIDS, quality management, clinical research, program evaluation, and policy development efforts. She actively participates in community planning, and leads biomedical prevention and routine testing implementation, TLC+ activities, and provides clinical oversight to the Ryan White system of HIV care for LAC.

Sonali Kulkarni, MD, Assistant Medical Director, provides oversight in the clinical management of HIV/AIDS, as well as directing quality management, clinical research, program evaluation, and policy development efforts for HIV prevention, testing, and treatment programs throughout the County.

Sophia Rumanes, MPH, Chief of Prevention Services oversees all OAPP-funded HIV prevention programs. She is a member of many local and national task forces and workgroups and also serves as the other governmental Co-Chair of the PPC and is LAC's delegate on the national Urban Coalition for HIV/AIDS Prevention Services (UCHAPS).

Mike Janson, MPH is the Chief of Research and Evaluation and has 15 years of quantitative data analysis experience. Mr. Janson has coordinated the GIS analyses conducted by OAPP for the last seven years. These analyses have included spatial statistical techniques and cluster

analysis of HIV and STD surveillance and program data that have actively informed Los Angeles County's HIV prevention planning process and prevention program evaluation.

Mary Orticke, RN, MPH, Chief of Quality Management reports to the Medical Director and is responsible for planning and directing the work of nurses, professionals and support staff responsible for the monitoring and evaluation of the quality of HIV/AIDS prevention and care services. The Chief of Quality Management oversees performance improvement and quality assurance activities, training and health education designed to prevent HIV transmission, engage clients in care and improve health outcomes of persons with HIV.

Carlos A. Vega-Matos, M.P.A., is Chief, Care Services Division and oversees program implementation and service delivery for LAC's Ryan White care program. He has over 20 years of experience in HIV prevention and care policy, programs, and capacity-building across the country. He has also served as a member of various advisory panels and committees to federal agencies including the CDC and the HRSA.

A detailed description for all proposed staff and job descriptions for both proposed and current budgeted staff to support and carry out the activities of the program including evaluation is provided in the budget narrative.

Biosketches and Resumes

On file (pages A303-A318)

Appendix V: References

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- ¹ HIV Epidemiology Program, Los Angeles County Department of Public Health. 2010 Annual HIV Surveillance Report, January 2011: 1-32.
- ² HIV Epidemiology Program, Los Angeles County Department of Public Health. 2010 Annual HIV Surveillance Report, January 2011: 1-32.
- ³ HIV Epidemiology Program. Based on preliminary number of persons reported with HIV from April 17, 2006 to December 31, 2010.
- ⁴ United Way of Greater Los Angeles: *The 2007 LA County Zip Code Data Book*, May 2007. Available at: <http://www.unitedwayla.org/getinformed/rr/socialreports/Pages/2007zipcode.aspx>.
- ⁵ HIV Epidemiology Program, Los Angeles County Department of Public Health. 2010 Annual HIV Surveillance Report, January 2011:1-32.
- ⁶ LAC ECHPP: Executive Summary
- ⁷ This only represents the number of cases recorded in HIV and AIDS names-based surveillance systems. It does not include the number of estimated undiagnosed cases or cases not captured due to reporting delays.
- ⁸ HIV Epidemiology Program, Los Angeles County Department of Public Health. 2010 Annual HIV Surveillance Report, January 2011: 1-32.
- ⁹ HIV Epidemiology Program, Los Angeles County Department of Public Health, An Epidemiological Profile of HIV and AIDS in Los Angeles County, 2009: 1-151.
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- ¹¹ Shoptaw S. and Reback CJ. Associations between Methamphetamine Use and HIV among Men who have Sex with Men: A Model for Guiding Public Policy. *J. Urban Health* 2006 Nov; 83(6):1151-7.
- ¹² Office of AIDS Programs and Policy, Los Angeles County Department of Public Health, HIV Counseling and Testing Annual Report 2009, 2010: 1-53.
- ¹³ HIV Epidemiology Program, Los Angeles County Department of Public Health, An Epidemiological Profile of HIV and AIDS in Los Angeles County, 2009: 1-151.
- ¹⁴ HIV Prevention Planning Committee, Los Angeles County Department of Public Health. Los Angeles County HIV Prevention Plan 2009-2013.
- ¹⁵ 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.
- ¹⁶ Los Angeles County, Department of Public Health, Sexual Transmitted Disease Program 2010 preliminary data reported in LAC PS1—1001 Annual Progress Report FY 2010
- ¹⁷ 2010 preliminary data from OAPP HIV Testing System as of August 05, 2011.
- ¹⁸ 2011 HEP estimate
- ¹⁹ 2011 HEP estimate
- ²⁰ 2011 HEP estimate
- ²¹ 2011 HEP estimate
- ²² 2011 HEP estimate
- ²³ HIV Epidemiology Program, Los Angeles County Department of Public Health. 2010 Annual HIV Surveillance Report, January 2011: 1-32.
- ²⁴ Office of AIDS Programs and Policy, Los Angeles County Department of Public Health. Research Brief: iPrEx Study, January 2011.
- ²⁵ Syndemics Overview-What Principles Characterize a Syndemic Orientation?
<http://www.cdc.gov/syndemics/overview-principles.htm> accessed August 25, 2011.

Appendix W: List of Acronyms

ADAP: AIDS Drug Assistance Program

ALCM: ARTAS Linkage Case Management

ART: Antiretroviral Treatment

ARTAS: Anti-retroviral Treatment and Access to Services

BOS: Board of Supervisors

CBOs: Community Based Organizations

CEDIS: Community Embedded Disease Intervention Specialists

CLIA: Clinical Laboratory Improvement Amendments

COH: Commission on HIV

CRCS: Comprehensive Risk Counseling Services

CSVs: Commercial Sex Venues

DPH: Department of Public Health

ECHPP: Enhanced Comprehensive HIV Prevention Planning

EDs: Emergency Departments

EIA: enzyme immunoassay

EMR: Electronic Medical Record

EPS: Enhanced Perinatal Surveillance

ETP: Expanded Testing Programs

GIS: Geographic Information Systems

HCT: HIV Counseling and Testing

HD: Health Department

HE/RR: Health Education/Risk Reduction

HEP: HIV Epidemiology Program

HTS: HIV Testing Services

IDGs: Interventions Designed for Groups
IDIs: Interventions Designed for Individuals
IFA: immunofluorescence assay
JHPP: Jurisdictional HIV Prevention Plan
LAC: Los Angeles County
MAC: Medical Advisory Committee
MCC: Medical Care Coordination
MD: Metropolitan Districts
Meth: methamphetamine
MM: Multiple Morbidity
MOA: Memorandum of Agreement
MSM: Men who have sex with men
NAAT: Nucleic Acid Amplification Test
NHAS: National Health HIV/AIDS Strategy
NHBS: National Health Behavioral Surveillance
OA: Office of AIDS
PCSI: Program Coordination and Service Integration
PEP: Post-exposure prophylaxis
PHIs: Public Health Investigators
PHL: Public Health Lab
PLWHA: Persons Living with HIV/AIDS
POL: Popular Opinion Leader
PPC: Prevention Planning Committee
PPG: Prevention Planning Group
PrEP: Pre-Exposure Prophylaxis

PS: Partner Services

PSD: Prevention Services Division

QA: Quality Assurance

RTA: Rapid Testing Algorithm

RW: Ryan White

SEPs: Syringe Exchange Programs

SFTP: Secure File Transfer Protocol

SNT: Social Network Testing

SPA: Service Planning Areas

SSL: Secure Socket Layering

SSPs: Syringe Services Programs

STD: Sexually Transmitted Disease

STDP: Sexually Transmitted Disease Program

TG: Transgender

TLC+: Testing, Linkage to Care, Plus treatment

WB: Western Blot