Orange County Health Care Agency

In Collaboration with

HIV Planning Council and
HIV Prevention Planning Committee

Comprehensive HIV Plan 2012-2014 Orange County, California

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Table of Contents

Chapter 3: Reducing New Infections

Chapter 4: Increasing Access to Care and Improving Health Outcomes

Glossary of Abbreviations and Acronyms

ACEP – AIDS Community Education Project

ACTION – AIDS Coalition to Identify Orange County Needs

ADAP – AIDS Drug Assistance Program

AIDS – Acquired Immune Deficiency Syndrome

AOP – AIDS Outreach Project

APAIT – Asian/Pacific Islander AIDS Intervention Team

ARC – AIDS-Related Complex

ARIES – AIDS Regional Informational and Evaluation System

ARP – AIDS Response Program

ART – Antiretroviral therapy

ARV – Antiretroviral

ASCEND – Advanced Skills for Consumer Education and National Development

ASF – AIDS Services Foundation of Orange County

ATS – Alternative Test Site

AZT – Zidovudine

CAC – California AIDS Clearinghouse

CAPER – Consolidated Annual Performance and Evaluation Report

CAQ – Client Assessment Questionnaire

CARE – Comprehensive AIDS Resources Emergency

CDBG – Community Development Block Grant

CDC – Centers for Disease Control and Prevention

CDI – Communicable Disease Investigator

CDPH – California Department of Public Health

CSAD – CARE System Assessment Demonstration

CSAP – Centers for Substance Abuse and Prevention

CSTEP – California Statewide Training and Education Project

DDI – Didanosine

DOS – Disk Operating System

EBI – Effective Behavioral Intervention

eHARS – Enhanced HIV/AIDS Reporting System

EIIHA – Early Identification of Individuals with HIV/AIDS

EIP – Early Intervention Program

EIS – Early Intervention Services

ELISA – Enzyme-Linked Immuno-Sorbent Assay

EMA – Eligible Metropolitan Area

ESG – Emergency Shelter Grant

GRID – Gay-related Immune Deficiency

HAB – HIV/AIDS Bureau

HARS – HIV/AIDS Reporting System

HCA – Orange County Health Care Agency

HCAC – HIV Client Advocacy Committee

HIV – Human Immunodeficiency Virus

HIVPAC – HIV Planning and Coordination Unit

HMO – Health Maintenance Organization

HOPWA – Housing Opportunities for Persons with AIDS

HRSA – United States Health Resources and Services Administration

HUD – United States Department of Housing and Urban Development

IDIS – Integrated Disbursement and Information Systems

IDU – Injection drug user

ILI – Individual-level interventions

IMACS – Information Management of AIDS Cases and Services

LAN – Latino AIDS Network

LIHP – Low Income Health Program

KABB – Knowledge, attitudes, beliefs, and behaviors model

MAI – Minority AIDS Initiative

MSI – Medical Services Initiative

MSM – Men who have sex with men

MSM/IDU – Men who have sex with men and who are injection drug users

NPSS – Non-prescription sale of syringes

OA – Office of AIDS

OB/GYN – Obstetrics and Gynecology

OC – Orange County

OCBF – Orange County Bar Foundation

OCCH – Orange County Center for Health

OCMA – Orange County Medical Association

OCRA – Orange County Ride for AIDS

QM – Quality Management

PAETC – Pacific AIDS Education and Training Center

PHS – Public Health Services

PLWH/A – Persons or People living with HIV/AIDS

PPC – Prevention Planning Committee

PSAP – Priority Setting, Allocations, and Planning Committee

REACH – Risk-Reduction Education and Community Health Program

SISTA – Sisters Informing Sisters about Topics on AIDS

SNAP – Supplemental Nutritional Assistance Program

STD – Sexually transmitted disease

TBRA – Tenant Based Rental Assistance Program

TGA – Transitional Grant Area

UCI – University of California, Irvine

UCIMC – University of California, Irvine Medical Centers

WIC – Women, Infants, and Children

The Center – The Center Orange County

Council – Orange County HIV Planning Council

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July 31, 2012

RE: Letter of Concurrence

As the director of Public Health Services for Orange County, I endorse the Orange County HIV Plan as developed by the Orange County Health Care Agency Public Health Services with the Orange County HIV Planning Council and the Orange County HIV Prevention Planning Committee. The plan reflects the scope of the epidemic and needs in Orange County and the commitment of the County of Orange to support a continuum of services that reduces new HIV infections, increases access to care, and improves health outcomes for residents living with HIV/AIDS.

David M. Souleles, MPH
Deputy Agency Director, Public Health Services
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June 22, 2012

RE: Letter of Concurrence

I, the undersigned, am in agreement with the overall content of this Comprehensive HIV Plan for Orange County, California. I do hereby attest that there was significant community involvement in the development of this plan. The contents of the plan were presented to and approved by the HIV Planning Council on May 9, 2012. Further, I pledge our continued support for all HIV/AIDS medical care, support services, and prevention efforts within the Orange County, California Transitional Grant Area.

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June 26, 2012

RE: Letter of Concurrence from Orange County HIV Prevention Planning Committee

We, the undersigned, are in agreement with the overall content of this Comprehensive HIV Plan for Orange County, California. I do hereby attest that there was significant community involvement in the development of this plan. The contents of the plan, particularly the sections related to reducing new HIV infections were reviewed by the HIV Prevention Planning Committee throughout the planning process. Further, we pledge our continued support for all HIV prevention, testing, and linkage to care efforts within the Orange County, California Transitional Grant Area.

Will Heilbut
Co-Chair, HIV Prevention Planning Committee

Tamarra Jones
Co-Chair, HIV Prevention Planning Committee

Richie Nguyen
Co-Chair, HIV Prevention Planning Committee

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Acknowledgements

The Orange County Health Care Agency (HCA), the Orange County HIV Planning Council (Council), and the HIV Prevention Planning Committee (PPC) would like to recognize the many individuals who contributed to the development of this plan. Their time and dedication was instrumental in the coordination and completion of this plan.

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The HIV Needs Surveys used in assessing the needs of people living with HIV the needs were completed through a collaborative effort between the HCA, the Council's HIV Client Advocacy Committee, HIV service providers, and community members. Appreciation is extended to Rebecca Mares from HCA HIV Surveillance for her work in compiling and analyzing results for the HIV Needs Survey. A very special thank you goes to the clients who completed the surveys and helped to inform this plan.

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Executive Summary

Introduction

As of December 2011, there are 6,674 people living with HIV/AIDS in Orange County who know their status, and another estimated 1,774 are living with the virus and do not know it. Each year another 325-375 people are newly diagnosed with HIV. Orange County's 2012-2014 Comprehensive HIV Plan provides an overview of the current landscape of HIV services in the county and identifies goals and strategies in moving forward to address the epidemic.

This Comprehensive HIV Plan combines what were previously two separate documents, the Comprehensive HIV Prevention Plan and the Comprehensive HIV Services Plan. Orange County's Comprehensive HIV Plan for 2012-2014 addresses the spectrum of HIV and mirror the goals outlined in the National HIV/AIDS Strategy. The goals of the plan are to: 1) reduce the number of people who become infected with HIV; 2) increase access to care and improve health outcomes for people living with HIV/AIDS; 3) reduce HIV-related disparities including disparities in new infections and health outcomes for people living with HIV/AIDS (PLWH/A).

The plan is the result of an open community planning process that took place over a series of meetings in 2011 and 2012. The plan represents the efforts of many individuals and communities including the HIV Planning Council (Council), the HIV Prevention Planning Committee (PPC), Orange County Health Care Agency (HCA), the HCA Ryan White Quality Management Committee, the Pacific AIDS Education and Training Center (PAETC) at University of California Irvine (UCI), persons living with HIV/AIDS, service providers, members of the Council's various committees, and affected individuals.

Background

Since the last Comprehensive HIV Plan was published, there have been significant developments that have led to changes in the response to HIV/AIDS in the nation and locally. One key action occurred in 2009, when Congress reauthorized the Ryan White Act and included mandates for local jurisdictions to provide estimates of the number of individuals who are unaware of their HIV status and develop a strategy to identify and link them to care. With this, Ryan White funds became more available to conduct activities that were previously only funded as HIV prevention.

The signing of National HIV/AIDS Strategy in 2010 presented another opportunity to provide a more seamless service system. The strategy called for improved coordination of the national response to HIV and included three major goals, including: 1) reducing new infections; 2) increasing access to care and improving health outcomes; and 3) reducing HIV-related disparities. The Centers for Disease Control and Prevention (CDC), which provides the bulk of funding to local programs for HIV Prevention services, responded by focusing on increasing HIV testing and linkage of HIV-positive people to care. These efforts have improved coordination of HIV prevention and care funding, which had historically been relatively disconnected.

The Affordable Care Act, passed in 2010, has the potential to improve access to comprehensive medical care for PLWH/A. Some key parts of the Act that impacts PLWH/A include the prohibition of coverage denial due to medical conditions (such as HIV/AIDS); requirement for

minimum coverage for services, including mental health and preventative care; portability of health insurance; and removal of coverage caps. The Affordable Care Act also establishes a mandate for all U.S. citizens and legal residents to maintain health coverage and expands Medicaid coverage to all legal residents living under 133% of the federal poverty level. In 2012, Orange County began part of the expansion of Medicaid health coverage by expanding the Low Income Health Program to cover health services for eligible individuals with HIV. Orange County estimates that over 900 persons living with HIV/AIDS may be covered by this program.

These opportunities to improve and expand care for those living with HIV also come with many uncertainties. With the implementation of Medicaid expansion and other health insurance for some PLWH/A, the future health care options for PLWH/A, including those currently covered by Ryan White may change significantly. The Ryan White Act is scheduled to be reauthorized in September 2013. The Ryan White Act has been the single largest piece of federal legislation to fund healthcare and supportive services to people living with HIV with no other source of care. The changing landscape of healthcare systems may lead to changes in the availability or scope of Ryan White services.

Orange County's Comprehensive HIV Plan for 2012-2014 considers these developments as well as the uncertainties of the future. As the plan is meant to be a living document, the HCA, the HIV Planning Council, and the HIV Prevention Planning Committee, will continue to review, monitor, and revise the plan as major changes or developments take place. The following provides a brief summary of some of the highlights from each chapter.

Chapter 1: Vision, Mission, and Shared Values

This chapter presents the vision, mission, and shared values of the HIV Planning Council. Key points include:

- **Vision Statement**: "Orange County will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."
- **Mission Statement**: "The Orange County HIV Planning Council in partnership with affected communities, service providers, philanthropists, and public health professionals, will support an accessible, culturally competent continuum of HIV prevention and care services that promotes optimal health, fosters self-sufficiency, reduces stigma and discrimination, and results in a community where new HIV infections are rare."
- **Shared Values:** The shared values statements address the Council's values regarding HIV-related service provision and planning processes. The values emphasize that services should be accessible, culturally competent, and promote the health and self-sufficiency of persons living with HIV/AIDS. In addition, the values stress the importance of community involvement and attention to data in the planning process.

Chapter 2: History

This chapter provides an historical overview of Orange County's response to the HIV/AIDS epidemic. Key points include:

- Orange County was one of the first and hardest hit locations of the HIV epidemic in the early 1980s. In response, Orange County developed an effective infrastructure to support the complex needs of PLWH/A.
- The key components of the local response are: surveillance; education and prevention; professional education; HIV testing and counseling; medical care and medications; HIV-related support services; and collaborative planning.

Chapter 3: Reducing New Infections

This chapter provides background on current trends and future goals related to Goal 1, to reduce new HIV infections in Orange County. These strategies also address Goal 3, to reduce disparities in new infections and populations who know their status. A summary of the rationale, current continuum of services, gaps and challenges, and next steps are provided for each strategy. Goals and strategies include:

Goal 1: By 2015, lower the annual number of new infections by 25% from 325-375 to 244-281.

Goal 3.1: By 2015, reduce disparities in populations with new infections.

Strategies:

1. Evidence-based behavioral interventions for HIV-positive individuals
2. Evidence-based behavioral interventions for high-risk populations
3. Condom distribution to HIV-positive and high-risk populations
4. Syringe services programs (Education regarding sharps disposal and cleaning needles for Injection Drug Users, , non-prescription sale of syringes, syringe exchange)
5. Social marketing, media, and mobilization

Goal 1.1: By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus.

Goal 3.1.1: By 2015, reduce disparities in populations living with HIV who know their status.

Strategies:

1. Promote HIV testing as part of routine health care.
2. Offer targeted HIV testing in non-healthcare settings.
3. Expand services that help HIV-positive individuals disclose their status to sex or needle sharing partners (Partner Services).

Chapter 4: Increasing Access to Care and Improving Health Outcomes

This chapter provides background on current trends and future goals related to Goal 2, to increase access to care and improve health outcomes for persons living with HIV/AIDS Orange County. These strategies also address Goal 3, to reduce disparities in access to care and health outcomes of persons living with HIV/AIDS. A summary of the rationale, current continuum of services, gaps and challenges, and next steps are provided for each strategy. Goals and strategies include:

Goal 2.1: By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of diagnosis from 71% to 82%.

Goal 3.2.1: By 2015, reduce disparities in newly diagnosed patients linked to clinical care within three months of diagnosis.

Strategies:

1. Ensure a network of medical providers serving HIV-positive patients in Orange County.
2. Educate community medical providers about available services for HIV-positive individuals.
3. Offer services that link newly diagnosed patients to care (Early Intervention Services).

Goal 2.2: By 2015, increase the proportion of persons living with HIV/AIDS who are in care.

Goal 3.2.2: By 2015, reduce disparities in proportion of persons living with HIV/AIDS who are in care.

Strategies:

1. Educate providers regarding Public Health Services Guidelines and available resources.
2. Expand services that bring individuals who have fallen out of care, back into care (Outreach Services).
3. Offer medical case management to clients who have difficulty remaining in medical care.
4. Provide peer support for staying in care.
5. Ensure access to continuum of HIV services.

Goal 2.3: By 2015, increase the proportion of persons living with HIV with suppressed viral load (less than 200 copies/mL).

Goal 3.2.3: By 2015, reduce disparities in proportion of persons living with suppressed viral load.

Strategies:

1. Educate HIV specialists about offering treatment based on Public Health Services Guidelines.

2. Educate providers regarding referring to HIV specialists for treatment.
3. Ensure client access to HIV-related medications.
4. Provide education and support to clients regarding initiation and adherence to medications.

Chapter 5: HIV Housing Strategy

The City of Santa Ana serves as the grantee for Housing Opportunities for Persons with AIDS (HOPWA) funding for all of Orange County. This chapter provides excerpts from the City of Santa Ana's Consolidated Plan and Annual Report related to individuals living with HIV/AIDS.

- **Consolidated Plan 2011-2012 Annual Update:** Housing services for persons living with HIV/AIDS was based on epidemiological data and community needs assessments. The 2011-2012 plan includes goals for serving persons with HIV with short term rent (100 individuals), mortgage/utility assistance emergency shelter (75 individuals), transitional housing (70 individuals), tenant-based rental assistance (50 individuals), and housing units under lease or under development (56 units).
- **Consolidated Annual Performance and Evaluation Report (CAPER) for 2010-2011:** In the context of a continuum of housing, 2010-2011 HOPWA projects met or exceeded planned goals. Housing services for persons living with HIV/AIDS include tenant based rental assistance administered by the Santa Ana Housing Authority, short-term emergency housing and/or utility assistance, transitional housing, housing coordination services, life skills training workshops, and medical detoxification bed services.

Summary of Goals

The goals of the Orange County Comprehensive HIV Plan are to: 1) reduce the number of people who become infected with HIV; 2) increase access to care and improve health outcomes for people living with HIV/AIDS; 3) reduce HIV-related disparities including disparities in new infections, access to care, and health outcomes for people living with HIV/AIDS (PLWH/A). The following is a summary of goals in this plan. Strategies for Goal 1, Goal 3.1, and 3.1.1 are described in Chapter 3 of this plan. Strategies for Goal 2, Goal 3.2.1, Goal 3.2.2., and Goal 3.2.3 are described in Chapter 4 of this plan.

Goal 1: Reduce New Infections

- Goal 1: By 2015, lower the annual number of new infections by 25% from 325-375 to 244-281.
- Goal 1.1: By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus.

Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV/AIDS

- Goal 2.1: By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of diagnosis from 71% to 82%.
- Goal 2.2: By 2015, increase the proportion of persons living with HIV/AIDS who are in care.
- Goal 2.3: By 2015, increase the proportion of persons living with HIV with suppressed viral load (less than 200 copies/mL).

Goal 3: Reduce HIV-Related Disparities

Reduce disparities in new infections.

- Goal 3.1: By 2015, reduce disparities in populations with new infections.
- Goal 3.1.1: By 2015, reduce disparities in populations living with HIV who know their status.

Reduce disparities in access to care and health outcomes for PLWH/A.

- Goal 3.2.1: By 2015, reduce disparities in newly diagnosed patients linked to clinical care within three months of diagnosis.
- Goal 3.2.2: By 2015, reduce disparities in proportion of persons living with HIV/AIDS who are in care.
- Goal 3.2.3: By 2015, reduce disparities in proportion of persons living with suppressed viral load.

Chapter 1: Vision, Mission, and Values

Introduction

It has been more than 30 years since the first diagnosis of HIV in Orange County. As of December 2011, 11,098 people have been diagnosed with HIV in Orange County; of them, 4,424 have died. Today, there are an estimated 8,448 people living with HIV/AIDS in Orange County. About one in five of these people do not know that they have the virus. Each year, another 325-375 people are diagnosed with HIV. Orange County's plan to address this epidemic must include a vision for how things should be, a mission that outlines how to get there, and shared values that define those things that are most important in the planning and delivery of services.

Background

Orange County's Comprehensive HIV Plan for 2012-2014 is the result of an open community planning process led by the Orange County Health Care Agency and HIV Planning Council (Council). Since 1998, the HIV Planning Council has adopted a vision/mission statement and shared values that provided a framework for HIV services in the county. For this plan, the HIV Planning Council considered the need for a dedicated vision statement for HIV prevention and services in the county. The vision for the Comprehensive Plan reflects that of the National HIV/AIDS Strategy on a local level. The Council made slight revisions to its mission statement to outline the HIV Planning Council's role in achieving its vision for Orange County. Finally, the Council reviewed and revised its shared values. These shared values represent the Council's guiding principles for the planning and provision of HIV prevention and care services.

Vision Statement

The vision for the Orange County Comprehensive HIV Plan is:

> *"Orange County will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."*

Mission Statement

The HIV Planning Council's mission statement is:

> *"The Orange County HIV Planning Council, in partnership with affected communities, service providers, philanthropists, and public health professionals, will support an accessible, culturally competent continuum of HIV prevention and care services that promotes optimal health, fosters self-sufficiency, reduces stigma and discrimination, and results in a community where new HIV infections are rare."*

Shared Values

Services should be provided in a manner that:

- promotes positive health outcomes
- enhances individual self sufficiency
- is culturally competent and responsive to the needs of disproportionately impacted and/or underserved populations
- integrates services such as testing, prevention, and care
- is geographically and economically accessible
- maximizes available resources, utilizing Ryan White Act funds as funding of last resort

Planning processes should:

- be collaborative and inclusive of all stakeholders: consumers, affected individuals, providers, and the community at large
- recognize and respect the value of each participant
- foster data-driven decision making
- analyze program effectiveness, efficiency, and quality of care
- anticipate and plan for changes in the epidemic, impact on various communities, and fiscal and political shifts affecting the delivery of care and services

Chapter 2: The History of HIV/AIDS in Orange County

Introduction

This chapter provides a summary of benchmarks in the history of HIV/AIDS in Orange County during the period 1981 to 2012 and a discussion of Orange County's response to the emerging and evolving epidemic. Areas discussed include: surveillance; education and prevention; professional education; testing and counseling; medical care and medications; laboratory services; HIV-related support services; and collaborative planning.

Surveillance

AIDS, originally identified as Gay-Related Immune Deficiency (GRID), was first identified in Orange County in 1981 in two men who were contacts of "Patient Zero." Nurses in the Health Care Agency's Epidemiology program conducted the first AIDS surveillance activities. In the early epidemic, AIDS was diagnosed by the presence of one or more of nine indicator conditions. In 1984, the Orange County Health Care Agency (HCA) received a Centers for Disease Control and Prevention (CDC) surveillance grant, and, in February of that year, the first full-time AIDS surveillance nurse was hired. Also in 1984, the Health Officer declared AIDS-Related Complex (ARC), a precursor to AIDS, a reportable condition. When HIV antibody testing became available in 1985, the Health Officer requested that physicians report HIV seropositivity with patient consent. Early HIV-disease-related data was compiled in a database called the HIV Registry.

In 1987, the first expanded AIDS case definition was instituted by the CDC. This new definition required physicians to report individuals with any of 23 indicator conditions and HIV antibody positivity as AIDS. At this time, a special encrypted CDC and California Department of Health (CDPH), Office of AIDS (OA) database, the HIV/AIDS Reporting System (HARS), was installed for the reporting of resident AIDS cases.

In 1993, the AIDS case definition was expanded again by the CDC to include three additional indicator conditions, pulmonary tuberculosis, recurrent pneumonia, invasive cervical carcinoma, and CD4 counts below 200 mm^3 and/or below 14%. With this expanded AIDS case definition, the AIDS databases were converted from an HIV-ARC-AIDS classification system, to a classification matrix based upon three clinical categories and three T-cell ranges. By the end of 2011, a total of 7,972 AIDS cases were reported in Orange County residents.

Beginning July 1, 2002, human immunodeficiency virus (HIV) infection joined the list of reportable diseases in California. Health care providers were required to submit confirmed HIV cases to local health departments using a non-name code system. On April 17, 2006, a new California law took effect, changing the reporting requirements for cases of HIV infection. The new law requires that health care providers and laboratories report HIV diagnoses by name on or after April 17, 2006. Between April 17, 2006 and December 31, 2011, 3,126 HIV cases were reported by name, 1,520 of which had been reported initially under the code-based system.

In 2009, the CDC decommissioned the initial DOS based electronic reporting system, HARS, and implemented a web based reporting system with greater functionality named the Enhanced HIV/AIDS Reporting System (eHARS) for national HIV and AIDS case reporting. The web based

system allows for secure file transfer to the CDC. Deduplication of cases, case amendments and laboratory report updates are expeditiously completed in the web based eHARS.

Education and Prevention

In 1984, the HCA was funded by the State of California to implement an AIDS Education Program. The funding was for a collaborative effort between the HCA's Public Health department and The Center Orange County (The Center) to define the role of each agency in the delivery of HIV education and prevention services. As a result of this activity, The Center targeted its programs solely to the gay/bisexual/transgender communities, while Public Health targeted these groups in addition to the general community and other at-risk groups, such as health care and public safety workers. The following year, the State funded only The Center's activities, which served to establish its AIDS Response Program (ARP). Initially, this program focused its educational efforts on gay and bisexual men, but has since added additional programs targeting at-risk youth and people of color.

In 1986, the HCA received funding for a Latino-focused AIDS Community Education Project (ACEP). Over the years, ACEP became well known for its culturally sensitive approaches and low-literacy educational materials. The OA subsequently adopted these approaches and materials for all Spanish communications through Alternative Test Sites.

From 1987 to 1997, a County Public Health Nurse was assigned to the local American Red Cross. She was charged with providing HIV education to the general public and the workplace, with establishing high school and college peer education programs, and with establishing an AIDS outreach program to the homeless and incarcerated. This collaborative partnership proved highly successful in providing the Orange County community with the excellent HIV/AIDS education programs and materials developed nationally by the American Red Cross. Training materials and programs for health care providers, emergency service workers, law enforcement, and correction officers were also developed.

In 1988, HCA Behavioral Health, with the cooperation of HCA Public Health, applied for and received funding for an AIDS Outreach Program (AOP) to target injection-drug users for HIV education. AOP staff also assumed the responsibility for testing and educational interventions at correctional facilities, including local jails, and halfway houses for parolees. This program is now called Risk Reduction, Education, and Community Health (REACH) Program. The current scope of services includes: HIV testing; risk assessment and disclosure counseling; syphilis screening; Hepatitis B and C testing; referral and linkage to appropriate services; HIV prevention case management; educational workshops; case management; medical transportation; and screening for medical detoxification for HIV-positive substance users.

Other cooperative efforts between Alcohol and Drug Abuse and Public Health resulted in the establishment of a six-bed shelter for homeless injection drugs users (IDU); enrollment of HIV-seropositive individuals in outpatient drug treatment programs; 10 to 12 inpatient medical detoxification beds set aside for substance dependent people living with HIV/AIDS (PLWH/A); and the development of a residential drug treatment program for 18 persons with HIV disease. This latter innovative project provides special services to this target population, and allows clients to participate in a therapeutic residential program while on methadone maintenance.

Another early HIV education program was located at the Orange County Center for Health (OCCH), which received both state and federal funds. OCCH had been the lead agency for a CDC-funded Minority AIDS Education Project that linked Planned Parenthood, the Coalition for Children, Adolescents and Parents, and the Hogar Latino project at The Center. OCCH provided mental health counseling services and case management services to Latinos with HIV/AIDS, with a particular focus on the neighborhoods surrounding the clinic. Planned Parenthood clinics provided HIV testing and education to clients and also provided HIV education to youth in probation institutions. OCCH closed its doors in 1994.

In 1996, OA implemented a change in the method by which it allocated HIV education and prevention funds in California. Previously, the OA conducted a statewide competitive process each year, and allocated funds directly to education and prevention service providers. Beginning July 1, 1996, however, allocation of these funds became the responsibility of local health departments based on HIV prevention plans developed by local planning bodies. At the HCA's request, the Orange County HIV Planning Council (Council) assumed responsibility for this mandated planning process. The Council delegated to its HIV Prevention Planning Committee the task of developing the required plan and submitting it for approval. The Prevention Committee is now a separate body that works in conjunction with the Planning Council. The Committee is co-chaired by a representative of the HCA and one or two community representatives chosen by committee members.

The HIV Prevention Planning Committee (PPC) previously worked with the HCA to produce a *Comprehensive HIV Prevention Plan*. The plan included specific, high-priority prevention strategies and interventions targeted to defined high-risk populations. As of 2012, Orange County has one *Comprehensive HIV Plan* that integrates both HIV prevention and care services.

In 2001, the OA implemented a policy shift regarding prevention for positives. The OA asked that, beginning in 2002, each recipient of an OA Education and Prevention grant allocate at least 25% of the grant to provide prevention programs for PLWH/A. Orange County requested and was granted a one-year waiver of the requirement to allow sufficient time for a thoughtful planning process and a competitive solicitation process to occur. The Prevention Planning Committee completed its priority setting and allocations process for the state fiscal year beginning in July of 2003 and, for the first time, allocated a minimum of 25% of program dollars to provide prevention interventions for those who are already positive.

In FY 2012, five agencies received OA funding from the Education and Prevention grant. These are AIDS Services Foundation (ASF), APAIT Health Center (formerly Asian Pacific AIDS Intervention Team), HCA Behavioral Health REACH Program, and The Center. HIV prevention services are targeted to the following populations:

- Men who have sex with men (MSM);
- Substance users; and
- High-risk populations.

The strategies and interventions incorporated into these HIV prevention programs are based on the knowledge, attitudes, beliefs, and behaviors (KABB) model, with a strong emphasis on peer-based support and leadership building. The KABB model is merged into peer-to-peer groups,

community outreach, small group discussions, personalized risk assessment and counseling, social marketing, and prevention case management. These prevention activities emphasize knowledge of risk, which includes sexual and injection-drug-using behaviors; risk-reduction skills; healthy beliefs; and peer support to reinforce behavior and attitude change. Members of the targeted populations learn self-protection skills and strategies to reduce their risk of contracting HIV.

Interventions targeted at PLWH/A include coordination with case managers for HIV clients to participate in risk assessments, prevention case management services and support groups.

Professional Education

The earliest provider of AIDS education for health care professionals in the county was the HCA. Later, the Pacific AIDS Education and Training Center (PAETC) was established at the University of California at Irvine (UCI), receiving federal funding to provide HIV/AIDS education to health care professionals. Since 1988, the HCA and PAETC have been collaborating in the production of an annual conference called the *HIV/AIDS on the Front Line Conference*. This conference is an important feature in the history of HIV/AIDS in Orange County, and one that demonstrates Orange County's proactive and multidimensional approach to the epidemic.

The *HIV/AIDS on the Front Line Conference* is a valuable source of current, state-of-the-art information on HIV disease for health care professionals, HIV service providers, members of the Council, PLWH/A, and other interested individuals. The stated goal of the conference is twofold: (1) to offer medical, education and health professionals, and others the opportunity to develop competence and compassion in caring for people with HIV disease; and (2) to provide participants with the opportunity to interface with other attendees and become more knowledgeable about HIV infection and available resources. Attended by approximately 300 health care professionals and interested individuals from Orange County, California, and the nation, the annual conference includes presentations by nationally recognized experts in the field of HIV disease 2012 marked the 25th anniversary of the Conference. Covered topics reflected advances in HIV treatments and included:

- HIV Patient Centered Medical Home;
- The Role of the Pharmacist in HIV;
- Technology in HIV Care;
- HIV Novel Therapies; and
- Hepatits C New Medications.

HIV providers also regularly attend other educational opportunities provided by the PAETC and community agencies. The PAETC offers courses with intensive hands-on clinical training for physicians, advanced degree nurses, registered nurses, nutritionists, and Social Workers. This "mini-residency" program offered at UCIMC Infectious Diseases/HIV Clinic helps providers enhance clinical competence in assessing and managing patients with HIV disease. Providers who attend the training also receive printed treatment guidelines. Medical providers also

attend monthly AIDS Grand Rounds provided at the UCIMC campus. To build basic knowledge and skills regarding HIV disease, providers are encouraged to attend some of the 100 presentations provided by PAETC at various work sites each year. Since January 2006, the HCA HIV Clinic supervisory team has coordinated one-hour trainings regarding HIV care twice a month for all clinic staff. Topics have included an Overview of STDs, Bloodborne Pathogens, and Introduction to Partner Services.

HIV Clinic Grand rounds also occur on the HCA 17th Street campus for 17th Street Care and community providers. Orange County Ryan White providers participate in quarterly meetings. In 2011, Orange County began participation in the in+care campaign to increase retention of clients in medical care. California Statewide Training and Education Project (CSTEP) offers treatment updates to providers working with HIV-positive individuals. Local or online trainings are available one to two times a year.

Counseling and Testing

One early, key decision as a strategy to target the highest risk groups including MSM, IDU, partners of MSM or IDU, partners of PLWH/A, sex workers, and transgender individuals, was to place the State's Alternative Test Site (ATS) program in the HCA's HIV Testing and STD Clinic (now known as 17th Street Testing and Treatment). The Center supported this decision, not wanting to develop an HIV test site in 1985 when the HIV antibody test first became available. Since that time, however, The Center has developed an HIV testing program that initially used funding from the Orange County Center for Health, and, later, from the HCA. The testing program at The Center as well as other community locations is a key component of the overall HIV counseling and testing program in Orange County.

Confidential and anonymous testing was offered at 17th Street Testing and Treatment on the first day that HIV testing became available nationally on May 31, 1985. HIV testing has always been available for anyone requesting the test on a walk-in basis, free of charge. All persons presenting during clinic hours receive pre-test counseling and an HIV test. The HCA's 17th Street Testing and Treatment and REACH Program also started offering rapid testing for HIV in June 2004. Rapid test results are available in 20 to 40 minutes. Results can be negative or preliminary positive. A confirmatory test is conducted for preliminary positive results. Counseling and testing services are currently available in several different locations within the County system, including the Women's and Men's Jails, and through the REACH program at county contracted residential and outpatient drug abuse clinics,. Additionally, the Laguna Beach Community Clinic, AIDS Services Foundation, and The Center have active HIV testing programs that are supported by the HCA.

Starting 2007, OA restructured the HIV Counseling and Testing Program into a two-tiered model. This allowed counselors to assess the needs of the clients prior to offering testing and counseling using a self administered Client Assessment Questionnaire (CAQ). The client was routed to the appropriate level of service based on their answers. Individuals considered to be at the highest risk for acquiring HIV were given 20 minutes of client centered harm reduction counseling in addition to being tested for HIV. Individuals that stated low risk behaviors were

also tested, but in lieu of counseling, they received a lower level intervention such as a pamphlet or an HIV video in the waiting area. As part of this restructure there was also greater importance placed on linking individuals that tested positive to care and a greater push towards increasing the utilization of HIV Partner services. HCA developed a Verified Medical Visit form to better track and ensure that those testing positive at test sites were linking to care. For Partner Services HCA had three staff trained to perform anonymous, third party field notifications. In 2009 California lost Prevention funds which resulted in another restructure. The HCA chose to continue to utilize the two tiered testing model and has continued strengthening efforts around linkage to care and Partner Services.

In 2006 the CDC released the "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Woman in Health Care Settings." The guidelines for testing in a health care setting highlight the following points: HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening), Persons at high risk for HIV infection should be screened for HIV at least annually, Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing, and Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings**.**

In 2012, the HCA began contracting with University of California, Irvine Medical Centers (UCIMC) to conduct routine opt-out HIV screening at medical centers in Anaheim, Orange, and Santa Ana. AltaMed, a primary care provider, received funding from OA to conduct routine opt-out testing at eight clinic sites throughout Orange County. The HCA is also implementing routine opt-out HIV testing County jail facilities. An estimated 3,000 tests will be conducted in a six-month period.

Medical Care and Medications

From the early days of the AIDS epidemic, the HCA's 17th Street Testing, Treatment and Care (formerly known as Special Diseases Clinic) provided counseling and medical evaluation to individuals concerned about possible exposure to HIV. Laguna Beach Community Clinic, located in the heart of the early epidemic, also began providing medical care to people living with HIV. Medical evaluation evolved over time and included anergy testing and T-cell monitoring, as well as treatment for opportunistic infections that could be managed in an outpatient setting. When Zidovudine (AZT) became available, it was prescribed and necessary medical follow-up were provided in the clinic. Later, clinic physicians prescribed Didanosine (DDI), another therapeutic agent for HIV disease, to patients unable to tolerate AZT. Linkages were soon established with the Infectious Disease Clinic for advanced HIV disease and specialty medical care and the California Collaborative Treatment Group (access to clinical trials) at the UCIMC. Starting in 1989, health education and case management services were added to the HCA's medical care services, using the OA AIDS Early Intervention Program (EIP) funds. Augmentation of funding for HIV ambulatory care was obtained, initially, through two federal grants: the AIDS Services Demonstration Project and the Preventive and Primary Care Grant for Persons with HIV

Infection or AIDS, and later through Ryan White Parts A, B, and C (formerly Titles I, II, and III, respectively) funds.

In 1997, significant changes in the treatment of HIV disease occurred with the incorporation of combination therapies, including protease inhibitors. At the same time, new laboratory tests became available that provided better management of the disease. In response to the expense of the new laboratory tests, OA began a program that funded viral load testing for all HIV patients enrolled in State EIP programs as well as other patients needing viral load testing. In 2000, the State began providing vouchers to fund resistance testing (genotype and phenotype). Today, the clinic continues to monitor patients' HIV disease (viral load, resistance testing), however the service is funded by Ryan White Parts A, B and C.

In 2005, the HCA transitioned from specialty medical care being provided at UCIMC to creating a community-based network of specialty providers serving clients who are eligible and funded by the Ryan White Act. The specialties provided by the select group of physicians include Gastroenterology, Neurology, Oncology, Immunology, Pulmonology, Ophthalmology, Dermatology, Radiology, Gynecology. In 2007, Psychiatry was added as a service available as part of specialty medical care. Various facilities throughout the county have also joined the network including Hoag Hospital. Today, both 17th Street Care and Laguna Beach Community Clinic provide medical care based on Public Health Service Guidelines including *Guidelines for the Use of Antiretroviral Agents in HIV Infected Adults and Adolescents* and *Guidelines for Prevention of Opportunistic Infections in Persons Infected with HIV.* Treatment for HIV now includes 24 different medications in five different classes of drugs including two triple drug combinations, single tablet medications.

In 2012, Orange County began part of the expansion of Medicaid health coverage under the Affordable Care Act by expanding the Low Income Health Program (LIHP) to cover health services for eligible individuals with HIV. Orange County estimated that LIHP, known as MSI (Medical Services Initiative) would cover over 900 persons living with HIV/AIDS who were previously covered only by Ryan White medical care. That same year, 17th Street Care became an HIV-specialty provider under MSI. LBCC remained available as both a medical home and an HIV-specialty provider under MSI. The expansion of Medicaid coverage added preventative care and emergency services that were previously unavailable to clients who were covered by Ryan White. MSI also began covering HIV-related drugs as part of this expansion.

Laboratory Services

Orange County's Public Health Laboratory was at the forefront of developing and implementing standardized HIV antibody testing in the nation. It was the first public health laboratory to purchase the ELISA kit and to culture the virus. The laboratory also participated in the development of the Western blot and the IFA confirmatory tests that are used after a positive ELISA test to validate the presence of HIV antibodies. The Orange County Public Health Laboratory is one of the few labs selected by the State of California to conduct viral load tests for the State-testing program. In 2010, the Public Health Laboratory began genotype testing,

which resulted in a significant cost savings in comparison to sending them to a contracted laboratory.

HIV-Related Support Services

The County has contracted with community-based organizations since 1987 for the provision of HIV-related support services. The first contract was with the AIDS Services Foundation and was funded under a federal AIDS Services Demonstration Grant. This funding was replaced in 1991 with Ryan White Part B funding, which was augmented in 1993 with Ryan White Part A and Housing Opportunities for Persons with AIDS (HOPWA) funds. These three grants constitute the principal sources of funding that now pass through the HCA to community providers of HIV services. Current community providers include: AIDS Services Foundation, APAIT Health Center, Delhi Center, Laguna Beach Community Clinic, Public Law Center, Shanti Orange County (formerly Laguna Shanti), Straight Talk, and The Center.

In consideration of funding changes and an evolving epidemic, the Planning Council and HIV Prevention Planning Committee work to expand the continuum of care and to increase the availability of high-priority services as determined by a needs assessment process.

Collaborative Planning

One of the earliest HIV planning forums in the county was a grassroots organization called the AIDS Coalition to Identify Orange County Needs (ACTION). It was formed in 1984 and served as a networking and coordinating body for persons living with HIV; providers of education, care, treatment, and supportive services; and all interested community members. ACTION identified numerous gaps in HIV education and services, and worked with the HCA and the community to fill as many of the gaps as possible. ACTION played an important role in the County until 1992 when the new HIV Planning Council assumed its functions.

In 1986, the HCA developed an HIV/AIDS Master Plan that inventoried existing services and identified general needs for expansion of HIV/AIDS services and education in Orange County. The following year, as a result of the plan, the HCA established an AIDS Coordination position on staff and an HIV Advisory Committee. This committee provided advice and recommendations to the County Health Officer regarding HIV policy issues. It served to provide direction and focus to early community-wide planning efforts for HIV prevention and service needs.

In 1988-89, an Interagency Task Force, which included the Sheriff, District Attorney, County Counsel, Probation, the HCA and community police and fire departments, was involved in planning and implementing the county's response to several new laws regarding involuntary HIV testing and disclosure. Public Health's Occupational Exposure Program grew out of the Task Force's recommendations and, to this day, provides testing and educational services to public safety officers who may have had an occupational HIV exposure. Also, in 1989, the HIV Advisory Committee, working closely with the HCA, encouraged the County Board of Supervisors to adopt an AIDS Antidiscrimination Ordinance. Unfortunately, the Board chose not to enact the ordinance. However, in 1997, the Board did pass an antidiscrimination resolution.

Orange County became eligible for Ryan White Part B funds from the State of California in 1991. To receive the funds, the County established an HIV CARE Consortium. The community asked the HIV Advisory Committee to assume the functions of the mandated HIV CARE Consortium and selected the HCA to serve as fiscal agent. Also in 1991, the federal government selected the HCA as one of four health departments in the nation to receive an automated AIDS case management system. This system, known as IMACS (Information Management of AIDS Cases and Services) has functioned as an important component of Orange County's HIV information management system. IMACS was updated with a Microsoft Windows-based system called *CaseWatch* in 2002. In 2008, Orange County transitioned to AIDS Regional Information and Evaluation System (ARIES), an Internet browser-based client case management information system, as its new HIV information management system.

In 1992, Orange County became eligible for Ryan White Part A funds from the federal government as an Eligible Metropolitan Area (EMA). To receive the funds, the Orange County Board of Supervisors was required to form an HIV Health Services Planning Council and appoint its members. To avoid duplication of effort, the HIV Advisory Committee/CARE Consortium asked the Board to incorporate the HIV Advisory Committee/CARE Consortium into the HIV Health Services Planning Council. The Board agreed, bylaws were written, and the body was named the Orange County HIV Planning Advisory Council. In January 1999, the word "Advisory" was dropped from the name.

Also in 1992, the County of Orange became eligible for HOPWA funds. These funds are provided through the United States Department of Housing and Urban Development (HUD) for housing assistance and supportive services for low-income persons with HIV disease. The County's Environmental Management Agency administered the original award. However, from 1993 onward, funding went to the city with the largest number of AIDS cases in the EMA, which in Orange County is the City of Santa Ana. From 1993 to the present, the City of Santa Ana, through its Housing and Redevelopment Commission, has used some of its HOPWA funds for construction of affordable housing projects for PLWH/A, and also for the provision of rental assistance to the same population. The City of Santa Ana contracts with the HCA for the expenditure of the remaining HOPWA funds. These funds are specifically for the delivery of HIV supportive and housing services. The HCA elected to rely on the Council for guidance in the expenditure of these funds. The Council, in turn, relies on the input and recommendations of its Housing Committee. The membership of this committee consists of PLWH/A, providers, community members, and Planning Council members who have an interest and expertise in housing issues. In 1999-2000 the Housing Committee worked with an outside consultant, AIDS Housing of Washington, to complete and begin implementation of a Comprehensive HIV Housing Plan. The Plan was last updated in 2005.

In 1995, as noted earlier in this chapter, OA implemented a change in the method by which it allocates HIV education and prevention funds. Beginning July 1, 1996, allocation of these funds became the responsibility of local health departments based on service priorities recommended by a local planning body established or chosen by the Health Department. The HCA asked the Council if it would take on this additional planning responsibility, and it agreed to do so. This action ensured an important linkage between HIV prevention and care services. As part of a

Council restructuring that occurred in FY 1998, the Planning Council delegated the responsibility for prevention planning to its Prevention Planning Committee.

At the end of 2009, Congress reauthorized the Ryan White Act and named it Ryan White HIV/AIDS Treatment Extension Act. When the Act was reauthorized in 2006 and named Ryan White HIV/AIDS Treatment Modernization Act, Orange County was designated as a Transitional Grant Area (TGA). New requirements enacted included a directive that more money be spent on direct health care for Ryan White clients. The 2006 Act also codified the Minority AIDS Initiative (MAI) for Ryan White programs. Orange County had received MAI funds as part of its Ryan White Part A award since 1999. The 2009 Act reauthorized the terms of the 2006 Act, but added additional increases to funding for each fiscal year through 2013. It also changed the way MAI funds are distributed from a competitive process to a formula-based one. Finally, it included language that placed a stronger emphasis on increasing serostatus knowledge.

The HIV Planning Council and its committees work in partnership with the HCA to establish funding priorities and allocations for Ryan White Parts A and B, HOPWA funding. The HCA and HIV Planning Council worked together to revise Orange County's Comprehensive HIV Services Plan every three years. The HCA also worked with the HIV Prevention Planning Committee to prioritize targeted populations for education and prevention funds that are allocated to the HCA through Office of AIDS. The HCA and HIV Prevention Planning Committee also worked together to revise Orange County's Comprehensive HIV Prevention Plan every three years.

The signing of National HIV/AIDS Strategy in 2010 presented an opportunity to provide a more seamless service system. The strategy called for improved coordination of the national response to HIV and included three major goals, including: 1) reducing new infections; 2) increasing access to care and improving health outcomes; and 3) reducing disparities to care. The CDC, which provides the bulk of funding to local programs for HIV Prevention services, responded by focusing on increasing HIV testing and linkage of HIV-positive people to care. These efforts have improved coordination of HIV prevention and care funding, which had historically been relatively disconnected. In response, Orange County's 2012-2014 Comprehensive HIV Plan combines what were previously two separate documents, the Comprehensive HIV Prevention Plan and the Comprehensive HIV Services Plan. The primary goals of Orange County's Comprehensive HIV Plan address the spectrum of HIV and mirror those outlined in the National HIV/AIDS Strategy. The goals are to: 1) reduce the number of people who become infected with HIV; 2) increase access to care and improve health outcomes for people living with HIV/AIDS; 3) reduce HIV-related disparities including disparities in new infections and health outcomes for people living with HIV/AIDS.

Benchmarks in the History of HIV Disease in Orange County

Appendix 2.A presents a chronological list of benchmarks in the history of HIV disease in Orange County. The table shows the remarkable progress Orange County has made in developing a

multi-faceted approach to reducing the transmission of HIV disease and providing services to enhance the length and quality of life for PLWH/A.

Conclusion

As the epidemic has grown, so has the response of the HCA, HIV Planning Council, and concerned community-based organizations throughout Orange County. In 1985-1986, the budget for AIDS services within the HCA was approximately $250,000, and funding for AIDS services in the community totaled $165,000. In 2012, an inventory of funding shows a total value for HIV Services in Orange County of over $55 million in public funds. As a result of the new medications, combination therapies, and advances in laboratory testing, an increasing number of individuals are *living* with HIV. This changing face of HIV will require increased collaboration with new partners and innovative strategies to reduce new infections and ensure that people living with HIV have access to care and best health outcomes.

Appendix 2.A Benchmarks of HIV/AIDS in Orange County (1981-2012)

1981	➢ First AIDS cases identified in Orange County
1984	➢ First CDC surveillance grant begins ➢ First AIDS surveillance nurse hired ➢ State-funded AIDS Education Program begins at Health Care Agency and The Center ➢ AIDS Response Program established at The Center ➢ AIDS Coalition to Identify Orange County Needs (ACTION) established
1985	➢ HIV-antibody testing begins
1986	➢ HCA's AIDS Community Education Project (ACEP) focused on Latinos begins
1987	➢ ACTION becomes HIV Advisory Committee ➢ AIDS Services Demonstration Project begins ➢ HCA establishes first contract with a community-based organization for provision of HIV services (case management, mental health, and social services) ➢ Orange County AIDS Walk established
1988	➢ HCA's AIDS Outreach Program (AOP) (now REACH) to target injection drug users for HIV education begins ➢ First "AIDS on the Front Line Conference" held ➢ AIDS Drug Assistance Program (ADAP) begins
1989	➢ HCA's Early Intervention Program (EIP) begins ➢ Pacific AIDS Education and Training Center (PAETC) established at University of California, Irvine Medical Center (UCIMC)
1990	➢ Ryan White Part C (formerly Title III) funding begins
1991	➢ Ryan White Part B (formerly Title II) funding begins ➢ HIV Advisory Committee assumes responsibilities of HIV CARE Consortium
1992	➢ HIV Advisory Committee assumes responsibilities of HIV Health Services Planning Council ➢ Housing Opportunities for Persons with AIDS (HOPWA) funding begins ➢ Latino AIDS Network (LAN) established
1993	➢ Ryan White Part A (formerly Title I) funding begins ➢ Americans with Disabilities Act enacted ➢ Availability of Ryan White Act-funded mental health and home health care services improved ➢ Latino Issues Task Force established by the HIV Planning Council
1994	➢ Special Latino Initiative established by the Council to develop capacity of Delhi Community Center to provide HIV-related services to Latinos ➢ Ryan White Act-funded gynecological services for women with HIV disease begin ➢ Ryan White Act-funded Buddy/Companion services begin ➢ Geographic access to Ryan White Act-funded primary medical care increased ➢ Hannah's House, an African-American-based organization brought into HIV service delivery system

Appendix 2.A continued on next page

Appendix 2.A Benchmarks of HIV/AIDS in Orange County (1981-2012) (Continued)

1995	➢ Transportation services added to the continuum of care funded through the Ryan White Act ➢ Ryan White Act-funded specialty medical care and legal services expanded ➢ Access to services program modified to early case management/client advocacy
1996	➢ HIV Prevention Planning Committee assumes responsibility for planning state education and prevention funds entering the county ➢ Psychiatric care added to Ryan White Act-funded continuum of care
1997	➢ Nutritional therapies added to Ryan White Act-funded continuum of care ➢ HIV/AIDS antidiscrimination resolution passed by Board of Supervisors
1998	➢ Transitional housing program established to serve clients that are homeless or at risk of homelessness
1999	➢ Genotype and phenotype testing offered to clients in care ➢ Initiated collaborative meetings with County Mental Health and Alcohol and Substance Abuse in effort to better meet the needs of clients with multiple diagnoses ➢ Local drug reimbursement program expanded to include ongoing payment for medications not covered by ADAP or private insurance
2000	➢ New services added to the continuum of care, including independent living skills, medical detoxification beds for substance users, and pharmacy consultation ➢ Resistance testing made available through State Office of AIDS
2001	➢ Planning Council Retreat on Underserved Populations ➢ HCA's BRIDGE Project to bring hard-to-reach PLWH/A into care begins
2002	➢ Retreat for Planning Council, Prevention Planning Committee, and providers on bridging cultural barriers to accessing care ➢ Code-based HIV reporting starts in California ➢ Enhanced Disclosure Program implemented
2003	➢ Laguna Beach Community Clinic institutes a mobile clinic to serve South Orange County residents ➢ The Public Law Center enhances services for PLWH/A with institution of the HIV Legal Checkup program and the addition of an immigration attorney
2004	➢ Implementation of the HRSA CARE System Assessment Demonstration (CSAD) Project to assess why out-of-care African-American and Latino PLWH/A may not seek care ➢ The Planning Council developed the Continuum of HIV/AIDS Services
2005	➢ HCA creates the CARE Network to provide specialty care for Ryan White Act clients throughout Orange County
2006	➢ Name-based HIV reporting starts in California ➢ Ryan White HIV/AIDS Treatment Modernization Act is reauthorized. Minority AIDS Initiative (MAI) is codified as part of Ryan White Act.
2007	➢ Psychiatric services added to Ryan White Act-funded service ➢ California Assembly Bill 682 simplified HIV test consent
2008	➢ Implementation of community outreach program to bring out-of-care PLWH/A into care. ➢ Implementation of the AIDS Regional Information and Evaluation System (ARIES)

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Appendix 2.A Benchmarks of HIV/AIDS in Orange County (1981-2012) (Continued)

2009	➢ The CDC decommissions the initial DOS based electronic reporting system, HARS and implements a web based reporting system named the Enhanced HIV/AIDS Reporting System (eHARS) for national HIV and AIDS case reporting. ➢ Ryan White HIV/AIDS Treatment Extension Act is reauthorized. Early Identification of Individuals with HIV/AIDS (EIIHA) is written into Ryan White legislation.
2012	➢ California's HIV data is published for the first time in CDC's Volume 22 HIV Surveillance Report, data through 2010. Orange County is noted as the Santa Ana Division and is under Los Angeles, California.

Chapter 3: Reducing New HIV Infections

Reducing New Infections At-A-Glance

Goal 1: By 2015, lower the annual number of new HIV infections by 25% from 325-375 to 244-281.

↳**Goal 3.1:** By 2015, reduce disparities in populations with new infections.

Strategies:

1. Evidence-based behavioral interventions for HIV-positive individuals
2. Evidence-based behavioral interventions to high-risk populations
3. Condom distribution to HIV-positive and high-risk populations
4. Syringe services programs
5. Social marketing, media, and mobilization

Goal 1.1: By 2015, increase from 79% to 90% the percentage of individuals living with HIV who know their status.

↳**Goal 3.1.1:** By 2015, reduce disparities in populations living with HIV who know their status.

Strategies:

1. Promote HIV testing as part of routine health care
2. Offer targeted HIV testing in non-healthcare settings
3. Expand Partner Services

Introduction

Reducing new HIV infections is the first step toward eliminating the HIV epidemic. Orange County has experienced dramatic declines in the number of new cases of HIV since the peak of the epidemic in the late 1980s when over 700 new cases were diagnosed each year. In the last 10 years, there continues to be about 315-365 new cases of HIV diagnosed each year.

Allowing the number of new infections to rise or remain the same imposes costs to the community and those living with the disease. The lifetime cost of treating HIV is estimated to be approximately $355,000 per person.[1] There are also untold costs to those living with HIV and to their families, friends, and support systems.

HIV infection is preventable. However, no single strategy will eradicate the number of new infections. Instead, strategies must be evidence based and address the many factors that contribute to infection. Key in the effort to reduce new HIV infections is addressing disparities in HIV infection. HIV prevention strategies and Interventions must be tailored to communities that are at greater risk for contracting HIV. Most importantly, reducing the stigma associated with HIV and those living with the virus are essential to identifying people living with HIV and helping them lead healthier lives. With focused, well-planned, and coordinated efforts, the number of new cases of HIV infections can be reduced significantly.

[1] Schaackman BR, Gebo KA, Walensky RP, et al. The lifetime cost of current human immunodeficiency virus care in the United States. *Med Care* 2006;44(11)990-97.

Background

The goals in this chapter correspond to goals in the National HIV/AIDS Strategy and the Centers for Disease Control and Prevention (CDC) guidance for reducing HIV infections. The Orange County HIV Prevention Planning Committee (PPC) is charged with reviewing, monitoring, and revising the goals and strategies in this chapter over the course of this plan.

The Orange County Health Care Agency (HCA) first received funding from the California Department of Public Health (CDPH), Office of AIDS (OA) from the Centers for Disease Control and Prevention (CDC) to provide HIV prevention services in 1984. The bulk of HIV Prevention funding in Orange County continues to come from the CDC via OA. Orange County receives approximately $1 million from OA to provide HIV prevention services including targeted HIV Counseling and Testing, Behavioral Interventions, and Partner Services, and another $450,000 for routine HIV testing in healthcare settings. These services are provided through community-based organizations and HCA programs. Orange County's priority and funding for services are developed with recommendations from the Prevention Planning Committee (PPC). Each year, the PPC reviews epidemiologic profiles to prioritize behavioral risk groups for which Prevention funding should be targeted.

In support of the National HIV/AIDS Strategy signed 2010, the CDC revised its Prevention Grants to focus on increasing HIV testing and linkage of HIV-positive people to care. The CDC provided guidance to state health departments by designating "Required" activities (HIV testing, comprehensive prevention with HIV-positive individuals, condom distribution, and policy initiatives) and "Recommended" activities (evidence-based interventions for high-risk populations, social marketing, media, and mobilization, and pre-exposure prophylaxis). In 2012, OA restructured its framework for prevention programs by designating Tier 1 and Tier 2 activities, which generally correspond with CDC's "Required" and "Recommended" activities, respectively. Orange County's approach to prevention considers these state and federal guidelines and includes strategies that are most relevant to the local epidemic.

Orange County has considered reports that of approximately 1 to 1.2 million persons living with HIV infection in the United States, approximately 21% are not aware of their infection; and transmission from persons not aware of their infection accounts for 54% to 70% of new infections.[2] In developing strategies to reduce new HIV infections, Orange County recognizes the importance of efforts to increase the serostatus knowledge among people living with HIV, and has indicated that as a subgoal of reducing new infections. While all strategies discussed in this chapter are aimed at reducing new infections overall, strategies discussed in the section regarding reducing new infections relate to activities that will reduce risk-taking behaviors among those most at risk. Strategies discussed in the section to increase serostatus knowledge among those living with HIV focus on HIV testing.

With strategies that aim to encourage all people to learn their HIV status, it is important to acknowledge that stigma related to HIV is a real barrier to HIV testing. When someone learns that they are HIV positive, they often feel shame and embarrassment, and may experience

[2] CDC, Recommendations and Reports, November 7, 2008, 1-63.

discrimination or even violence. This stigma is more pronounced in some communities, increasing disparities in new infections and knowledge of HIV status. To address this, the community must work toward reducing stigma in the general population and in specific communities so that individuals feel safe in finding out about and disclosing their HIV status. Faith communities, businesses, schools, community-based organizations, social gathering sites, and media outlets should take responsibility for affirming nonjudgmental support for people living with HIV and high-risk communities. In addition, healthcare professionals must be encouraged to approach HIV infection as a treatable condition and offer HIV testing to all patients at least once in their lifetime, regardless of their perception of the individuals' risk. These efforts will move our community away from perpetuating stigmas about HIV and toward reducing HIV infections in the county.

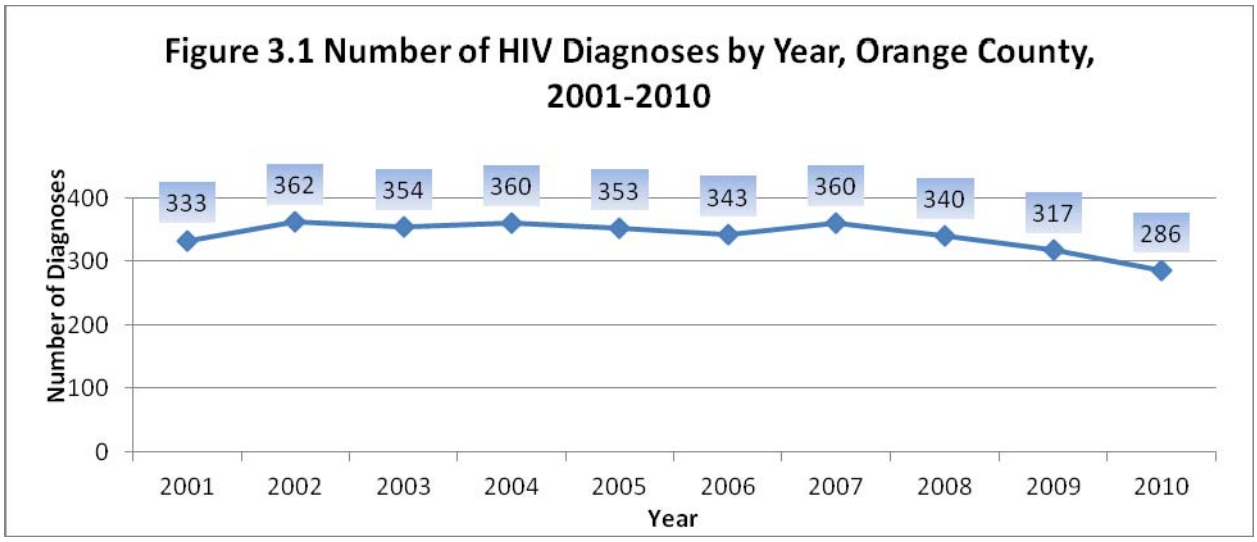
Goal 1: Reduce New Infections

Current Trends and Future Goals

Goal 1: By 2015, lower the annual number of new infections by 25% from 325-375 to 244-281.

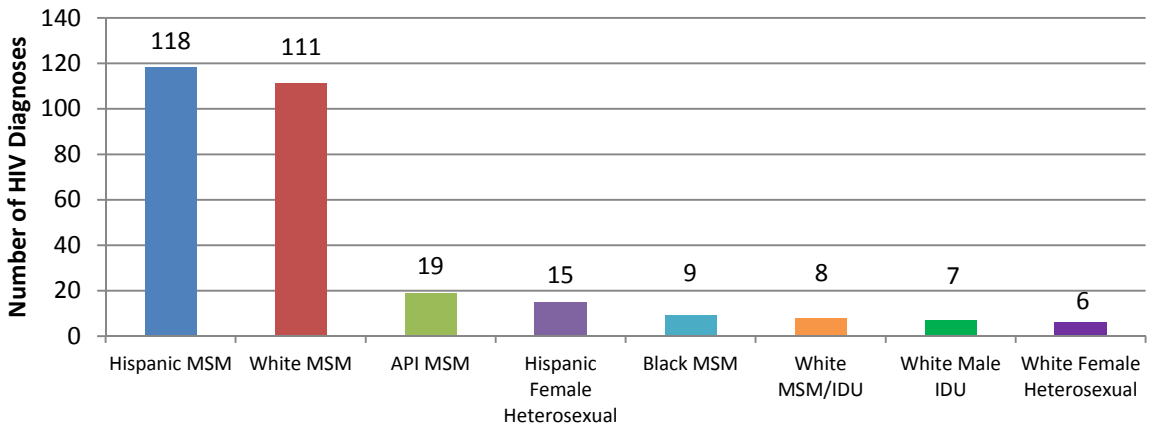
↳Goal 3.1: By 2015, reduce disparities in populations with new infections.

Figure 3.1 shows the number of new cases of HIV in the last 10 years. As shown, the number of new cases of HIV has remained between 325 and 375 each year. Orange County's goal is to reduce the annual number of new infections by 25% by 2015 to 244-281 new cases each year. This goal reflects that of the National HIV/AIDS Strategy as well as California's goals to reduce new infections.



Orange County's epidemic is predominately one among men who have sex with men (MSM). Figure 3.2 shows the one-year average number of new cases of HIV by race, gender, and mode of exposure diagnosed in Orange County between 2006 and 2010. Though all MSM are disproportionately impacted, regardless of race or ethnicity, White and Hispanic MSM make up the vast majority of new cases.

Figure 3.2 One-Year Average Number of HIV Diagnoses by Race, Gender, and Exposure Category, Orange County, Cumulative 2006-2010



Strategies discussed in this section relate to activities and interventions that will reduce risk-taking behaviors among those most at risk. These strategies include 1) evidence-based behavioral interventions to HIV-positive individuals; 2) evidence-based behavioral interventions to HIV-positive individuals; 3) condom distribution to HIV-positive and high-risk populations; 4) syringe education and services; and 5) social marketing, media, and mobilization. In reviewing this goal and disparities in reducing new infections, the PPC is reviewing targets and strategies based on the demographics of newly diagnosed individuals such as gender, race/ethnicity, age group, and reported mode of exposure.

Strategies 1 and 2: Implement evidence-based behavioral interventions to HIV-positive individuals (Strategy 1) and high-risk populations (Strategy 2)

Rationale

Prevention for people who are HIV-positive or at high-risk of getting HIV is critical to reducing new HIV infections. Evidence-based behavioral interventions are aimed at building knowledge, attitudes, and skills that can help persons living with HIV/AIDS (PLWH/A) from transmitting HIV and those at high-risk from getting HIV. These interventions are also important as a means of

promoting other HIV prevention strategies such as HIV testing, condom distribution, education for syringe services, and social marketing, media, and mobilization around HIV prevention. Evidence-based interventions should be based on local epidemiology, intervention effectiveness, and cultural/ethnic appropriateness necessary to reduce HIV transmission. The CDC provides tools for implementing specific evidence-based interventions known as Effective Behavioral Interventions (EBI) in the Compendium of Evidence-Based HIV Behavioral Interventions at www.effectiveinterventions.org. EBIs have been proven effective through research studies that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Studies employed rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions.

Current Continuum of Services

There are a variety of HIV prevention interventions to HIV-positive and high-risk populations in Orange County. Some of those interventions are based on CDC EBIs and some are locally developed programs tailored to the community and its needs.

AIDS Services Foundation of Orange County (ASF) implements two versions of the Mpowerment project, a CDC EBI for young gay and bisexual men. The project is a community-level intervention for young gay men. The project is run by a core group of 12-20 young men who aim to mobilize young gay men to reduce sexual risk taking, encourage regular HIV testing, build positive social connections, and support peers to have safer sex**.** ASF implements this project in English and in Spanish. ASF also implements individual-level interventions (ILIs), which are three-part risk-reduction counseling sessions designed to assist clients in developing and implementing a risk reduction plan.

The HCA Risk Reduction Education and Community Health (REACH) Program implements Positive Thinking, which is based on the Healthy Relationships CDC EBI. The goal of the program is to reduce the rate of HIV transmission from HIV-positive substance users to their sexual and substance using partners. Positive Thinking is a six-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

In addition to interventions for HIV-positive individuals, five providers offer interventions targeting high-risk populations. ASF offers the MPowerment intervention, described previously, to high-risk Hispanic MSM. REACH offers the only court-ordered community-wide HIV prevention education course for individuals convicted of certain drug-related or sex offense. The classes offer basic information regarding HIV transmission as well as provide linkage to HIV testing. APAIT Health Center (APAIT) offers ILIs targeted to high-risk Asians and Pacific Islanders while The Gay and Lesbian Community Services Center of Orange County (The Center) offer ILIs to high-risk MSM. The Orange County Bar Foundation (OCBF) conducts the Madres Unidas program with funding from the Centers for Substance Abuse and Prevention (CSAP). The program educates Latina women 26 to 50 years of age about prevention of substance abuse and HIV/AIDS and offers HIV testing onsite. OCBF also offers Hermana, a program based on the CDC

EBI SISTA that has been tailored for Latinas. The Hermana curriculum includes behavioral skills practice, group discussions, lectures, role-playing, a prevention video and take-home exercises to help address issues of risky behaviors such as alcohol and drug use and risky sexual activity, which can lead to STDs and HIV infection. The Center offers group workshops to high-risk MSM that provide information and build skills for risk-reduction. The Center also implements *Hermosa Y Protegida*, a pageant in which transgender women learn about HIV and develop HIV prevention messages. APAIT and The Center also conduct 10-minute risk-reduction counseling at local bars and clubs where high-risk individuals are known to congregate.

Gaps and Challenges

The following are gaps and challenges in implementing evidence-based interventions for HIV-positive and high-risk individuals in Orange County:

1. **More information needed on risk taking behaviors of recently diagnosed individuals.** To best target evidence-based interventions, more information is needed to determine the risk taking behaviors of recently diagnosed individuals.
2. **Lack of formal evaluation of locally-developed programs.** The effectiveness of locally-developed programs may be questioned as they may not have been developed based on rigorous study designs (i.e. use of intervention and control groups to determine that positive outcomes are attributed to the interventions). Resources to employ such designs are limited.
3. **Limited training and resources regarding evidence-based interventions.** Evidence-based interventions must be research-based. In addition, evidence-based interventions must be conducted in a manner that is consistent with the original design of the intervention. Trainings for interventions are often not local or limited based on funding source.

Next Steps

The following are next steps in implementing evidence-based interventions for HIV-positive and high-risk individuals in Orange County:

1. **Review available data regarding recently diagnosed individuals.**
    - Orange County Health Care Agency and HIV Prevention Planning Committee will review available epidemiological and Counseling and Testing data for information about the demographics and risk behaviors of recently diagnosed individuals and those receiving HCA-funded counseling and testing services.
2. **Conduct assessment regarding risk taking behaviors of recently diagnosed individuals.**
    - Orange County Health Care Agency will conduct an assessment to identify the risk taking behaviors of recently diagnosed individuals, especially MSM.
    - The findings of the assessments will help to determine appropriate evidence-based interventions for future HIV Prevention services. This may include the need to apply rigorous evaluation to locally-developed programs to determine their effectiveness.

3. **Provide resources to implement evidence-based interventions.**
    - Orange County Health Care Agency will coordinate trainings of appropriate evidence-based interventions for HIV prevention providers.

Strategy 3: Condom distribution to HIV-positive and high-risk populations

Rationale

In 2011, over 90% of Orange County's new HIV cases report having been exposed through sexual activity (either through men who have sex with men or heterosexual contact). Correct and consistent use of male condoms is estimated to reduce the risk of HIV transmission by 80 percent.[3] An effective HIV prevention strategy should include ensuring that condoms are available at no cost to those who may transmit the disease and those most likely to be infected.

Current Continuum of Services

Each of the four funded HIV prevention providers offer free condoms as part of their interventions. Condoms are distributed at outreach sites such as bars and clubs. Condoms are also distributed by medical clinics that provide family planning services and STD screenings. Some college campuses also distribute condoms at health centers. Office of AIDS funds the California AIDS Clearinghouse (CAC), which has a condom distribution program. The CAC is available to partner with local venues (e.g. community-based organizations, community health centers, clubs, bars) to distribute free condoms to their respective target populations.

Gaps and Challenges

The following are gaps and challenges in making condoms available to HIV-positive and high-risk populations in Orange County:

1. **More information needed on gaps in condom availability.** While condoms are distributed by HIV prevention sites, there is no comprehensive inventory of the availability of condoms to people living with or at risk for HIV.
2. **More information needed on which venues should distribute condoms.** More information is needed regarding which venues HIV-positive and high-risk individuals, particularly MSM, frequent and would prefer to obtain condoms from.

Next Steps

The following are next steps in increasing condom availability to HIV-positive and high-risk individuals in Orange County:

[3] Weller S, David, K. Condom effectiveness in reducing heterosexual HIV transmission (Cochrane Review). In: *The Cochrane Library,* Issue 4, 2003. Chichester, UK: John Wiley & Sons.

1. **Conduct resource inventory regarding condom availability.**
    - Orange County Health Care Agency will conduct a resource inventory to determine where condoms are currently available.
2. **Determine venues for condom distribution.**
    - Orange County Health Care Agency will conduct an assessment to find out where HIV-positive and high-risk individuals, particularly MSM, frequent and would prefer to get their condoms from.

Strategy 4: Syringe services programs

Rationale

In Orange County, exposure of HIV through injection drug use (IDU) or men who have sex with men who are injection drug users (MSM/IDU) account for approximately 9% of new HIV infections or about 31 new cases each year.[4] This represents a dramatic decline in the number and proportion of HIV infection among IDU and MSM/IDU, who had accounted for almost 20% of new cases with almost 150 new cases each year in the late 1980s. Strategies aimed at clean and safe use of syringes can continue to reduce the number of infections in the county. Syringe services programs include education about sharps disposal and needle cleaning, non-prescription sale of syringes (NPSS), and syringe exchange programs. Such programs, implemented as part of a comprehensive approach to HIV prevention, have been shown effective in reducing HIV infection.[5]

Continuum of Services

In Orange County, syringe services programs consist of education about clean and safe use of syringes at community-based organizations and other HIV prevention programs. The HCA REACH program distributes bleach kits to at-risk populations through outreach and other interventions to IDU who request them. California Senate Bill 1305 made it illegal to dispose of medical waste in home waste and recycling containers beginning in 2008. Instead, sharps disposal is available at various waste collection sites throughout the county. In 2011, California passed Senate Bill 41, which permitted all pharmacies to provide NPSS without the special registration requirements previously required. Most pharmacies in Orange County do not sell non-prescription syringes. This may change as more pharmacies become familiar with the law and understand how to implement it at the local level. There are no syringe exchange programs in Orange County.

[4] Orange County HIV Registry data as of December 2011, one-year average of HIV/AIDS cases diagnosed 2006-2010
[5] World Health Organization. 2004. Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Available at http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf.

Gaps and Challenges

The following are gaps and challenges in implementing syringe services programs in Orange County:

1. **Concerns over unintended consequences of syringe services.** Although syringe service programs have been shown to reduce the risk of HIV transmission, there are concerns that provision of such services may increase or promote intravenous drug use. At the federal level, such concerns have led to the FY 2012 Omnibus Appropriations bill, which reinstated the ban on federal funding for syringe exchange programs.
2. **Difficulty coordinating services.** Syringe services programs involve a variety of stakeholders including multiple health department offices (Environmental Health, Public Health, and Behavioral Health), pharmacies, medical providers, and clients. This makes coordinating a response for syringe services including conducting a resource inventory, providing education, and implementing programs more challenging.
3. **Need for education regarding proper sharps disposal.** Though sharps disposal is available, they may not be readily accessible; IDU and others who use syringes may not be aware of sites for disposal.

Next Steps

1. **Conduct an assessment regarding syringe services programs.**
    - Orange County Health Care Agency will conduct a resource inventory regarding sharps disposal sites and pharmacies participating in NPSS.
    - Orange County Health Care Agency will coordinate an assessment regarding the need for sharps disposal education.

Strategy 5: Social marketing, media, and mobilization

Rationale

Social marketing is the use of commercial marketing techniques to educate high-risk populations, healthcare providers, and other relevant audiences about HIV prevention. Marketing can be done through a variety of media including television, radio, magazines, newspapers, billboards, bus boards, or on the internet. Social media includes the use social networking sites (e.g. Facebook, Twitter, blogs, LinkedIn), texting, and web applications to reach high-risk populations. Mobilization includes efforts to rally community members and stakeholders and raise awareness, fight stigma, and encourage safe behaviors. Increased education about HIV through these methods is especially important as public attention about the HIV epidemic has waned. Six in 10 Americans say most of what they know about HIV/AIDS comes from the media, putting it ahead of other sources like school, their doctors, friends and family, and the church. Media is the top information source on HIV across racial/ethnic groups and for younger and older adults alike. Substantial shares of the public, and much larger shares among blacks and Latinos, say they'd like to have more information on a variety of HIV-related

topics, including how to prevent the spread of HIV, how to know whether to get tested and where to go to do so, and how to talk with children, partners, and doctors about the disease.[6] In its guidance to local health jurisdictions, OA has provided health messages for social marketing, media, and mobilization activities fundable through its HIV prevention dollars.[7] These messages focus on improving linkage to and retention in care, promoting medication adherence, and promoting care as HIV prevention. As a whole, social marketing, media, and mobilization around HIV prevention should create an environment that is more aware of HIV, where there is less stigma about HIV, and where HIV prevention activities are the accepted as the norm.

Current Continuum of Services

Social marketing campaigns related to HIV and HIV testing generally appear in Orange County as part of state or national campaigns. Social marketing messages are also developed and distributed as part of campaigns from HIV pharmaceutical companies. Residents of Orange County may also be exposed to social marketing messages about HIV prevention when they are in neighboring counties such as Los Angeles, where social marketing related to HIV is more visible.

Social media includes the use of technologies such as social networking sites, texting, and web applications to reach highest-risk populations. Some community-based organizations have begun using social networking sites to disburse information about HIV prevention activities and messages. Participants in ASF's MPowerment intervention, SOMOS, produced several videos promoting safe sex and reducing risk of HIV transmission. The SOMOS project targets gay and bisexual Hispanic men ages 18 to 29. The videos were made available on YouTube and viewed at the annual Mr. SOMOS event and the 2011 National HIV Prevention Conference.

The HCA HIV Planning and Coordination website is another venue that is utilized to disseminate information to educate individuals (HIV-positive and negative), healthcare providers, and other relevant audiences about HIV and services in the community. The website includes an event calendar, which posts HIV-related events in the county including times and locations for rapid testing, support groups, and educational workshops. It also includes information on services available throughout the county. The website was recently redesigned with the assistance of the HIV Client Advocacy Committee to be more user-friendly. One of the major changes included having a list of questions on the homepage which include: "don't know your status?," "newly diagnosed or out of care?," and "already a client?" These simple questions help to better navigate individuals seeking information via the internet.

Mobilization includes efforts to rally community members and stakeholders to raise awareness, fight stigma, and encourage safe behaviors. There has been a history of mobilization efforts in Orange County that have largely been coordinated based on national HIV awareness events such as National HIV Testing Day, World AIDS Day, National Latino HIV/AIDS Awareness Day, National Asian and Pacific Islander HIV/AIDS Awareness Day, and National Women and Girls HIV/AIDS

[6] Kaiser Family Foundation. *HIV/AIDS at 30: A Public Opinion Perspective*. June 2011. Available at http://kff.org/kaiserpolls/upload/8186.pdf.

[7] California Department of Public Health, Center for Infectious Diseases, Office of AIDS. Information for Prevention Program Planning in the California Project Area FY 2012-13. February 2012.

Awareness Day. Partners in these efforts include a wide range of community stakeholders including HIV providers, faith-based organizations, college campuses, local business, and community centers. For instance, December 1st of each year has been designated as World AIDS Day. Each year, agencies and individuals commemorate this day by hosting a variety of awareness events. Events include but are not limited to candlelight vigils, art exhibitions, and other community events, some of which provide HIV testing as an attempt to get more people tested as well as to decrease HIV/AIDS-related stigma. In addition, each year the Orange County Board of Supervisors proclaim December 1st as World AIDS Day. The proclamation acknowledges those who live with the disease, those who have died from the disease, doctors and scientists who provide care and continue to search for a cure, and public health professionals who provide services to people living with and/or affected by HIV/AIDS.

Another major mobilization effort in Orange County is the Orange County AIDS Walk. AIDS Walk is a major event to raise funds for community-based organizations that provide HIV/AIDS services in the county. The event is utilized to increase awareness and support for issues related to HIV/AIDS prevention and care. AIDS Walk first took place in Orange County in 1987 and continues to be a widely supported and publicized event. Over 2,000 people participated in the 2012 AIDS Walk, which is estimated to raise $500,000 for the provision of HIV/AIDS services in Orange County. The revenue and walker participation is approximately 10% below participation and revenue from the 2011 Walk. The economy, Walk competition, and AIDS fatigue, are assumed to be contributing factors to the decline. In 2010, ASF also began producing the Orange County Ride for AIDS (OCRA). The ride is another mechanism to raise funds and awareness about HIV/AIDS in Orange County.

Gaps and Challenges

The following are gaps and challenges in implementing social marketing, media, and mobilizations in Orange County:

1. **Difficulty tracking outcomes and limited resources in implementing a social marketing campaign.** Social marketing campaigns can be costly to implement and outcomes are difficult to track. In addition, to implement these campaigns well requires understanding of marketing principles, which may be limited.[8]
2. **Difficulty directing social marketing to target populations.** Orange County's population is dispersed, and no significant urban center exists. It can be difficult to target social media campaigns to specific populations with greatest disparities in new infections such as White and Latino MSM. This is especially true when the media market for the county is based largely in the neighboring county of Los Angeles.
3. **Difficulty creating relevant and sustainable social media efforts.** The use of social media to promote HIV prevention is a relatively new strategy. With rapid changes in technologies and shifts in the public's attention, creating and maintaining a social media effort that is relevant can be a challenge.

[8] Bloom P, Novelli, K. Problems and challenges in social marketing. *Journal of Marketing* Spring 1981;45(2)79-88.

4. **Need for a coordinated strategy that builds on mobilization efforts.** Orange County's activities around social marketing, media, and mobilization have largely focused on mobilization efforts such as AIDS Walk and events for World AIDS Day and national observances related to HIV. There is a need to build on these efforts and ensure a more coordinated HIV prevention strategy through social marketing and social media.

Next Steps

The following are next steps in implementing social marketing, media, and mobilizations in Orange County:

1. **Determine partners who could begin research and discuss resources available for a social marketing strategy.**
   - Orange County Health Care Agency will put together a task force to begin exploring target audiences and messages appropriate for social marketing in Orange County.
2. **Identify and develop ways to social media to communicate information, raise awareness, and mobilize the community.**
   - Orange County Health Care Agency will work with community providers to identify ways to increase the use of social media in HIV prevention efforts.
3. **Develop a coordinated environmental strategy to address HIV prevention.**
   - Orange County Health Care Agency and the Prevention Planning Committee will determine next steps in prioritizing populations and messages around HIV prevention.
   - Based on community input, develop an environmental strategy that encompasses social marketing, media, and mobilization to address HIV prevention Orange County.

Goal 1.1 Increase Serostatus Knowledge

Current Trends and Future Goals

Goal 1.1: By 2015, increase from 79% to 90% the percentage of individuals living with HIV who know their status.

↳ Goal 3.1.1: By 2015, reduce disparities in populations living with HIV who know their status.

To prevent HIV, we should strive to ensure that all people living with HIV know their HIV status and are linked to and maintained in high-quality care. There is evidence that people who test HIV-positive take steps to keep others from being exposed to the virus.[9] The CDC estimates that

[9] Marks G, Crepaz Nicole, Janssen, RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS* 2006; 20(10): 144-1450.

79% of people living with HIV in the United States do not know their HIV status. Using the CDC's Back Calculation Methodology (0.21 / 0.79 x 6,674 diagnosed persons living with HIV), **there are 1,774 individuals in Orange County are living with HIV and do not know it.** To increase serostatus knowledge to 90%, 1,033 individuals who are living with HIV as of 2011 must be informed of their status.

The challenge with utilizing a back calculation methodology to determine this goal is that each new diagnosis impacts the estimate. This would mean that progress toward this goal would result in an increase in the reported number of new HIV infections and, consequently, an increase in the estimate. To address this challenge, Orange County has defined two measures that would indicate that more individuals living with HIV are being informed of their status:

Measure 1: Increased HIV testing.

Measure 2: Decreased proportion of persons diagnosed with HIV at the same time of their AIDS diagnosis (concurrent diagnosis).

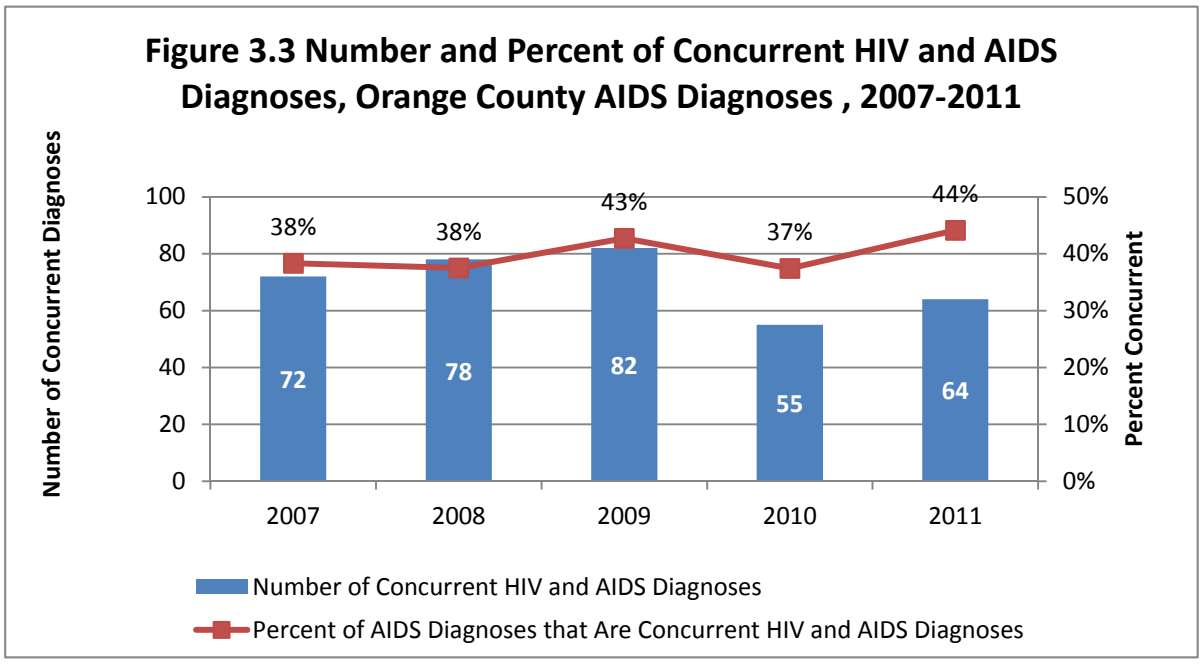
Measure 1: Increased HIV Testing.

Historically, HIV testing is largely provided at Alternative Testing Sites, targeting high-risk populations. In 2011, the HCA funded 9,003 tests for high risk individuals including MSM and substance users. Expansion of HIV testing beyond these tests will be one measure used to assess progress toward informing individuals of their status. Specific strategies, to be discussed later in this chapter, include promoting HIV testing as part of routine health care and increased targeted testing in non-healthcare settings.

Measure 2: Decreased proportion of persons diagnosed with AIDS at the same time of their HIV diagnosis (concurrent diagnosis).

People who are unaware of their HIV status for an extended period of time may also enter care too late to have the maximum benefit from therapy, and may unintentionally expose others to HIV.[10] A measure of assessing progress toward informing individuals of their status is a decrease in the proportion of persons diagnosed with HIV and AIDS at the same time. Figure 3.3 shows the number (blue bars) and percent (red line) of Orange County AIDS diagnoses that found out that they were HIV positive at the same time they were diagnosed with AIDS between 2007 and 2011. As shown, **each year between 37% and 44% of people diagnosed with AIDS do not know they were HIV-positive**. **In 2011, the 64% of these concurrent diagnoses were diagnosed at hospitals and the majority had health insurance.** With expanded HIV testing, more individuals should be finding out about their HIV status earlier in their disease and this proportion should decrease.

[10] Bisset L, Cone RW, Huber W, et al. Highly active antiretroviral therapy during early HIV infection reverses T-cell activation and maturation abnormalities. *AIDS* 1998; 12(16):2115-23.



Strategies discussed in this section relate to activities and interventions that would increase serostatus knowledge. These strategies include 1) promote HIV testing as part of routine health care; 2) offer targeted HIV testing in non-healthcare settings; and 3) expand services that help HIV-positive individuals disclose their status to sex or needle sharing partners (Partner Services). In reviewing this goal and disparities in reducing new infections, the PPC is reviewing targets and strategies based on the demographics of those who are most likely to be concurrently diagnosed with HIV and AIDS such as gender, race/ethnicity, type of insurance, and facility of diagnosis. In Orange County, women of color, those over the age of 40, those diagnosed at hospitals, and people with insurance are more likely to be diagnosed with HIV at the same time of their AIDS diagnosis. However, the number of new infections in some of these groups can be quite low. This presents a challenge when developing strategies that target disparities. Healthcare systems must therefore approach HIV infection as another treatable condition and offer HIV testing to all patients at least once in their lifetime, regardless of their perception of the individuals' risk. In addition, strategies must address stigma in communities where learning about one's HIV status can be so shameful that individuals delay it until they are very sick.

Strategy 1: Promote HIV testing as part of routine health care

Rationale

Since HIV tests became available, HIV testing in Orange County has largely been conducted at Alternative Testing Sites that target high-risk populations such as men who have sex with men and injection drug users. However, the strategy of targeting testing to individuals who are perceived to be at high-risk for HIV has not lead to declines in the incidence of HIV in the county in the last 10 years. In 2006, the CDC published the *Revised Recommendations for HIV Testing of*

Adults, Adolescents, and Pregnant Women in Health-Care Settings. The revised recommendations advocated for routine voluntary HIV screening as a normal part of medical practice, similar to screening for other treatable conditions. The recommendations were that all individuals between the ages of 13 and 64 are aware of their status and those at high risk are tested annually.[11]

The CDC's rationale for changing these requirements is substantiated by data for Orange County. The CDC states that persons with HIV infection visit healthcare settings (e.g. hospitals, acute-care clinics, and sexually transmitted disease clinics) years before receiving a diagnosis but are not tested for HIV. In Orange County, the majority of those diagnosed concurrently with AIDS and HIV have insurance. Despite the availability of HIV testing at Alternative Testing Sites throughout the county since 1985, the largest number of new HIV diagnoses in Orange County is still occurring at hospitals. The CDC also cites that changing demographics of those infected with HIV to include women, racial/ethnic minorities, and heterosexuals reduce the effectiveness of risk-based testing. While men who have sex men still make up the vast majority of new HIV cases, over the past 30 years, women, racial/ethnic minorities, and heterosexuals have made up increasing proportions of the epidemic. The CDC cites the success of universal screening among pregnant women and screening blood donors in nearly eliminating perinatal and transfusion-associated HIV infection, respectively. Increased routine screening of HIV in healthcare settings provides an opportunity to screen all individuals, reaching those who may not have been aware of their HIV status.

There have been many challenges to implementing CDC's 2006 revised recommendations to conduct routine HIV testing in healthcare settings. Initial barriers to offering routine HIV testing included legislative restrictions that required written consent prior to testing and lack of reimbursements for tests not associated with a diagnosis. To address these barriers, Assembly Bill 682 was enacted in January 2008 to eliminate the requirement for written consent for an HIV test when ordered by medical care providers. On January 1, 2009, Assembly Bill 1894 was enacted, which required that insurance companies covered testing for HIV in medical care settings regardless of whether the test was related to a primary diagnosis.

Current Continuum of Services

In 2010, the HCA collaborated with University of California, Irvine (UCI) site of the Pacific AIDS Education and Training Center (PAETC) and CalOptima (Orange County's Medi-Cal managed care system) to conduct a survey to determine HIV testing practices among medical care providers in Orange County. The goal of the survey was to identify ways to increase HIV testing in healthcare settings. The HCA distributed approximately 900 surveys in late 2010 through the following: 1) during two symposiums by the American College of Physicians, 2) via mail to CalOptima medical providers (internists, family practitioners, and OB/GYNs) in various cities in Orange County, 3) by email to physicians of the Orange County Medical Association (OCMA), and 4) online using a link on the OCMA website. Of the surveys distributed, 252 surveys were received.

[11] Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR : Morbidity and Mortality Weekly Report* September 22, 2006; 55(RR14):1-17

Key findings of the survey were that most (71.4%) providers do not offer HIV testing as part of a regular primary care visit. The major reason that physicians indicated for not testing regularly was that they felt their patients "were not at risk for HIV." When asked what would help provider improve HIV testing, the top two responses were "training on how to talk to patients about HIV," and "more education with providers about risk of HIV." In addition, many comments regarding challenges to testing related to concerns about reimbursement for testing. Based on this needs assessment, a key component in ensuring routine HIV screenings is to build the capacity of providers to discuss HIV testing and care with their patients and bill appropriately for such services.

To increase understanding and implementation of routine HIV screening, the survey included a separate educational document with information about the CDC's revised recommendations for testing, answers to frequently asked questions about HIV testing and consent requirements, and information about how to report, refer, and link patients who tested HIV positive. Technical assistance via the HCA or UCI PAETC was also offered. Resources to increase HIV testing including patient communication about HIV tests are also available through OA at their website (http://www.cdph.ca.gov/programs/aids/Pages/OAHIVTestResources.aspx).

While not a part of routine healthcare in most settings, HIV testing has been offered as one of the tests offered at STD clinics including the HCA 17th Street Testing and Treatment and Planned Parenthood medical clinics in the county. In 2011, Orange County also received funding from the CDC through OA to conduct high-volume HIV screening in healthcare settings. In 2012, the HCA began contracting with University of California, Irvine Medical Centers (UCIMC) to conduct routine opt-out HIV screening at medical centers in Anaheim, Orange, and Santa Ana. AltaMed, a primary care provider, received funding from OA to conduct routine opt-out testing at eight clinic sites throughout Orange County. The HCA is also implementing routine opt-out HIV testing at all County jail facilities. An estimated 3,000 tests will be conducted in a six-month period. Tests will be added to lab orders when a blood draw is taken for other indications. A condition of the funding is that individuals who test HIV-positive are linked to medical care, Partner Services, and HIV prevention services.

There has also been a strong effort made to increase routine testing within the HCA programs including Pulmonary Diseases, Family Health, Drug and Alcohol services, and indigent and low-income health services programs. Agency Policy and Procedures have been rewritten to reflect the changes in CDC guidelines regarding the consent process and trainings have been done for staff on how to implement the new testing process.

Gaps and Challenges

The following are gaps and challenges in implementing routine HIV testing in healthcare settings in Orange County:

1. **Stigma associated with HIV.** The most significant barrier to providing routine HIV testing is stigma about the topic of HIV and the sexual and injection drug using behaviors that have historically been associated with it. This stigma makes it difficult for patients to accept getting the test and providers to offer it.

2. **Need for resources and expertise for initiating routine HIV testing in diverse settings.** Healthcare settings and systems in Orange County are diverse and complicated; they include private medical doctor offices, HMOs, hospitals, jails, and community health centers. These settings currently lack the infrastructure, policies, and procedures to implement routine HIV testing. In order to implement routine HIV testing, each will need education about available testing technologies, requirements about documentation, reporting, care, and referrals that are specific to their setting. There are limited resources to assist these settings in implementing routine HIV screening.
3. **Need for provider education regarding offering routine HIV testing.** While Assembly Bill 682 eliminated the requirement for written consent prior to providing an HIV test, there are still requirements for provision of basic information about the test. In the HCA survey, many healthcare providers indicated that they did not offer HIV tests because it was not their area of expertise. Providers need assistance in learning how to talk to their clients about HIV.
4. **Provider perception of patient risk.** In HCA's survey of providers, the number one reason that providers did not offer routine HIV testing was that they do not view their patients as at risk for HIV.
5. **Reimbursement concerns.** Many providers are unaware that routine HIV testing can be reimbursed and/or how to bill for testing.

Next Steps

The following are next steps in implementing routine HIV testing in healthcare settings in Orange County:

1. **Prioritize sites to implement routine testing.**
    - Determine sites that are most likely to find HIV-positive individuals to focus initial efforts for implementing routine testing. Orange County does not have a public hospital, therefore, emergency departments and community health centers are most often the primary healthcare providers for populations with no other source of care and most likely to find newly identified HIV-positive individuals. Recent projects offering routine HIV testing in similar healthcare settings in other areas including Los Angeles, Houston, and North Carolina have shown a positive rate of between 0.67%[12] and 1.5%.[13]
    - Orange County Health Care Agency will initiate conversations with sites most likely to yield higher HIV positivity rates to assist them in implementing routine HIV testing.
2. **Offer education and technical assistance for initiating the implementation of routine testing.**

[12] North Carolina Epidemiologic Profile for HIV/STD Prevention and Care Planning (12/10) Chapter 3
[13] CDC. Rapid HIV Testing in Emergency Departments – Three U.S. Sites, January 2005 – March 2006. MMWR 2007; 56(24): 597-601.

- Orange County Health Care Agency's contract with UCIMC to implement high volume HIV testing includes a subcontract with the UCI PAETC. UCI PAETC will create a resource manual to share policies, procedures, and protocols based on UCIMC's experience in implementing routine testing. By 2015, this manual should be available online as a resource to other healthcare settings.

Strategy 2: Offer targeted HIV testing in non-healthcare settings

Rationale

Individuals at highest risk for HIV may not access healthcare services and when they do, are often not offered an HIV test. Positivity rates of targeted HIV tests offered in non-clinical settings are higher than those in clinical settings,[14] which indicate that offering HIV testing at sites targeting those at highest risk for HIV remains an important means of identifying PLWH/A. Non-healthcare settings serving high-risk populations include community-based organizations, substance abuse clinics, bars, or clubs. It is important to distinguish this strategy from HIV testing at community events that do not target high-risk individuals, which may serve as a community mobilization activity that reduces stigma associated with HIV and HIV testing.

Current Continuum of Services

HIV testing in Orange County has historically been in non-healthcare settings targeted at high-risk populations such as men who have sex with men, substance users, and partners of infected individuals. The HCA provides support for HIV counseling and testing services in Orange County through the provision of HIV rapid test kits funded by OA. These Counseling and Testing sites include 17th Street Testing and Treatment (the HCA HIV testing and STD clinic), the REACH Program, which provides services to substance users, and community-based organizations including ASF and The Center Orange County. Tests are provided at no cost to individuals. In addition to offering tests onsite, these programs often partner with venues that serve high-risk populations such as bars and clubs to offer tests. Each year, approximately 9,000 tests are provided at Counseling and Testing sites and about 1.0% of test results are positive.

Gaps and Challenges

The following are gaps and challenges in offering HIV testing in non-healthcare settings in Orange County:

1. **More information needed regarding locations to target HIV testing in non-healthcare settings.** To best identify non-healthcare setting locations to offer HIV testing to the most high-risk populations, more information is needed regarding HIV testing history of recently diagnosed individuals.

[14] CDC. Results of the Expanded HIV Testing Initiative – 25 Jurisdictions, United States, 2007—2010. MMWR 2011; 60(24);805-810

2. **More information on the need and feasibility of mobile HIV testing.** The Prevention Planning Committee has recommended that HIV testing be brought to settings to serve high-risk individuals. Mobile testing may be an option for settings that are less accessible to high-risk populations. Mobile testing vehicles to conduct HIV testing has been cost prohibitive. More information is needed on the need and feasibility of this method of targeted testing.
3. **Stigma associated with HIV.** Stigma continues to be a barrier to HIV testing. This stigma makes it difficult for individuals to access HIV testing at known AIDS Services Organizations throughout the county.

Next Steps

The following are next steps in offering targeted HIV testing in non-healthcare settings in Orange County:

1. **Review available data regarding recently diagnosed individuals.**
   - Orange County Health Care Agency and HIV Prevention Planning Committee will review available epidemiological and Counseling and Testing data for information about the demographics and testing history of recently diagnosed individuals.
2. **Conduct assessment regarding testing history of recently diagnosed individuals.**
   - Orange County Health Care Agency will conduct assessment to identify testing history of recently diagnosed individuals.
   - The findings of the assessments may help to determine locations for implementing and expanding HIV testing in non-healthcare settings that can increase testing of high-risk populations.
3. **Prioritize sites to expand HIV testing in non-healthcare settings.**
   - Determine sites that are most likely to find HIV-positive individuals.

Strategy 3: Expand services that help HIV-positive individuals disclose their status to sex or needle-sharing partners (Partner Services)

Rationale

Partner Services offers HIV-positive individuals assistance with letting their sex or needle sharing partners know that they may have been exposed to HIV. The service can be provided at any time including soon after a person has been diagnosed and as they receive care. Partner Services offers three options for disclosing: 1) self notification in which an individual receives coaching to tell their partner(s) of the exposure; 2) dual notification in which an individual discloses their status while a provider is in the room; or 3) third party disclosure in which a trained staff anonymously notify partners of exposure. Upon notifying the partner, the individuals is offered an HIV test, risk reduction counseling, and if positive, linkage to medical

care and supportive services. Due to the high positivity of those tested as a result of Partner Services, this service is an effective strategy in increasing serostatus knowledge in PLWH/A.[15]

Current Continuum of Services

Partner Services activities in Orange County are coordinated through a Partner Services Coordinator at the HCA 17th Street Testing and Treatment funded through OA. HIV service providers at Ryan White provider locations, community physicians caring for HIV-positive individuals, and OA-funded Counseling and Testing sites have been trained to provide Partner Services and refer PLWH/A for third party notifications. Two staff in Orange County have had specialized training in conducting field work for third party notifications. Trainings have also been conducted for consumers on the topics of sexual health, disclosure, and Partner Services. Over the past three years, there have been a total of 73 partners identified and tested through Partner Services in Orange County. Of those tested, six were newly identified as HIV positive, representing a positivity rate of 8%.

In 2011, a campaign was developed to market Partner Services. The campaign included posters and tear-off sheets in Spanish and English distributed to medical providers and HIV service providers throughout the county. An advertisement regarding Partner Services was also posted in *The Blade*, a local magazine for lesbian, gay, bisexual, and transgender populations.

Gaps and Challenges

The following are gaps and challenges in providing partner services in Orange County:

1. **Stigma associated with HIV.** The most significant barrier to encouraging disclosure about HIV status is likely stigma about the topic of HIV. If individuals feel that disclosing their status, especially when it means possible exposure of someone to HIV, can lead to adverse outcomes, they are much less likely to do so.
2. **Difficulty tracking services and outcomes.** As stated, Partner Services can be provided in one of three ways, including self disclosure by an HIV-positive person who receives Partner Services coaching. Tracking whether the PLWH/A informed his/her partner(s) and the outcome of those disclosures can be difficult as it relies on the HIV-positive individual's report. Even if PLWH/A inform a provider about their disclosure, reports of Partner Services activity at sites not funded by OA can be difficult. Finally, Partner Services information is tracked in three statewide databases funded by OA including a separate database for HIV Prevention, HIV Care, and STD surveillance. Linking these databases and outcomes associated with Partner Services from various sources is a challenge.
3. **Small number of Partner Services referrals.** Despite available trainings and resources and recent increases, the number of Partner Services referrals received by the HCA has remained relatively low. This may be due to preferences for self disclosure as a Partner

[15] Hogben M, McNally T, McPheeters M, Hutchinson A. The Effectiveness of HIV Partner Counseling and Referral Services in Increasing Identification of HIV Positive Individuals: A Systematic Review. *Am J Prev Med* 2007;33(2S).

Services modality and difficulty in tracking that service (as previously indicated). However, the reason for this low number is unknown.

4. **Difficulty sustaining Partner Services message.** Partner Services is a service that should be part of the spectrum of HIV Care and offered to all individuals living with HIV on an ongoing basis. One challenge has been determining how to offer Partner Services to all clients consistently and throughout their time in care.
5. **Diversity of Partner Services providers.** Partner Services can be offered by a variety of providers who provide services to HIV-positive individuals including medical providers, case managers, and counselors. The varied nature of these providers and services can make coordination of trainings and tracking outcomes a challenge.

Next Steps

The following are next steps in providing Partner Services in Orange County:

1. **Identify gaps in Partner Services.**
   - Orange County Health Care Agency will work with HIV-positive and community providers to determine gaps and needs in increasing Partner Services referrals.
2. **Identify ways to improve data collection and management.**
   - Orange County Health Care Agency will continue work with OA and the STD Control Branch to evaluate possibilities to improve data collection and reporting.

Chapter 4: Increasing Access to Care and Improving Health Outcomes

Increasing Access to Care and Improving Health Outcomes At-A-Glance

Goal 2.1: By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of diagnosis from 71% to 82%.
Strategies:
1. Ensure a network of medical providers serving PLWH/A.
2. Educate community medical providers about available services for PLWH/A.
3. Offer services that link newly diagnosed patients to care.

Goal 2.2: By 2015, increase the proportion of PLWH/A who are in care.
Strategies:
1. Educate providers regarding PHS guidelines and resources.
2. Expand services that bring individuals back into care.
3. Offer medical case management.
4. Provide peer support for staying in care.
5. Ensure access to continuum of HIV services.

Goal 2.3: By 2015, increase proportion of PLWH/A with suppressed viral load.
Strategies:
1. Educate HIV specialists about offering treatment based on PHS guidelines.
2. Educate providers about referring to HIV specialists for treatment.
3. Ensure access to HIV medications.
4. Provide education and support for adherence to medications.

↳ **Goals 3.2.1-3.2.3:** Reduce disparities in populations linked to care, retained in care, and with suppressed viral load.

Introduction

As of December 2011, there are 6,674 individuals diagnosed and living with HIV/AIDS in Orange County. Orange County estimates that almost **one in four persons diagnosed with HIV/AIDS have not received medical care in the last year** and **about half may not be viral load suppressed.** This is despite available public health care services through Medi-Cal, Medicare, and the Ryan White Act.

While there is not yet a cure for HIV infection, medical care and treatment for those living with HIV can significantly improve and extend the lives of those living with the disease. Ensuring that persons living with HIV/AIDS (PLWH/A) are accessing medical care and adhering to medications also helps to reduce HIV transmission in the community.

Efforts to ensure that those living with HIV access care and have improved health outcomes must mean a coordinated response that follows individuals from their initial diagnosis and continues to support their engagement in medical care, including adherence to medications. These efforts must also consider all the needs of those living with HIV/AIDS who often struggle with issues of lack of insurance, poverty, mental illness, homelessness, substance use, among other challenges. Providing a seamless continuum of services that addresses these needs will be critical in ensuring access to services and improved health outcomes.

Background

The goals in this chapter correspond to goals in the National HIV/AIDS Strategy and Healthy People 2020. The HCA HIV Planning and Coordination Unit's (HIVPAC) Ryan White Quality Management (QM) Committee is charged with reviewing, monitoring, and revising the goals in this chapter over the course of this plan.

Services for people living with HIV/AIDS in Orange County are funded by a variety of sources including Ryan White, other federal, state, and local funding. Orange County receives approximately $8.4 million of Ryan White funding to provide medical care and support services to over 2,500 persons living with HIV/AIDS each year. These services are provided through community based organizations and the HCA programs. Orange County's priority and funding for services are recommended by the HIV Planning Council. Each year, the HIV Planning Council with the help of its Priority Setting, Allocations, and Planning (PSAP) Committee reviews epidemiologic profiles, service utilization data, and cost data to recommend priorities and allocations to areas of greatest need for Ryan White clients. Another $27 million in Ryan White funding comes through the State's AIDS Drug Assistance Program (ADAP) program to provide medications to the 2,000 Orange County residents on the ADAP. Orange County is also home to the Pacific AIDS Education and Training Center (PAETC) at the University of California at Irvine (UCI), which provides training and technical assistance to medical providers to improve quality of medical care to HIV-positive patients.

In developing goals and strategies to increase access to care and improve health outcomes of those living with HIV/AIDS, Orange County considered all key partners in providing a continuum of services including general practitioners, HIV specialists, pharmacists, Ryan White providers, and PLWH/A. These strategies are based on the premise that services to reduce risk of transmission and inform individuals of their status, discussed in Chapter 3, will be expanding. With increased numbers of PLWH/A being identified, there is also an increased need to assure a continuum of services that is accessible and of high quality. As part of these efforts, Orange County has joined the national in+care campaign, a collaborative campaign with the U.S. Health Resources and Services Administration (HRSA) and the National Quality Center to retain Ryan White patients in care. Definitions of each of the goals in this chapter are consistent with those outlined in the in+care campaign. While each goal has strategies that are specific to them, strategies for Goal 2.1 (Increase linkage to care) and Goal 2.2 (Increase retention in care) also serve to meet the Goal 2.3 (Increase the proportion of PLWH/A who are viral load suppressed). Suppression of viral load serves as a marker of patient linkage and retention in care and also helps to reduce the Community Viral Load. Reduction of Community Viral Load impacts rates of new infection in the county and helps to meet the primary goal of reducing new HIV infections.[1]

Finally, each of these strategies must address Goal 3 of the Comprehensive HIV Plan, which is to reduce health disparities by closing the gap in linkage to care, retention in care, and viral load suppression in groups that are disproportionately impacted. The Ryan White QM Committee will continue to review data to determine populations with the greatest HIV-related disparities.

[1] Das M, Chu PL, Santos G-M, Scheer S, Vittinghoff E, et al. (2010) Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco. PLoS ONE 5(6): e11068.

These health disparities may be affected by social determinants that are outside the scope of the medical office. Most importantly, stigma and discrimination in the community can be absolute barriers to HIV testing, linkage to care, and retention in care. People living with HIV who experience more stigma have poorer physical and mental health and are more likely to miss doses of their medication.[2] One step to addressing these disparities is ensuring that services are geographically accessible and service providers are culturally and linguistically competent. Another important step in addressing stigma is ensuring the rights of people living with HIV/AIDS. This would mean enforcement of such acts as the *Americans with Disabilities Act,* the *Fair Housing Act,* the *Rehabilitation Act*, and other civil rights laws that were put in place to ensure that all PLWH/A are able to access the services without fear of discrimination. In Orange County, the Public Law Center's AIDS Legal Assistance Project provides this support through client and case manager trainings, focused publications, and direct and free referral services.

Goal 2.1: Increase linkage to care

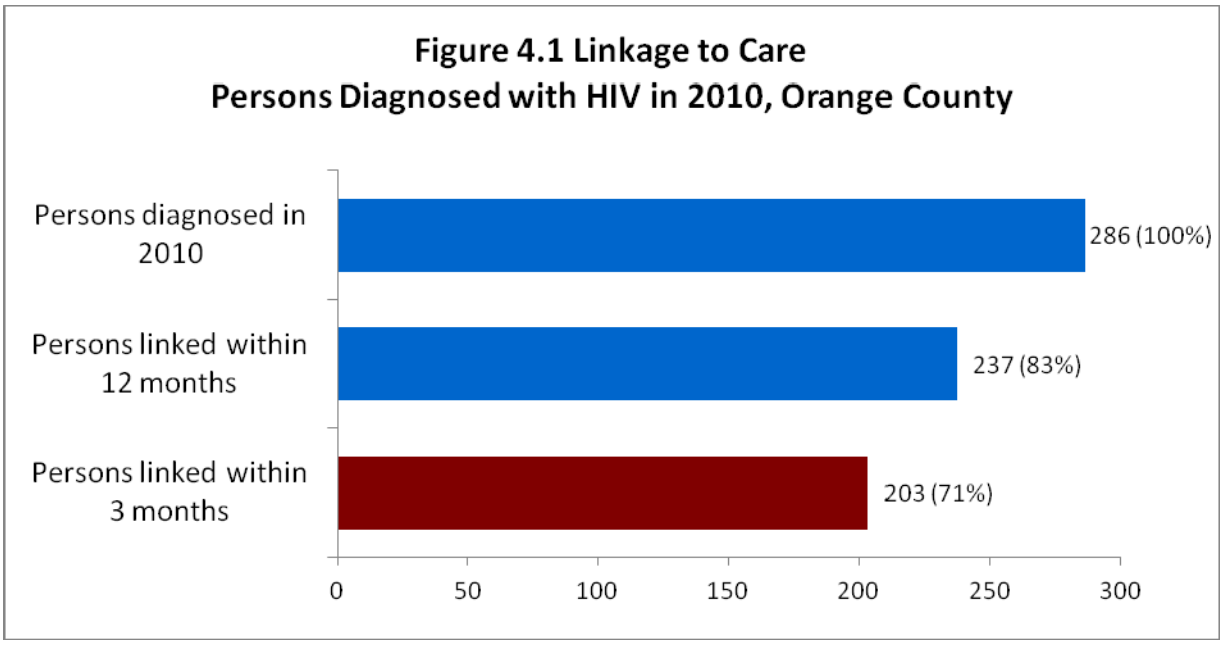
Current Trends and Future Goals

Goal 2.1: By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of diagnosis from 71% to 82%.

Goal 3.2.1: By 2015, reduce disparities in newly diagnosed patients linked to clinical care within three months of diagnosis.

Linkage to medical care is the first step toward ensuring that individuals with HIV/AIDS are accessing medical care services. Longer delays in linkage with medical care are associated with greater likelihood of progression to AIDS. Similar to individuals with undiagnosed infection, HIV-infected individuals not engaged in care pose a greater risk of ongoing HIV transmission.[3] As shown in Figure 4.1, **in Orange County, 71% of the 286 people diagnosed with HIV in 2010 were linked to medical care within three months of their diagnosis.**[4] Receipt of medical care was defined as report of a lab (CD4 or viral load) and/or a medical care visit entered in Orange County's Ryan White client database (ARIES). In efforts to improve the quality of data for this goal, the HCA HIV Surveillance program will begin efforts to follow up with HIV testing sites to determine whether newly identified HIV-positive patients received a medical care visit.

[2] Valdiserri RO. HIV/AIDS stigma: an impediment to public health. *American Journal of Public Health* 2002;92(3):341-342.
[3] Metsch LR, Pereyra M, Messinger S, et al. HIV transmission risk behaviors among HIV-infected persons who are successfully linked to care. *Clin Infect Dis.* 2008;47:577–84.
[4] Based on CD4 and viral load labs reported to the HCA HIV Surveillance Program.



Orange County's goal is to increase the proportion of persons diagnosed with HIV linked within three months of diagnosis from 71% to 82%. Strategies to increase the proportions of PLWH/A in Orange County who are linked to care within three months are described in this section. These strategies include 1) ensuring a network of medical providers who can serve HIV-positive individuals; 2) educating HIV testing sites about available services; 3) and offering services that help link newly diagnosed patients to care. In reviewing this goal and disparities in linkage to care, the Ryan White QM Committee is reviewing targets and strategies based on the facilities at which individuals received their diagnosis. For instance, the proportion of patients diagnosed at private medical doctor offices who were linked to care within three months was lower than the total proportion (66% compared to 70%, respectively). Strategies to increase the proportion of clients linked to care may therefore include specific strategies for private medical offices.

Strategy 1: Ensure a network of medical providers serving HIV-positive patients in Orange County

Rationale

To ensure that individuals receive needed care, there must to be a network of providers who are able to care for all PLWH/A. This includes both primary care physicians to provide basic primary care for patients and HIV specialists who can attend to the patients' HIV treatment. Ensuring that there are providers who can serve HIV-positive patients includes making sure that providers are able to provide care in a culturally competent manner. Health care services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.[5]

[5] AHRQ. 2009 *National Healthcare Quality Report*. March 2010.

Current Continuum of Services

There are approximately 50 physicians and nurse practitioners in Orange County who are specializing in serving persons living with HIV/AIDS.[6] The network of providers is composed of Ryan White-funded providers, private practitioners, and HMOs. There are two Ryan White-funded clinics in Orange County; one in Santa Ana (Central County) and the other in Laguna Beach (South County), that provide care to over 1,500 patients each year. The Ryan White program also includes a network of over 20 specialty care providers that provide an array of services including Gastroenterology, Neurology, Oncology, Immunology, Pulmonology, Ophthalmology, Dermatology, Radiology, Gynecology, and Psychiatry. Under the 1115 Medicaid Waiver Program, Orange County has and will continue its expansion of healthcare services to people who traditionally have not qualified for Medicaid (Medi-Cal in California) or the County's Medical Services Initiative (MSI) program. This new Low Income Health Program (or LIHP) has been folded into the MSI program. Of the 1,500 clients receiving Ryan White-funded medical care services, about 900 clients are anticipated to be eligible for and transitioned to MSI for care. CalOptima (Orange County's Medi-Cal managed care system) also provides care to a substantial number of PLWH/A in Orange County; serving approximately 1,500 patients annually.

The management of HIV disease necessitates both specialty and primary care expertise. Unfortunately, the nation faces a shortage of both infectious disease specialists and primary care providers. In HIV Medicine Association's workforce and capacity survey of Ryan White Part C-funded clinics, 69% report difficulty recruiting HIV clinicians and cited reimbursement and lack of providers as leading causes.[7]

In July, 2011, the Orange County Health Care Agency conducted a survey to get a better understanding of Orange County HIV medical provider's capacity and willingness to take additional HIV-positive patients into their practice. The survey was distributed to 62 providers known to provide a range of HIV-related care, including but not limited to, internal medicine physicians, infectious disease doctors, nurse practitioners, psychiatrists, pharmacists, and family practitioners. A total of 28 providers responded to the survey (a 45% response rate) with 26 indicating that they currently treat HIV-positive patients. Providers had a range of caseloads. The largest proportion of providers who reported seeing HIV-positive patients saw less than 50 HIV-positive patients, while 16% saw more than 300 HIV-positive patients. Of providers who responded, 20% were not taking any new patients. Provider willingness to accept new patients indicated a link to insurance. Half of providers were willing to take more patients with Medi-Cal, while 68% were willing to see more Medicare patients or patients with Medi-Medi (Medi-Cal and Medicare). Reasons cited for not taking on new patients ranged from capacity, low reimbursement rates, and retirement.

Addressing the issues of workforce capacity in Orange County must therefore take into account issues of reimbursement, medical education at the residency level, and education regarding care

[6] Includes Orange County physicians and nurse practitioners part of the Infectious Disease Society of America and American Academy of HIV Medicine in Orange County.
[7] Weddle and HIVMA, 2008.

for people living with HIV. The University of California, Irvine's (UCI) Department of Medicine sponsors a fully accredited Internal Medicine residency training, with a specialty in Infectious Diseases. These opportunities allow medical residents studying in Orange County to learn about treatment of PLWH/A. UCI is also home to the Pacific AIDS Education Training Center (PAETC), which provides trainings to residents and providers including a monthly AIDS Grand Rounds.

Gaps and Challenges

The following are gaps and challenges in ensuring a network of medical providers in Orange County:

1. **Concerns about healthcare systems and reimbursement.** Changes in the Affordable Care Act and reimbursements for publicly-funded programs, such as Medi-Cal (California's Medicaid program) and Medicare, may impact the number of physicians willing to see those living HIV.
2. **Complexity of providing care.** In the Health Care Agency's 2011 survey, the top two obstacles in providing care to HIV-positive patients was reported as complexity of medical conditions and complexity of psychosocial issues. These obstacles may decrease the number of physicians willing to provide HIV care in the future.
3. **Increasing HIV prevalence.** There are 6,674 people living with HIV who know their status and another 1,774 people living with HIV who aren't aware of their status. This number of people living with HIV grows by about 4% each year. With the number of providers able to serve PLWH/A remaining the same or decreasing due to retirement, there will be a need for more providers to offer care to PLWH/A.

Next Steps

The following are next steps in ensuring a network of medical providers in Orange County:

1. **Identify and address issues related to changes in publicly-funded programs and communicate accurate information.**
    - Orange County Health Care Agency will work with stakeholders such as Medical Services Initiative (MSI), CalOptima (Orange County's Medi-Cal Managed Care Program), and private physicians to evaluate issues related to changes in healthcare and develop a communication plan.
2. **Ensure that providers are well trained to address healthcare needs of PLWH/A.**
    - Orange County Health Care Agency will collaborate with PAETC, the National Quality Center, and the State Office of AIDS to coordinate trainings for providers.

Strategy 2: Educate community medical providers about available services for HIV-positive individuals

Rationale

As discussed in Chapter 3 of this plan, Orange County's goal of increasing serostatus knowledge of people living with HIV/AIDS will mean expansion of HIV testing in healthcare and non-healthcare settings. Many of these community medical providers (e.g. community health centers, emergency departments, private doctor's offices) will have little knowledge about available services for patients who test positive. It is critical that all sites that conduct HIV testing are aware of where to refer clients for medical care and the services, such as medical case management, that are available to ensure that newly diagnosed individuals are linked to medical care.

Current Continuum of Services

In recent years, there have been increased efforts to ensure that information about HIV medical and support services is readily available. In 2009, the California Department of Public Health (CDPH) Office of AIDS (OA) launched the California HIV/AIDS Service Referrals website (http://cdcnpin.org/ca/) to help individuals find HIV testing, prevention, care and treatment, and support services in their local area. Individuals can enter their zip code to find local organizations. There is also a hotline and chat room associated with the website to assist individuals in linking to care. The HCA HIV Planning and Coordination website (http://www.ochealthinfo.com/hiv) was also redesigned with the intent of helping link newly diagnosed individuals to care. The website includes information about services available in Orange County for those who are newly diagnosed or out of care. The website link was shared in an informational handout that was included in the HCA's 2010 survey of physicians about HIV testing practices. The survey and handout were distributed via mail to approximately 200 internists, family practitioners, and OB/GYNs in CalOptima's network (Orange County's managed care system for Medicaid recipients).

State law requires health care providers and clinical laboratories to report HIV infection and AIDS diagnoses by patient name. In addition, laboratories are required to report all CD4 or viral load labs. The HCA HIV Surveillance Program employ three Communicable Disease Investigators (CDIs) who investigate cases at facilities that send in reports to ensure complete and accurate reporting. When a provider that has never before submitted an HIV-positive result reports a case, a CDI follows up with the office to provide assistance with HIV reporting and provide information about available HIV services for referral. One challenge in this is that the follow-up would occur after the provider has reported the case and likely after the client has received the result; this may lead to missed opportunities for referring the client to services. Education of these sites would thus be more effective if it were conducted before the positive test.

Gaps and Challenges

The following are gaps and challenges in educating HIV testing sites about available services for HIV-positive individuals in Orange County:

1. **Large number and diversity of testing sites.** With expansion of HIV testing and the goal of promoting HIV testing in healthcare and non-healthcare settings that serve high-risk individuals, the potential number and diversity of testing sites is large. Informing all of these sites of areas for referral will prove challenging, especially with limited resources.

Next Steps

The following are next steps in educating HIV testing sites about available services for HIV-positive individuals in Orange County:

1. **Determine initial sites for outreach and education.**
   - Orange County Health Care Agency and HIV Prevention Planning Committee will review available epidemiological and Counseling and Testing data for information about the community medical providers that are most likely to return HIV positive results.
   - Orange County Health Care Agency will provide education and information to prioritized sites regarding options for referral and linkage to care.

Strategy 3: Offer services that link newly diagnosed patients to care (Early Intervention Services)

Rationale

Receiving an HIV-positive test result is often an emotional event. In addition to their new diagnosis, HIV-positive individuals are more likely to be struggling with other issues such as mental health problems, substance use issues, poverty, or homelessness, that make it difficult for them to access care.[8] Early Intervention Services (EIS) are services that help to identify, inform, refer, and link newly identified HIV-positive individuals into care. HIV prevention and testing programs have provided assistance and support in identifying, information, and referring newly diagnosed individuals to care. More resources are needed to assure that individuals are linked to care. With the expansion of HIV testing, EIS should also be expanded to ensure that individuals diagnosed in other settings have assistance in being linked to a medical provider within three months of their diagnosis.

[8] Moore, RM, Gebo, KA, Lucas, GM, Keruly, JC. Rate of Co-morbidities Not Related to HIV infection or AIDS among HIV-Infected Patients, by CD4 Count and HAART Use Status. *Clin Infect Dis* 2008; 27(8): 1102-1104.

Current Continuum of Services

As indicated, HIV prevention and testing programs funded by the HCA through OA prevention funds have historically been responsible for identifying, informing, and referring individuals to care. These services are described in more detail in Chapter 3. The Care Outreach Project at 17th Street Testing and Treatment (the HCA HIV testing and STD clinic) offers Outreach services for clients at the clinic who do not return for positive test results. In 2012, the HIV Planning Council has set aside $50,000 in funding for Early Intervention Services to Ryan White Part A funds to expand existing EIS.

In 2012, Orange County also implemented several expanded testing projects with CDC funding via OA. These projects will conduct high-volume HIV testing in healthcare settings (described in Chapter 3) and include EIS Coordinators at each testing site. The EIS Coordinators will assist clients in getting linked to services. The expanded testing project at UCIMC also includes an EIS Liaison at the HCA who will build linkages with community providers and to inform, refer, and link newly diagnosed PLWH/A to appropriate services.

Gaps and Challenges

The following are gaps and challenges in offering services that link newly diagnosed patients to care in Orange County:

1. **Limited access to newly diagnosed PLWH/A who need linkage to care services.** Strict state and federal laws regarding ensuring the confidentiality of client information has been a challenge in sharing of information regarding clients and bringing them into care. These laws prevent providers from disclosing client information without an individual's expressed consent. Without such consents, the HCA or a contracted EIS provider must either enter into individual contracts with agencies allowing them to act on their behalf in finding clients and bringing them to care or each agency must employ their own staff in such efforts. Though there have been parties interested in collaborating to address those who are not in care, confidentiality restrictions have proven to be the most difficult challenge in creating a network for Care Outreach and EIS.
2. **Difficulty tracking linkage to care.** Confirmation that linkage to care occurred can be difficult to track as the systems that identify and refer patients (i.e. HIV prevention and testing programs) may not have access to the systems that provide medical care such as doctor's offices and HMOs.

Next Steps

The following are next steps in offering services that link newly diagnosed patients to care in Orange County:

1. **Assist community medical providers in developing consents and policies and procedures to provide linkage to care.**

- Orange County Health Care Agency will work with UCI PAETC to develop consent forms that allow for the HCA to assist in following up with newly diagnosed individuals who have been lost to care.
- UCI PAETC will develop and assist community health providers on how to follow up with newly diagnosed individuals to ensure that they are informed of their status and enter care through education and development or policies and procedures.

2. Develop marketing materials for EIS for community medical providers.

- Orange County Health Care Agency EIS Liaison will develop materials that offer EIS to individuals testing HIV positive at testing sites that are not currently funded through the HCA. These materials will offer EIS to newly identified individuals to link them to care.

Goal 2.2 Increase retention in care

Current Trends and Future Goals

Goal 2.2: By 2015, increase the proportion of persons living with HIV/AIDS who are in care.

↳ Goal 3.2.2: By 2015, reduce disparities in proportion of persons living with HIV/AIDS who are in care.

Successful HIV treatment requires that those living with HIV/AIDS are receiving medical care throughout the course of their lives.[9] Those who fall in and out of care are at increased risk for developing Opportunistic Infections[10] and becoming resistant to medications.[11] For these reasons, it is important that once linked to care, PLWH/A remain engaged in their treatment; this means attending regular medical appointments with providers who can offer quality care.

The National HIV/AIDS Strategy restricts the goal for retention in care to Ryan White Ambulatory Care clients. Orange County has considered the need to include all PLWH/A in the county in efforts to ensure that clients are receiving quality care, including clients receiving services through a Ryan White medical provider and those accessing medical care through other systems. Orange County has developed two measures for this goal.

> **Measure 1**: By 2015, increase the proportion of Ryan White ambulatory care patients who are in continuous care from 70% to 80%.

[9] Mugavero MJ, Lin HY, Willig JH, et al. Missed visits and mortality among patients establishing initial outpatient HIV treatment. *Clin Infect Dis.* 2009;48:248–56.
[10] Lundberg BE, Davidson AJ, Burman WJ. Epidemiology of Pneumocystis carinii pneumonia in an era of effective prophylaxis: the relative contribution of non-adherence and drug failure. *AIDS.* 2000;14:2559–66.
[11] Parienti JJ, Massari V, Descamps D, et al. Predictors of virologic failure and resistance in HIV-infected patients treated with nevirapine- or efavirenz-based antiretroviral therapy. *Clin Infect Dis.* 2004;38:1311–6.

Measure 2: By 2015, increase the proportion of persons living with HIV/AIDS in Orange County who have at least one medical visit in a 12-month period from 76% to 84%.

It is important to note that treatment plans for HIV-positive patients vary greatly. Some patients may require more frequent visits to their medical care provider while others may require fewer visits and still meet the standard of care. While the measures for this goal are based on a specific number of medical visits a patient has gone to in a time period, this is not a substitute for an assessment of the quality of an individual's medical care.

Measure 1: By 2015, increase the proportion of Ryan White ambulatory care patients who are in continuous care from 70% to 80%.

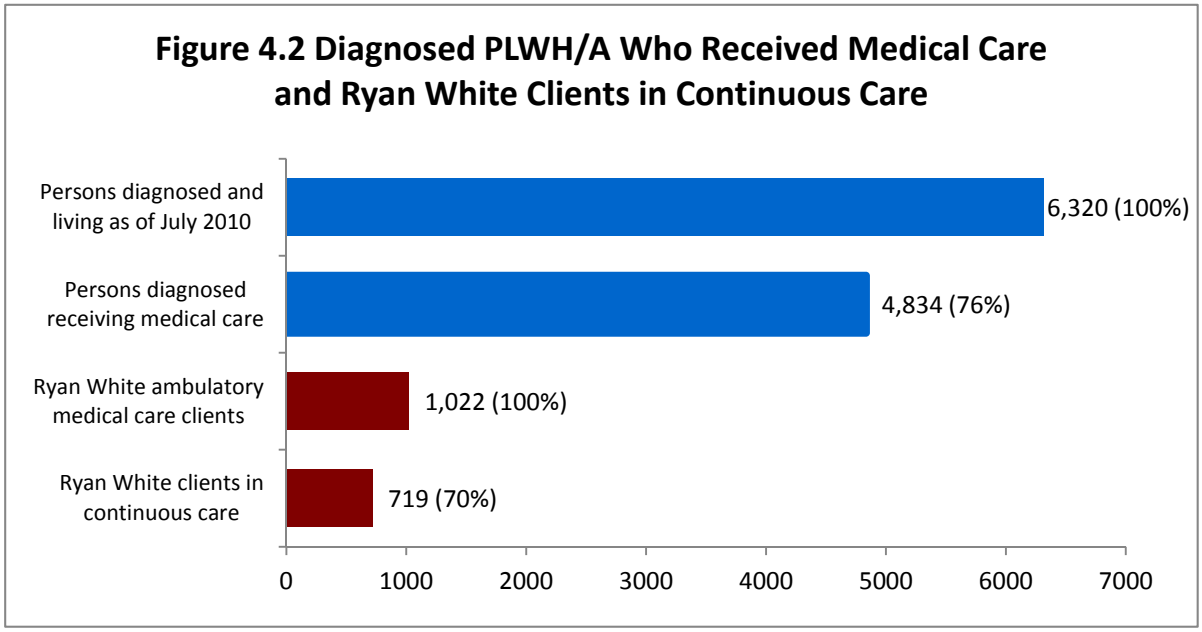
In measuring the proportion of Ryan White ambulatory care patients who are in continuous care, Orange County utilized the in+care campaign's measurement for clients who have the appropriate number of medical visits. This is defined as at least one HIV medical visit in each six month period of a 24-month measurement period with a minimum of 60 days between medical visits. As shown in the red bars in Figure 4.2, **of the 1,022 clients enrolled in Ryan White ambulatory medical care, 70% were in continuous care.**[12]

Measure 2: By 2015, increase the proportion of persons living with HIV/AIDS who have at least one medical visit in a 12-month period from 76% to 84%.

Orange County develops an "unmet need estimate" each year; this estimate identifies the number of diagnosed PLWH/A in Orange County who did not receive primary medical care in the last 12 months. Medical care is defined as a reported CD4 or viral load lab, HIV-related medical visit, or receipt of ART at any time in the previous 12 months. The blue bars in Figure 4.2 provide information about the 6,320 individuals who were diagnosed and living with HIV/AIDS as of June 30, 2010 in Orange County including those not receiving Ryan White medical care. As shown, **of the 6,320 individuals diagnosed with HIV as of July 1, 2010, 76% received medical care in the previous 12 months.**[13] Local estimates for the number of PLWH/A in *continuous care* as defined by in+care are unknown.

[12] For the 24-month period of December, 2009 through November, 2011, there were 1,022 unduplicated clients who had a medical visit with a Ryan White provider with prescribing privileges in the first six months (between December, 2009 and May, 2010). Of those, 719 (70%) also had visits in each subsequent six-month period.

[13] Data sources include linked utilization database from OA for Ryan White client-based data systems (ARIES), Medicaid, ADAP, and State electronic HIV/AIDS Reporting System; local lab reports and chart reviews; and estimates from Veteran's Administration.



Complexities related to the management of HIV disease in addition to challenges associated with everyday life can contribute to barriers that may prevent PLWH/A from regularly accessing medical care. In addition, HIV-positive individuals are more likely to be struggling with other issues such as mental health problems, substance use issues, poverty, or homelessness, that make it difficult for them to be maintained in care and adherent to medications.8 Therefore, issues such as poverty, language barriers, legal status, and homelessness are a just a few matters that need to be taken into consideration in order to keep PLWH/A involved in and retained in their care.

Strategies to increase the PLWH/A who are in continuous care consider the complex lives and needs of those living with HIV/AIDS and include: 1) educating providers regarding Public Health Service guidelines and available resources; 2) expanding services that bring individuals who have fallen out of care back into care; 3) offering case management to clients who have difficulty remaining in medical care; 4) providing peer support for staying in care; and 5) ensuring client have access to the continuum of HIV services.

Strategy 1: Educate providers regarding Public Health Services Guidelines

Rationale

Educating providers who care for and treat persons living with HIV/AIDS (PLWH/A) on the United States Public Health Service (PHS) HIV/AIDS clinical guidelines (www.aidsinfo.nih.gov/) is integral in ensuring that PLWH/A receive appropriate medical care and are retained in treatment. Guidelines for the frequency of medical visits can vary based on the patient's treatment plan. HIV specialists should therefore be aware of guidelines regarding the frequency of medical visits based on each patient's presentation and treatment plan. Other providers serving PLWH/A including general practitioners and medical case managers should be familiar

with PHS guidelines in order to better help their patients remain engaged in their HIV care. This is especially true for medical case management, for which helping clients keep medical appointments is a key component.

Current Continuum of Services

Orange County is home to the Pacific AIDS Education Training Center (PAETC) located at the University of California, Irvine (UCI). Based on assessed local needs, the PAETC conducts targeted, multi-disciplinary education and training programs, consultation, capacity building, and technical assistance for diverse groups of clinicians.

AIDS Grand Rounds are hosted by the PAETC monthly and are one-hour informational sessions targeting clinicians and cover a wide range of topics including retention of patients. The PAETC also coordinates the annual *HIV/AIDS on the Front Line* conference, which has as its goal to "provide healthcare professionals the opportunity to enhance knowledge with new and updated data to improve HIV/AIDS treatment for patients and their families, enrich compassionate caring skills, and provide an overview of the methodology and statistics that will serve to support the treatment, prevention and education of HIV." 2012 was the 25th anniversary of the *HIV/AIDS on the Front Line* conference; retention of patients in care was a key theme throughout the plenary and the breakout sessions.

HIV Clinic Grand rounds also occur on the HCA 17th Street campus for 17th Street Care and community providers. Orange County Ryan White providers participate in quarterly meetings. In 2011, Orange County began participation in the in+care campaign to increase retention of clients in medical care. Care provider meetings include time to discuss quality improvement around retaining clients in care. California Statewide Training and Education Project (CSTEP) offers treatment updates to providers working with HIV-positive individuals. Local or online trainings are available one to two times a year.

With the release of the National HIV/AIDS Strategy and the implementation of the Affordable Care Act, the role of the PAETC is of increased significance. Efforts to expand medical coverage and routinize HIV testing will lead to more people being informed of their serostatus and being brought into care. The PAETC's role educating providers will be an important step in retaining those newly identified with HIV in care.

Gaps and Challenges

The following are gaps and challenges in educating providers regarding Public Health Service Guidelines in Orange County:

1. **Large number and diversity of providers.** There are many providers who serve PLWH/A. Providers come from different areas of the county, have different professional backgrounds (e.g. medical doctors, case managers, pharmacists, etc.), and have varying levels of knowledge about HIV. Creating a strategy that addresses all of these providers' needs can be a challenge, especially with limited resources.

2. **Competing priorities of providers.** Most HIV providers serve many different populations with differing psychosocial and medical needs. It may be difficult for providers to prioritize their time to learning about PHS Guidelines specific to HIV in light of the many other demands for their time.

Next Steps:

The following are next steps in educating providers regarding Public Health Service Guidelines in Orange County:

1. **Assess knowledge of PHS Guidelines among providers.**
   - Orange County Health Care Agency will work with PAETC conduct an assessment of the awareness of and knowledge pertaining to PHS treatment guidelines.
   - Assessment findings will help identify training needs for medical providers.
2. **Provide education to Ryan White medical case managers and providers.**
   - Orange County Health Care Agency will share information with Ryan White providers regarding guidelines for frequency of medical visits. Information should include populations with highest disparities in retention in care.
   - Orange County Health Care Agency will work with Ryan White providers to develop quality improvement projects to improve retention of clients in care.

Strategy 2: Expand services that bring individuals back into care (Care Outreach Services)

Rationale

Outreach services are instrumental in getting PLWH/A who are hardest to reach into and retained in care. By conducting outreach, individuals who are either unaware of their HIV disease or who know their status but have failed to maintain their medical care are made aware of their status and/or become enrolled in medical care. According to the Health Resources and Services Administration's (HRSA) HIV/AIDS Bureau (HAB), populations with the highest HIV infection rates have a correspondingly greater need for treatment, yet other behavioral and service delivery factors such as cultural and linguistic biases, racial and gender discrimination, and lack of insurance have a profound influence on access to medical care. Research shows that outreach interventions play a key role in connecting underserved individuals to care by dispelling myths and improving knowledge about HIV, facilitating access to HIV care and treatment, providing support, and reducing barriers to care.[14] Identifying and implementing

[14] Rajabiun S, Mallinson RK, McCoy K, Coleman S, Drainoni ML, Rebholz C, Holbert T (2007) "Getting Me Back on Track": The Role of Outreach Interventions in Engaging and Retaining People Living with HIV/AIDS in Medical Care. *AIDS Patient Care & STDs, 21, Supplement 1:* S20-S29.

creative and effective models of outreach to underserved HIV positive individuals not in care is a critical element in responding to the HIV/AIDS epidemic.

Current Continuum of Services

In Orange County, there is currently one program funded to conduct outreach to PLWH/A. The Care Outreach Program is funded through the HCA with funding from OA at $123,000 each year for one and a half staff people's time. Care Outreach staff attempt to locate patients who have fallen out of care and help them to address barriers that may prevent them from accessing or remaining in care. Since its inception in 2000, over 600 PLWH/A have been successfully linked to medical care in Orange County.

Gaps and Challenges

The following are gaps and challenges in expanding outreach services in Orange County:

1. **Need resources for staff training.** The Care Outreach Program is an OA-funded program based on the Bridge Project, a federal demonstration project that proved effective in linking clients to care. In the past, Bridge Project staff were trained by and a network of the Bridge Projects across the state met regularly to discuss progress and barriers. With decreased State funding, the Bridge Project was changed to Care Outreach Services and available trainings and support for staffing was eliminated.
2. **Limited access to PLWH/A who have fallen out of HIV-related medical care.** Strict state and federal laws regarding ensuring the confidentiality of client information has been a challenge in sharing of information regarding clients and bringing them into care. These laws prevent providers from disclosing client information without an individual's expressed consent. Without such consents, the HCA or a contracted Care Outreach provider must either enter into individual contracts with agencies allowing them to act on their behalf in finding clients and bringing them to care or each agency must employ their own staff in such efforts. Though there have been parties interested in collaborating to address those who are not in care, confidentiality restrictions have proven to be the most difficult challenge in creating a network for Care Outreach. In acknowledgement of these barriers, OA has expressed interest in exploring the use of information reported to HIV Surveillance programs to assist in linking clients to care.

Next Steps:

The following are next steps in expanding outreach services in Orange County:

1. **Develop networks to facilitate Care Outreach services.**
    - Orange County Health Care Agency will work with available networks including UCI PAETC, CalOptima, Ryan White providers, and HIV Surveillance to determine ways to best facilitate linkage to care for clients who have fallen out of care.

2. Request technical assistance in offering Care Outreach services.

- Orange County Health Care Agency will request technical assistance and training in offering Care Outreach services for the HCA staff and Ryan White providers interested in providing Care Outreach.

Strategy 3: Offer medical case management to clients who have difficulty remaining in medical care

Rationale

In addition to managing the complexities of living with HIV, many PLWH/A are having to deal with a variety of other co-occurring conditions (e.g., heart disease, mental health problems, drug or alcohol addiction) which may impede their ability to access and/or maintain medical care. Medical case management services play a significant role in assisting clients in meeting their needs in order to optimize health and well being. In Orange County, medical case management is client-centered with the goal being to enhance independence and increase quality of life through adherence to medical care. Although the primary focus of medical case management is the coordination and follow-up of medical care, case managers also promote self sufficiency while assisting clients with accessing needed resources to meet their basic needs. When individuals have their basic needs (e.g., food, shelter) met, they are more likely to prioritize and access medical care. [15]

Current Continuum of Services

Medical case management services for PLWH/A are provided utilizing various models at several locations throughout Orange County. Although medical case management may be provided to PLWH/A who receive privately funded medical care, a majority of medical case management programs that specialize in HIV in Orange County are contracted through the HCA with Ryan White funding from HRSA. There are currently five federally-funded medical case management providers in Orange County who receive approximately $1.2 million Ryan White funding to provide medical case management each year to approximately 1,300 clients each year.

AIDS Services Foundation of Orange County (ASF), Shanti Orange County, and the HCA Risk Reduction, Education, and Community Health (REACH) Program all provide community-based medical case management to PLWH/A. Clients are provided with a range of client-centered services that link clients with health care, psychosocial, and other supportive services. Clients participate in the development and implementation of comprehensive individualized service plans and case managers work closely with clients to periodically review plans in order to modify or adapt them as necessary. The REACH Program specializes in medical case management for HIV-positive substance users. Approximately 761 medical case management clients were served by the service providers listed above in FY 2011.

[15] Sherer R, Stieglitz K, Narra J, Jasek J, Green L, Moore B, Shott S, Cohen M. HIV multidisciplinary teams work: support services improve access to and retention in HIV primary care. *AIDS Care* 2002 August; 14 Suppl 1: S31-44.

Orange County's case management system is enhanced by Minority AIDS Initiative (MAI) funding under Ryan White Part A. ASF and Delhi Center provide MAI-funded medical case management to African-American and Latino PLWH/A in an effort to reduce disparities and to improve access to care in these disproportionately impacted communities of color. This service promotes the need for primary HIV medical care and has the primary goal of ensuring that clients remain in medical care. In FY 2011, approximately 281 clients received MAI-funded medical case management services.

17th Street Care (the HCA HIV ambulatory clinic) provides early intervention medical case management in addition to transitional case management in the jails. Early intervention medical case management is interdisciplinary and provided by Master's level social workers to assess immediate and ongoing needs and coordinate care for 17th Street Care patients. Transitional jail case management is also provided to PLWH/A who are about to be, or who have been recently released from county jails and state prisons.

Gaps and Challenges

The following are gaps and challenges in offering medical case management services in Orange County:

1. **Shifts in needs for medical case management services.** In the past, case management was used as a service to assist clients in accessing services when systems of care were new and most patients were too medically fragile to navigate these systems on their own. With advancements in the field of HIV medicine, individuals are now living longer with the disease and many are able to access services without much help. Services should shift to meet the needs of these clients such that ongoing case management is not used as a mechanism for eligibility screening or access to support services. Instead client advocacy or referral services should assist those able to remain in medical care without assistance, while medical case management services assist those with the greatest needs or newly diagnosed.
2. **Difficulty coordinating between medical and medical case management providers.** In order to maximize the effectiveness of the system of care providing support to PLWH/A, there should be seamless coordination between a patient's HIV specialist, primary care physician, and medical case manager. This is can be a challenge as these providers can be part of very different systems and answer to differing requirements. Patient consents to disclose information can also be a barrier to sharing of information between providers.

Next Steps:

The following are next steps in offering medical case management in Orange County:

1. **Ensure medical case management of PLWH/A with higher assessed acuity and those who are newly diagnosed.**
    - With limited resources, prioritization of clients who are most likely to fall out of care including those who are newly diagnosed and/or with high assessed acuity is essential to keeping those at highest risk of falling out of care in care.

2. Increase communication between medical and support providers.

- Orange County Health Care Agency will increase partnerships with various providers serving PLWH/A to increase communication and coordination for client retention.

Strategy 4: Increase peer support for staying in care

Rationale

People living with HIV/AIDS have been involved in the continuum of HIV care since the early days of the epidemic by providing outreach, HIV education, and emotional support. Based in part on the success of peer interventions to decrease risk behaviors, provide HIV-related education, and promote healthier behaviors, there is a growing interest in utilizing HIV positive peers to support access to HIV primary care and adherence to treatment. [16,17 18, 19]

Current Continuum of Services

Orange County has utilized peer models to finding HIV-positive individuals who had fallen out of care to bring them into care. The Care Outreach Program (described on page 4:14), volunteer buddy programs, and street outreach projects evolved out of these early interventions. As funding and training became more available, these programs became more formalized, with paid staff helping to meet the needs of the community.

Today, there are various activities sponsored by community-based organizations that involve people living with HIV/AIDS and their support systems to people living with HIV/AIDS remaining in care. AIDS Services Foundation, Delhi Center, REACH, and Shanti Orange County each offer drop-in support groups that are meant to build relationships and provide support to those living with HIV/AIDS and help them stay in care. Support groups are tailored to the diverse populations living with HIV, including groups for women, those with a history of substance use issues, and groups in Spanish; some groups are also open to families and friends. Community-based organizations have also helped to build a sense of community and support through educational seminars and social gatherings. For instance, Shanti Orange County and AIDS Services Foundation collaborate to host the Big 7 Seminars, which are designed to provide everything from basic information about HIV to up-to-date treatment issues. Shanti Orange County also hosts the Empower Seminars, which are designed to provide life style skills to persons living with HIV. These seminars provide an opportunity for people living with HIV to find information, support, and a sense of community for staying in care. Some Orange County's

[16] Harris G. E., Larsen, D. (2007). HIV peer counseling and the development of hope: Perspectives from peer counselors and peer counseling recipients. *AIDS Patient Care and STDs*. 21(11).

[17] Simoni JM, Amico KR, Pearson CR, et al. Strategies for promoting adherence to antiretroviral therapy: A review of the literature. *Current Infectious Disease Reports.* 2008;10(6):515–521.

[18] Medley A, Kennedy C, O'Reilly K, et al. Effectiveness of peer education interventions for HIV prevention in developing countries: A systematic review and meta-analysis. *AIDS Education and Prevention.* 2009;21(3):181–206.

[19] Kalichman SC, Rompa D, Cage M, et al. Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people. *American Journal of Preventive Medicine.* 2001;21(2):84–92.

faith-based organizations also provide support to those living with HIV through retreats, support groups, and ministries for PLWH/A.

More formal efforts to help people living with HIV/AIDS support their peers in staying in care have occurred through funded programs and trainings. In 2011, the AIDS Alliance for Children, Youth & Families of Washington, DC provided the Advanced Skills for Consumer Education & National Development (ASCEND) Leadership Training in San Diego. The goal of the training was to increase the number of persons living with HIV/AIDS who had the skills and leadership to engage other persons living with HIV/AIDS who were not in care and bring them to care. Three members of the HIV Planning Council's Client Advisory Committee (HCAC) participated in the training. Using skills that they developed during the training, graduates of the training presented information to their peers and created personalized community resource lists to encourage and assist out-of-care individuals living with HIV to enter and stay in care.

Gaps and Challenges

The following are gaps and challenges in increasing peer support for PLWH/A to stay in care in Orange County:

1. **Need for more information regarding program models for utilizing peers in HIV care.** Past programs have utilized HIV-positive individuals to bring peers into care. Orange County's current continuum of care does not have a formal system utilizing persons living with HIV to interact with their peers to bring them into care. More information is needed regarding how current program models are utilizing peers programs to support persons living with HIV.
2. **Need for resources to coordinate and sustain peer programs.** Peer programs often rely on volunteer time and resources. This may be difficult to sustain as volunteers themselves have competing and varied priorities, time, and resources. A peer program would require some resources to ensure that efforts are coordinated and sustained.

Next Steps:

The following are next steps in increasing peer support for PLWH/A to stay in care in Orange County.

1. **Conduct literature review of peer-based programs specific to HIV.**
   - Orange County Health Care Agency will review current literature regarding the use of peers in increasing access to and retention in care.
   - Findings from the literature review will help identify resources, benefits, and limitations in use of peer-based HIV services in Orange County.
2. **Assess appropriateness and feasibility of implementing peer programs.**
   - Orange County Health Care Agency will work with HIV service providers and persons living with HIV/AIDS to determine the feasibility and possible next steps of implementing peer programs.

Strategy 5: Ensure access to continuum of HIV services

Rationale

The importance of ensuring an accessible continuum of HIV services including medical and supportive services in fostering engagement by HIV-infected individuals in HIV care has long been recognized. Patients who receive a range of services that address needs and barriers to care such as case management, mental health services, substance abuse treatment, transportation, and housing assistance are more likely to receive any medical care, regular care, and have more visits.[20] Health services that are tailored to the expressed needs of patients lead to better care and improved health outcomes.

Current Continuum of Services

Orange County's continuum of HIV services encompasses a comprehensive range of services that are designed to meet the needs of PLWH/A throughout all stages of illness. Services for PLWH/A are funded through a variety of sources including approximately $8.4 million of Ryan White funding (including Part A, B, and C) to 2,500 PLWH/A, $27 million through the State's ADAP for approximately 2,000 Orange County residents, and $4 million through Medi-Cal to serve approximately 1,500 patients each year. A complete summary of anticipated public funding for continuum of HIV services is shown in Appendix A.

Table 4.1 shows the continuum of HIV services available to PLWH/A. A complete summary of services available within the established continuum of HIV/AIDS services and the providers offering services is shown in Appendix A. Services in the Continuum of HIV Services are classified into four areas:

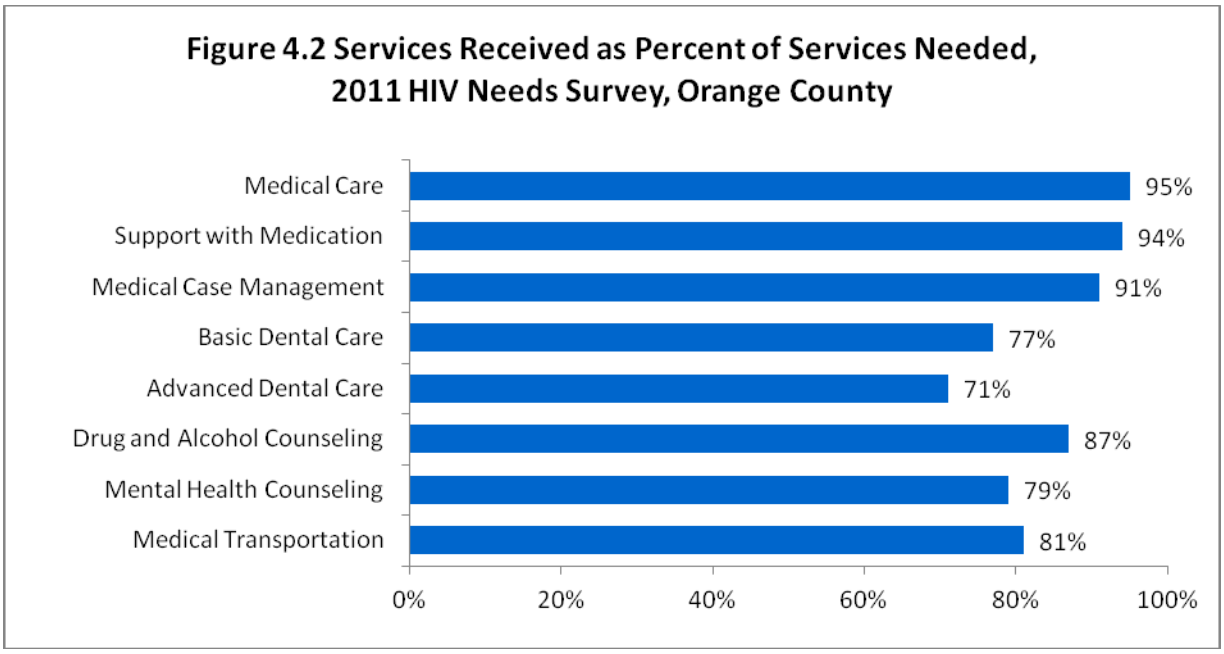
1) Prevention Services, which are services that help prevent HIV transmission and identify persons living with HIV/AIDS.
2) Health Care and Treatment services, which directly treat PLWH/A for HIV-related medical, mental health, or substance use conditions.
3) Access Services, which are designed to increase client access to care and/or provide ancillary support to persons coping with various HIV-related issues.
4) Sustaining Services, which assist clients in obtaining the basic necessities that sustain and enhance life such as food and housing.

[20] Sherer R, Stieglitz K, Narra J, Jasek J, Green L, Moore B, Shott S, Cohen M. HIV multidisciplinary teams work: support services improve access to and retention in HIV primary care. *AIDS Care* 2002 August; 14 Suppl 1: S31-44.

Table 4.1 Orange County Continuum of HIV/AIDS Care

Health Care/Treatment Services	
▪ Outpatient/Ambulatory Medical Care	▪ Home Health Care
▪ Medications and Medication Assistance	▪ Home and Community-Based Health Services
▪ Oral Health Care	▪ Hospice
▪ Mental Health Services	▪ Rehabilitation
▪ Substance Abuse Services	▪ Treatment Adherence Education
▪ Assistance with Health Insurance Premiums and Cost Sharing	
Access Services	
▪ Medical Case Management	▪ Legal Services
▪ Benefits Counseling	▪ Early Intervention Services
▪ Client Advocacy	▪ Care Outreach
▪ Medical Transportation	
Sustaining Services	
▪ Emergency Financial Assistance for Housing and Utilities	▪ Food Pantry
▪ Short Term Assistance for Rent	▪ Food Assistance (WIC, SNAP)
▪ Transitional Housing	▪ Nutritional Supplements
▪ Housing Coordination	▪ Home-Delivered Meals
▪ Shelter Plus Care	▪ Independent Living Skills
	▪ Complementary Therapies / Supportive Services
Prevention with Positives	
▪ Individual Risk Reduction Counseling	▪ Skills Building Group Workshops
▪ Peer Education	▪ Partner Services

Orange County Health Care Agency strives to ensure that services are geographically accessible, as well as linguistically and culturally appropriate. As part of its planning process, the Orange County Health Care Agency and the HIV Planning Council conducts a semi-annual survey through a survey of PLWH/A to determine needs for HIV services in the community through. The 2011 Needs Survey revealed that persons with HIV in Orange County are generally receiving services that they need. Of 350 respondents, 70% did not mention any problems getting needed services. An overwhelming majority (95%) of survey respondents indicated that they received needed medical care. Figure 4.2 shows the percent of survey respondents who indicated receiving needed select services.



As shown, while most service needs are being met, there are services that some clients have not been able to access. Of those who indicated having problems receiving services, "didn't qualify," "financial difficulty," and "immigration status" were the top three most cited problems in getting to needed services. Also, access to services varied based on gender, race/ethnicity, and primary language. Females were more likely to report service gaps in transitional housing, food pantry, and legal services, while men were more likely to report service gaps in accessing home health care, nutritional supplements, and group counseling services. Latinos were more likely to report service gaps in home health care, legal services, and transitional housing. HIV Planning Council allocations for Ryan White services consider these gaps.

Gaps and Challenges

The following are gaps and challenges in ensuring clients have access to the continuum of HIV services in Orange County:

1. **Gaps in services due to limited resources and providers.** Due to limitations in funding and eligibility restrictions from some funding sources, there are services that are not available to all clients who want services. Some services such as oral health care and psychiatric services are limited as there are a limited number of providers willing or able to accept public funding (such as Ryan White or Medi-Cal) to serve HIV-positive clients.
2. **Cultural and language barriers to services.** Orange County is home to many diverse communities. Combined, Hispanics and Asians and Pacific Islanders make up a majority of the county's population and almost half of persons living with HIV/AIDS. Each of these communities includes individuals who may have immigrated from many different countries and have differing attitudes, beliefs, and stigmas related to HIV and accessing services.
3. **Cofactors and co-morbidities can limit ability to access services.** Homelessness, mental illness, substance use, recent incarceration, and poverty are all factors that can make it more

difficult for individuals to access the continuum of HIV services. *Challenges and resources related to Housing Services are discussed in Chapter 5.*

4. **Difficulty traveling to services.** More than three million people live in the nearly 800 square miles that make up Orange County. The county's population is dispersed, and no significant urban center exists. As a result, services may be 25 miles or more from a client's residence. Many HIV-positive clients, especially African Americans and Latinos, rely on public transportation, which in Orange County is a bus-based system that may require a full day to travel from home to services and back.

Next Steps:

The following are next steps in ensuring that clients have access to the continuum of HIV services in Orange County:

1. **Prioritize and fund services based on assessed and anticipated needs.**
   - Orange County Health Care Agency will work with the Orange County HIV Planning Council and the HIV Client Advocacy Committee to determine services that are most important to PLWH/A.
   - Orange County HIV Planning Council will allocate funding based on assessed needs and priority of services.
   - Orange County Health Care Agency will ensure that services are cost effective and eligibility requirements are set based on need of the services.
2. **Ensure services are culturally and linguistically appropriate.**
   - Orange County Health Care Agency will work with providers to ensure that services consider and address cultural barriers to care.
   - Orange County Health Care Agency will work with providers to ensure that services are provided in a language that clients can understand.
3. **Coordinate services with other stakeholders and programs.**
   - Orange County Health Care Agency will work with providers to ensure that services are coordinated with County Behavioral Health Services to address mental health and substance use issues.
   - Orange County Health Care Agency will work with City of Santa Ana, HOPWA Grantee for Orange County, to provide a continuum of housing services for PLWH/A. *Challenges and resources related to Housing Services are discussed in Chapter 5.*
   - Orange County Health Care Agency will work with County Correctional Medical Services to coordinate care for PLWH/A who are in or transitioning from incarcerated settings.

Goal 2.3 Increase viral load suppression

Current Trends and Future Goals

Goal 2.3: By 2015, increase the proportion of persons living with HIV with suppressed viral load (less than 200 copies per mL).

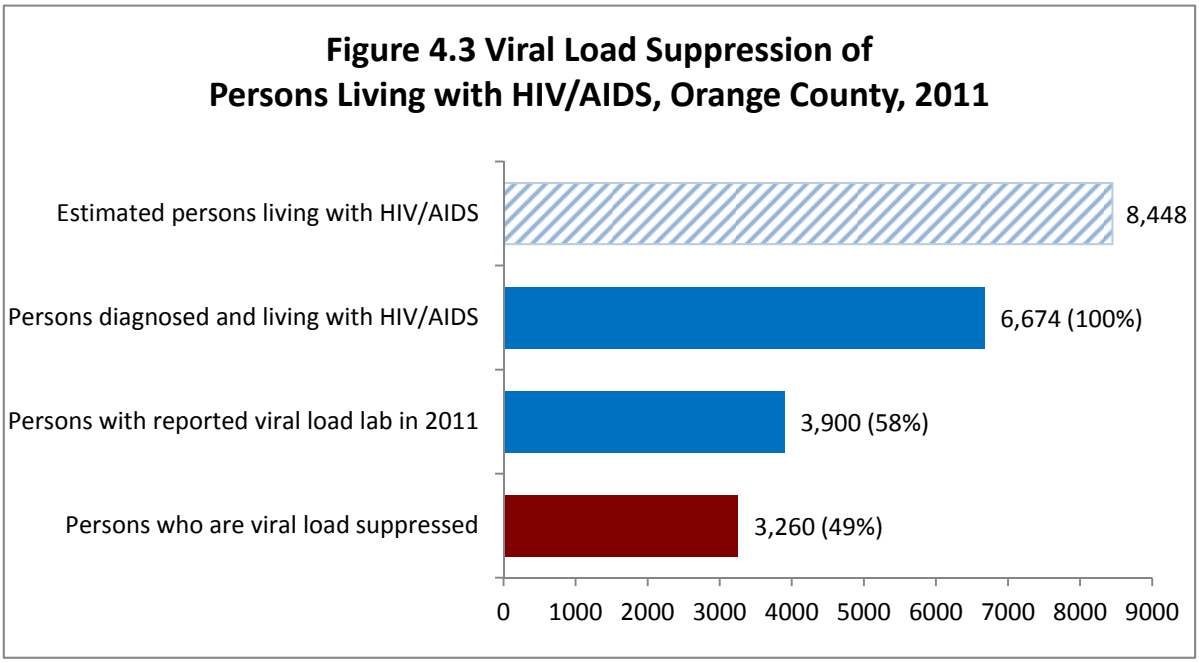
↳ Goals 3.2.3: By 2015, reduce disparities in persons living with HIV with suppressed viral load.

Viral load is a way of measuring the amount of the HIV virus in a person's body; it is a key indicator for health and transmissibility of HIV. A high viral load (5,000 to 10,000 copies per milliliter (mL) of blood) means that a person's HIV disease is progressing and that they are more infectious. A low viral load (40 to 500 copies per mL of blood) indicates that a person's HIV progression is not as rapid.[21] Besides disease progression, individuals with high viral loads are more likely to transmit HIV to uninfected partners than people with low viral loads.[22] Suppression of viral load is defined as viral loads of fewer than 200 copies per mL. Increase in the proportion of PLWH/A with suppressed viral load is an important step in reducing morbidity and mortality for those individuals and reducing infection in the population.

State law requires health care providers and clinical laboratories to report to report all CD4 and viral load tests. Figure 4.3 shows the proportion of PLWH/A who have suppressed viral load. As shown, there are an estimated 8,448 PLWH/A in Orange County. Of these, 6,674 (79%) have been diagnosed and are assumed to know their status. Viral load lab results have been received for 3,900 individuals and of those. This means that **only 58% of the 6,674 persons living with HIV/AIDS in Orange County had reported labs in 2011**. While viral loads for the 42% PLWH/A with no reported labs is unknown, for the purposes of this analysis, they are assumed to not be viral load suppressed.[23] **About half (49%) of the 6,674 individuals diagnosed and living HIV/AIDS in 2011 had lab reports indicating a suppressed viral loads.**[24] This does not consider the 1,674 individuals who are estimated to be living with HIV/AIDS in the county but do not know their status. It is important to note that of those with reported labs, the vast majority (84%) had viral loads under 200 copies per mL.

[21] Sterling TR, Vlahov D, Astemborski J, et al. Initial Plasma HIV-1 RNA levels and progression to AIDS in women and men. *New England Journal of Medicine* 2001; 344(10):720-725.
[22] Donnell D, Baeten JM, Kiarie J, et al. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohert analysis. *Lancet* 2010; 374(9731):29092-8.
[23] Gardner EM, McLees MP, Steiner JF, et al. The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. *Clin Infect Dis.* March 15, 2011; 52(6): 793-800.
[24] Orange County HIV Case Registry, Data as of December 31, 2011 (persons living with HIV/AIDS). Lab data as of January 31, 2012. Suppressed viral load defined as last reported lab in 2011 under 200 copies per mL.

Figure 4.3 Viral Load Suppression of Persons Living with HIV/AIDS, Orange County, 2011



Nationally, it is estimated that 20% of PWLH/A are not viral load suppressed.[23] The National HIV/AIDS Strategy aims to increase the proportion of groups with higher HIV-related disparities (gay and bisexual men, blacks, and Latinos) by 20%. In Orange County, the Ryan White QM Committee is continuing to review this data to determine the best targets for the community. The committee is keenly interested in the statistic that 84% of those with reported viral load labs are viral load suppressed, which points to an emphasis on linkage to care and retention in care as important elements in this goal. Strategies for this goal focus on ensuring access to medications and supporting adherence to medications and include: 1) educating HIV specialists about offering treatment based on Public Health Services guidelines; 2) educating general practitioners regarding referring to HIV specialists for treatment; 3) ensuring client access to HIV-related medications; and 4) providing education and support regarding initiation and adherence to medications.

In addition to strategies to lower viral load, the Ryan White QM Committee is also interested in improving the quality of the data on viral load suppression by looking at ways to increase lab reporting or determining which individual lab reports may not be available for (e.g. individuals who are deceased, individuals who have moved out of the jurisdiction).

Strategy 1: Educate HIV specialists about offering treatment based on Public Health Services Guidelines

Rationale

In order for patients to have the best chances of viral load suppression, their medical providers must be well versed in the PHS Treatment Guidelines for the use of antiretroviral (ARV) drugs in HIV-infected individuals (www.aidsinfo.nih.gov/). These guidelines include recommendations

for baseline assessment, treatment goals, indications for initiation of ART, choice of the initial regimen in ART-naive patients, drugs or combinations to be avoided, management of adverse effects and drug interactions, management of treatment failure, and special ART-related considerations in specific patient populations. Part of this education should include information about how to build trust with patients and discuss issues related to adherence and their effects of transmission.

Current Continuum of Services

As mentioned on page 4:13, Pacific AIDS Education Training Center (PAETC) located at the University of California, Irvine (UCI) does much to educate local clinicians about HIV care and retention. Education provided by the PAETC is designed to assist providers with the complex issues related to HIV including the management of antiretroviral therapy (ART). UCI PAETC provides trainings to medical providers in Southern California. In 2011, PAETC provided 156 training events to approximately 1,200 HIV specialists. Over half of training programs conducted in 2011 were focused on HIV treatment and management.

UCI PAETC also partners with the HCA to offer the *HIV/AIDS on the Front Line* conference each year. This annual, one-day conference provides information on a variety of topics related to HIV/AIDS primary care and is well attended by health care professionals, as well as HIV-infected and affected consumers in the community. UCI PAETC and 17th Street Care (the HCA HIV ambulatory clinic) each offer monthly AIDS Grand Rounds, which offer opportunities for clinicians to receive information about medication and management of opportunistic infections.

Gaps and Challenges

The following are gaps and challenges in educating HIV specialists about offering treatment based on Public Health Services guidelines in Orange County:

1. **Rapidly changing guidelines.** The PHS Guidelines themselves are frequently updated based on the availability of new agents and clinical data. Information included in the guidelines are sometimes not consistent with approved labeling for the particular product or indications in question. Ensuring that clinicians have the most up to date information can be challenging.
2. **Complexity of guidelines and treatment plans.** The PHS Guidelines provide general recommendations based on the latest knowledge. However, presentations of clients are highly individual, treatment plans are complex, and clinician preferences for treatment may differ.
3. **Difficulty addressing cultural, linguistic, and other cofactors that prevent patient adherence.** In addition to education about offering treatment based on PHS Guidelines, providers must also build trust and rapport with clients to address cultural and other factors that may be barriers to adherence. Limited training resources and time during patient visits may make this important element of patient care difficult to prioritize.

Next Steps

The following are next steps in implementing routine HIV testing in healthcare settings in Orange County:

1. **Provide treatment updates to HIV specialists.**
    - PAETC will offer trainings to HIV specialists that highlight changes to PHS Guidelines as needed.
2. **Provide trainings that help HIV specialists address barriers to adherence.**
    - PAETC will offer trainings to HIV specialists that address barriers to adherence including cultural competency, alternative medicines, and building trust with patients.

Strategy 2: Educate providers regarding referring to HIV specialists for treatment

Rationale

Multiple studies have demonstrated that better outcomes are achieved in HIV-infected outpatients cared for by a clinician with HIV expertise, which reflects the complexity of HIV infection and its treatment.[25] General practitioners, other medical providers, or those provider alternative health services should be informed of the need to refer a patient to an HIV specialist for treatment if they do not have one and coordinate care with the HIV specialist if they do.

Current Continuum of Services

In addition to providing trainings for medical providers who specialize in HIV, UCI PAETC also provides trainings to non-HIV specialists. In 2011, approximately 13% or 190 of providers who attended PAETC trainings were non-HIV providers. These trainings provide an opportunity to educate non-HIV specialists about PHS treatment guidelines and the need to consult or refer to HIV specialists for treatment.

Gaps and Challenges

The following are gaps and challenges in implementing routine HIV testing in healthcare settings in Orange County:

1. **Large number and diversity of providers.** There are many providers who may provide health care to PLWH/A, including primary care physicians, emergency department doctors, and alternative medicine providers. Providers come from different areas of the county, have different professional backgrounds and philosophies, and have varying levels of knowledge

[25] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.

about HIV. Creating a strategy that addresses all of these providers' needs can be a challenge, especially with limited resources.

Next Steps

The following are next steps in implementing routine HIV testing in healthcare settings in Orange County:

1. **Determine sites to conduct education.**
    - Determine healthcare settings that are most likely to treat HIV-positive individuals without HIV specialist.
2. **Provide education and follow up for select sites.**
    - Orange County Health Care Agency can identify sites that are caring for HIV-positive patients and provide information about appropriate referrals.
    - Orange County Health Care Agency can follow up with sites to assist with referrals and linkage to care.

Strategy 3: Ensure client access to HIV-related medications

Rationale

Viral load suppression is made possible when PLWH/A take prescribed medications. Therefore, it is important to ensure the PLWH/A have access to HIV-related medications including assistance with in obtaining coverage for medications, financial assistance for medications, and enrollment in clinical trials as appropriate.

Current Continuum of Services

In Orange County, low-income PLWH/A with no health insurance coverage for medications can receive needed medicines through the State's AIDS Drug Assistance Program (ADAP). California's ADAP formulary covers over 180 medications. Approximately 2,000 Orange County residents are on ADAP. In 2012, Orange County began part of the expansion of Medicaid health coverage by expanding the Low Income Health Program (LIHP). LIHP is known in Orange County as Medical Services Initiative (MSI) and covers health services including medications for low-income individuals, including those with HIV. Orange County estimates that about 900 PLWH/A may be covered by this program. Low-income PLWH/A who are pending ADAP enrollment, or who need medications not on the ADAP formulary, can receive assistance through a Part A-funded emergency financial assistance for medications program. Funding is also available for short-term payment of health insurance while clients apply for long-term health insurance premium programs.

Gaps and Challenges

The following are gaps and challenges in ensuring client access to HIV-related medications in Orange County:

1. **Gaps in coverage due to transition to MSI.** The implementation of the expansion of Medicaid and the shifting of about an anticipated 900 clients from Ryan White funded services such as ADAP to MSI has created some gaps in coverage. MSI was originally developed as a medical care program to provide emergency services for low-income individuals. The system is challenged with meeting the needs of 900 new patients whose medical and medication needs are complex and costly.
2. **Uncertainty of ADAP.** ADAP is a costly program; $27 million is spent on Orange County residents alone. The formulary is one of the largest in the nation with about 150 medications. Currently ADAP does not require co-pays for medications. As financial forecasts for the State show deficits and cuts to State program must be made, proposals to reduce the ADAP formulary, implement client co-pays, or start ADAP waiting lists are often proposed. Implementation of these measures may lead to gaps in coverage for many who use the services.

Next Steps

The following are next steps in ensuring client access to HIV-related medications in Orange County:

1. **Coordinate transition of clients with ADAP and MSI.**
   - Orange County Health Care Agency will work with ADAP, eligibility workers, HIV providers, and MSI to ensure that there are no gaps in HIV-related medication coverage for PLWH/A.
2. **Provide information and education regarding access to medications.**
   - Orange County Health Care Agency will work with stakeholders to provide information to PLWH/A regarding options for medication coverage.

Strategy 4: Provide education and support to clients regarding initiation and adherence to medications

Rationale

Adherence to medications is an important facet of HIIV medical care, and especially so for the ARV drugs, which can lead to treatment resistance if not taken as prescribed. Patients often experience difficulty taking medications as prescribed. This may be due to the complicated nature of some regimens as well as interaction with supplements, over-the-counter medications, other prescribed medications, and side effects associated with the medications. Co-occurring issues such as mental illness, homelessness, and substance use can also make it difficult for patients to adhere to medications. Cultural barriers including beliefs about

medications or alternative remedies, literacy, or language can influence a patient's understanding and ability to take medications as prescribed. Finally, as people live longer and longer with HIV, patients are expected to adhere to these often complicated regimens over many years, which can prove challenging.

Current Continuum of Services

Medical providers offer education regarding medications as part of the provision of medical care. Orange County has four HIV specialty pharmacies; these pharmacies provide support for clients including pharmacist consultations, pill boxes, delivery options, and insurance assistance. Treatment adherence counseling is also a key component of medical case management services. As part of services provided, Ryan White medical case managers discuss issues related to challenges and goals related to adhering to treatment regimens with clients. Shanti Orange County also offers Club MedZ Minute, an online resource that provides information about drug interactions, medications, adherence, side effects, and effective ways to take medications. Treatment adherence is also a topic of many seminars and workshops for PLWH/A conducted by community based organizations including the Empower Series, the Big 7 Series, Positive "U", and Viviendo Positivamente.

Gaps and Challenges

The following are gaps and challenges in providing education and support regarding initiation and adherence to medications in Orange County:

1. **Limited provider time and resources.** Providers often have limited time to discuss adherence to treatment regimens during medical visits.
2. **Diversity of client understanding and beliefs about medications.** Providing education and support to clients with differing literacy, beliefs, and attitudes toward medications can be challenging.
3. **Complexity of medication regimens.** Some clients have very complicated medication regimens, especially those with co-occurring conditions requiring additional medications.

Next Steps

The following are next steps in providing education and support regarding initiation and adherence to medications in Orange County:

1. **Determine priorities and develop strategy for treatment adherence support.**
    - Orange County Health Care Agency to work with providers and HIV Client Advocacy to determine needs and service gaps for treatment adherence support.
    - Needs assessment findings will help identify priorities for treatment adherence support for clients.

Chapter 5: HIV Housing Strategy

Introduction

Access to housing is an important precursor to getting many people into a stable treatment regimen. Increasing the percentage of Ryan White clients with permanent housing is one of the goals of the anticipated results of the National HIV/AIDS Strategy. Studies have shown that people living with HIV are much more likely to access health services and stay in continuous care.[1] In Orange County, housing services for persons living with HIV/AIDS (PLWH/A) are largely provided through Housing Opportunities for Persons with AIDS (HOPWA) funding. The City of Santa Ana serves as the grantee for HOPWA funding for all of Orange County. The HIV Planning Council and its Housing Committee provide to the city in addressing the needs and gaps in housing services for PLWH/A. This chapter provides excerpts from the City of Santa Ana's Consolidated Plan and Annual Report related to individuals living with HIV/AIDS.

Background

As a recipient of federal funds from the US Department of Housing and Urban Development (HUD), the City of Santa Ana is required to prepare and submit a Consolidated Plan at least every five years. This Consolidated Plan document covers the five-year period of fiscal years 2010-2011 through 2014-2015. Four federal grant programs received by the City of Santa Ana are subject to the Consolidated Plan: Community Development Block Grant (CDBG), HOME Investment Partnerships Grant (HOME), Emergency Shelter Grant (ESG), and Housing Opportunities for Persons with AIDS Grant (HOPWA).

The HOPWA grant is administered by the City of Santa Ana on behalf of the entire Orange County region. The Consolidated Plan is a multifaceted document designed to be a collaborative process whereby Santa Ana stakeholders help establish a vision for the improvement of the community and the allocation of federal grant funds.

The Consolidated Plan includes:

- An assessment and prioritization of housing and community needs
- Identification of local, state and federal resources available to meet needs
- An outline of strategies to address priority needs over a five-year period
- An action plan with specific one-year goals to address priority needs

The 2010/11 to 2014/15 Consolidated Plan is available at:
http://www.santa-ana.org/cda/ConPlanEnglish.asp.

[1] Aidala A, Lee G, Abramson DM, Messeri P, Siegler A. Housing need, housing assistance, and connection to medical care. *AIDS Behav* 2007;11(Supp2):S101:S115.

Excerpts from City of Santa Ana 2011-2012 Consolidated Plan Annual Update

The 2011-2012 Action Plan provides specific information regarding the resources the City of Santa Ana will utilize and the activities the City will undertake to address priority needs and objectives during a 12-month period. The Action Plan will serve as the link between the objectives developed to address priority housing and community needs identified in the City's 2010-2014 Consolidated Plan/Strategic Plan with federal resources allocated to the City by HUD. The specific timeframe for the 2011-2012 Action Plan begins July 1, 2011, and ends June 30, 2012.

The following are excerpts from the City of Santa Ana Consolidated Plan Annual Update for 2011-2012 relevant to housing for persons living with HIV/AIDS (PLWH/A). The 2011-2012 Annual Update is available at:
http://www.ci.santa-ana.ca.us/cda/documents/11-12APPart1of2.pdf.

"HOPWA funds for Program Year 2011-2012 will be utilized to undertake eligible activities to meet the needs of individuals living with HIV/AIDS that presently are not met by other public and private resources. To identify program gaps, a countywide survey to assess the needs for the region's HIV/AIDS population was conducted during the 2004-2005 Program Year. This survey was a community-based planning effort that incorporated the input of interested community members including individuals living with HIV/AIDS, representatives of HIV/AIDS service and housing organizations, housing developers, representatives of local government agencies, advocates, and others. Relevant planning, housing, homelessness, and epidemiological data were reviewed and incorporated into the planning effort. Critical issues and service gaps were identified and an advisory committee developed recommendations. These findings have been used by the Housing Committee of the Orange County HIV Planning Council to develop a list of recommended activities for HOPWA funding during FY 2011-2012, as well as the expenditure of over $5.5 million in Ryan White and $342,000 in Minority AIDS Initiative resources that are expected to be available during 2011-2012.

The specific activities to be undertaken in program year 2011-2012 will be to provide supportive housing services and tenant-based rental assistance. To better measure the intended outcomes of HOPWA-funded activities, HUD has implemented a comprehensive reporting document. The City will work with its subrecipients to ensure all required data is captured and reported. As required by HUD, the following information is provided regarding HOPWA-funded activities for the 2011-2012 Program Year:

HOPWA ANNUAL GOALS 2011-2012

HIV/AIDS Housing Program	Annual Goal
Short Term Rent	100 Individuals
Mortgage/Utility Assistance	75 Individuals
Emergency Shelter	75 Individuals
Transitional Housing	70 Individuals
Tenant-Based Rental Assistance	50 Individuals
Housing Units Under Lease or Under Development	56 Units

In order for grassroots, faith-based and other community organizations to have access to HOPWA-funded housing services, the City of Santa Ana ensures that all such organizations are invited to the HIV Planning Council's strategic planning meeting. These same agencies are also invited to participate on the Housing Committee of the HIV Planning Council. Furthermore, nonprofit housing development agencies are provided information regarding housing development opportunities that are funded through HOPWA.

Monitoring

Below are the standards and procedures that the City will use to monitor activities funded during 2011-2012. The goal of the City's monitoring program is to ensure long-term compliance with respective program requirements, including minority business outreach. […]

Housing Opportunities for Persons with AIDS

A comprehensive report of all activities funded under the HOPWA program is prepared annually and submitted as part of the comprehensive annual performance report to HUD. The City has established a formal monitoring system for HOPWA-funded activities.

In addition to quarterly, annual and project close out reports, the City monitors all HUD-funded programs with the assistance of the Finance Department to ensure all federal funds are spent in a timely manner. Finally, HUD's Integrated Disbursement and Information System (IDIS) allows the City to monitor line of credit balances and project status. Santa Ana has taken extensive measures to safeguard public funds and ensure timely use of funds."

ANTICIPATED FEDERAL GRANT RESOURCES FOR FY 2011-2012

Resources	Anticipated Amount
Community Development Block Grant (CDBG)	$6,216,745
CDBG Program Income	$0
CDBG Prior Year Program Income	$0
CDBG Reprogrammed Funds	$0
HOME Investment Partnership Program (HOME)	$2,295,965
HOME Program Income	$0
Emergency Shelter Grant (ESG)	$301,897
ESG Reprogrammed Funds (from prior years)	$579
Housing Opportunities for Persons With AIDS (HOPWA)	$1,540,447
Housing Opportunities for Persons With AIDS (HOPWA) – Prior Yr	$26,899
TOTAL	**$10,382,532**

PLANNED USE OF 2011-2012 HUD FUNDS * […]

Activity	Funding Source	Funding Amount
HOPWA Administration – Program oversight [1]	HOPWA	$46,213
Support Services – Supportive services & housing for dually with HIV/AIDS [2]	HOPWA	$921,133
Tenant Based Rental Assistance – Rental assistance for persons with HIV/AIDS [2]	HOPWA	$600,000

* "Funding Amount" is based on anticipated 11-12 grants – does not include additional prior year/reprogrammed funds.
1. Santa Ana receives and administers HOPWA funds on behalf of the entire Orange County region.
2. HOPWA-funded programs and services will be available countywide.

Excerpts from City of Santa Ana 2010-2011 CAPER

In addition to updating the Consolidated Plan on an annual basis, via an annual Action Plan, the City of Santa Ana is required to provide the public and HUD with an assessment of its accomplishments utilizing these funds at the end of each fiscal year. This annual assessment is known as the Consolidated Annual Performance and Evaluation Report (CAPER).

The following are excerpts from the City of Santa Ana 2010-2011 Consolidated Annual Performance and Evaluation Report (CAPER) for HOPWA funding. The report is available at: http://www.santa-ana.org/cda/documents/2010-2011CAPER1of2.pdf

Relationship of HOPWA Funds to Goals & Objectives

During the 2010-2011 report period the City of Santa Ana continued its efforts to implement strategies to address the housing and supportive service needs of individuals living with HIV/AIDS on a regional basis. As outlined in the Consolidated Plan, goals and objectives for HOPWA resources are established via a countywide assessment process sustained by the Orange County HIV Planning Council and managed by the City. Each year a planning session is held by the City to prioritize the use of HOPWA funds and to provide the City direction and support. **EXHIBIT 4** provides summary goal attainment data.

Progress toward Meeting Affordable Housing Goals Using HOPWA Funds

Addressing the lack of housing for individuals with HIV/AIDS was identified as a primary goal for the use of HOPWA funding. During the 2010-2011 report period the City continued to utilize these limited resources to provide both short-term and long-term rental assistance. Short-term assistance included one-time rent/utility payments and rent assistance for up to three months. This type of assistance is critical to help stabilize a household facing an emergency or crisis situation related to their HIV/AIDS. Longer-term rental assistance (i.e., Tenant Based Rental Assistance) was also provided to those individuals and households living with HIV/AIDS that were in a more stable situation yet needed financial assistance to maintain housing. Housing placement services and life skills training was also made available to the regions HIV/AIDS clients via HOPWA funding. For homeless individuals with HIV/AIDS, emergency shelter, transitional housing and detox center residences were also made available. **EXHIBIT 4** provides a summary of the City's efforts to meet the permanent housing (i.e., Tenant Based Rental Assistance) and short-term/supportive housing service needs of the regions HIV/AIDS population.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA): ANNUAL PROGRESS REPORT – MEASURING PROJECT PERFORMANCE

PART 1-A: HOPWA EXECUTIVE SUMMARY
GRANTEE AND COMMUNITY OVERVIEW
1. Descriptions of 2010-2011 Activities: As the most populous city in Orange County, Santa Ana has administered the region's Housing Opportunities for Persons With AIDS (HOPWA) funds since 1993. During the 2010-2011 report period, HOPWA funds were utilized to support a variety of activities on a regional basis. These services including the following:

- Supportive services and housing offered via contracts with the Orange County Health Care Agency including:
    - Short-term emergency housing and/or utility assistance
    - Transitional housing
    - Housing coordination services
    - Life skills training workshops
    - Medical detoxification-bed services
- Tenant based rental assistance administered by the Santa Ana Housing Authority.
- Program administration

2. Grant management oversight of project sponsor activities including how recipient was chosen:

As the designated recipient of HOPWA funds for Orange County, the City of Santa Ana is responsible for grant management and oversight. While HOPWA funds are critical to meeting the needs of individuals with HIV/AIDS, it is not the only resource available. The County of Orange receives and manages additional resources for HIV/AIDS services. In order to ensure an array of housing and supportive service needs of people living with HIV/AIDS is provided, a regional planning process has been designed and charged with prioritizing the housing/service needs of the county's HIV/AIDS population. The Orange County HIV Planning Council has been established to coordinate services provided by the Ryan White Care Act - Santa Ana is a member of this council.

The City contracts with the County of Orange Health Care Agency (OC HCA) for HIV/AIDS supportive housing services. (The OC HCA is the primary regional public health service agency.) In turn the OC HCA issues Request for Proposals (RFP) soliciting program proposals to meet the needs of the County's HIV/AIDS population. While the RFP process is open to all service providers, there are a limited number of qualified HIV/AIDS service providers in the County. During the 2010-2011 report period the City awarded a contract for supportive housing services to the OC HCA. Since the OC HCA has access to additional HIV/AIDS resources, it is positioned to leverage HOPWA funding and to ensure a holistic approach to serving persons with HIV/AIDS. The OC HCA subcontracted with several agencies that provided specialized services to persons with HIV/AIDS. The City ensured oversight of the County's contracting efforts by serving on the Orange County HIV Planning Council (the latter approves programs that are awarded HOPWA funds). During the report period, the City's Housing Authority administered the Tenant Based Rental Assistance (TBRA) program. Authority staff regularly monitored tenant files and enforced Housing Quality Standards.

PART 1-B. ANNUAL PERFORMANCE UNDER THE ACTION PLAN

1. Summary of Housing Activities:

a. Supportive Housing Activities: During 2010-2011, the following supportive housing accomplishments were achieved through the expenditure of HOPWA funds:

- 7 individuals received treatment via the Medical/Social model residential detoxification program
- 13 individuals were provided with supportive housing for substance abusers

b. Housing Assistance for the Homeless:

- 106 homeless individuals received transitional housing services. These clients include those who were previously incarcerated, leaving substance abuse facilities, and those living in motels or other temporary housing
- 51 individuals/families were provided with permanent housing rental assistance

c. Other housing activities:

- 149 individuals/families received short-term emergency financial assistance to prevent homelessness
- 33 individuals/families received short-term rental assistance
- 343 individuals/families received housing coordination and linkage services

- 148 individuals received life skills training

2. Progress Evaluation:
Overall, and especially in the context of a continuum of housing, 2010-2011 HOPWA projects met or exceeded planned goals. Details for each project goal and accomplishment follow:

3. Housing Stability and Homelessness Risk Reduction:
The goal of the Emergency Financial Assistance, Short Term Rental Assistance, and the Housing Coordination programs is homelessness prevention and risk reduction. Housing Coordination also serves as a primary linkage service to care providers throughout the region
Ninety-one percent of the clients leaving the General Population Emergency Shelter left for Stable or Temporarily Stable housing situations (24% to Permanent Stable housing and 67% to Temporarily Stable). Of the clients who received supportive housing for substance abusers through the Start House program, 31% successfully transitioned to permanent, independent housing solutions.

4. Leverage and Housing Units Developed:
Two sub-contractors of the County of Orange Health Care Agency leveraged HOPWA funds by approximately $49,314 (ASF Orange County and Straight Talk).
Since 1993, the City has utilized HOPWA funds to develop 93 new housing units for persons with HIV/AIDS. Although the required 10 year covenant with Hagan Place has passed, the development still only houses HIV+ clients, and their numbers are included. During the program year, 159 unduplicated households/ individuals utilized these units.

5. Projects in Developmental Stage:
The HIV/AIDS community through a regional strategic planning process has prioritized the development of permanent housing for individuals with HIV/AIDS. The populations that have been identified are the undocumented, ex-offenders, women with children, and people with multiple diagnoses (including the seriously mentally ill) as subpopulations who are often unable to secure housing stability within the existing HIV/AIDS housing continuum.
To attract a development partner, approximately $500,000 is required. HOPWA funds not allocated for housing support services and direct housing payments are set aside in a development pool, which is expected to reach the $500,000 level again in a few years.

6. Distribution Analysis
The longer-term transitional and permanent housing units funded by HOPWA are scattered across the County of Orange including cities in the north (Anaheim), central (Santa Ana), west (Westminster) and south (Laguna Beach) portions of the county. Those activities which are individual-based (as opposed to unit-based), such as rental assistance, life skills training, and housing coordination, are available to any qualified client regardless of location.

D. Part 1-C: Barriers or Trends Overview:
Even with the recent downturn from record prices, the Orange County housing market remains one of the least affordable in the United States, and costs are showing signs of growth again after peaking in 2007. Rental costs did not decline as housing prices did, and have held to within 90% of their market high from 2007.

As of June 2010, the median house price countywide was $445,000 and the average 2-bedroom apartment rent was $1,540 per month. The amount of subsidy required to make housing affordable is very high. For example, the average housing assistance payment for the HOPWA rental assistance program was $910 per month. The cost of developing and/or acquiring and rehabilitating housing units to reserve for this population continues to climb. As Orange County nears complete build-out, vacant land is scarce and primarily located in foothill areas, commanding top prices. Special needs development, such as for the HIV+ community, is focused on rehabilitation of existing structures and in-fill housing.

A trend identified through the City of Santa Ana's HOPWA strategic planning process, and through the HOPWA-funded HIV/AIDS housing study of 2006, is the lack of affordable housing for subpopulations such as the undocumented, ex-offenders, and the dually-diagnosed. Future acquisition and rehabilitation projects will target these populations, where feasible. Copies of the 2006 Orange County HIV Housing Plan and the City of Santa Ana Consolidated Plan are available for public review at Santa Ana City Hall, 20 Civic Center Plaza, Santa Ana, CA 92702."

Appendix A: Summary of HIV Funding and Services

The following is a summary of estimated anticipated public funding for HIV services in Orange County for FY 2012:

FY 2012 Estimate of Anticipated Public Funding for Orange County HIV Services

Services	FY 2012 Priority	Ryan White Part A Funds		Other Federal Funds		State Funds		Local Public Funds		Total Funds
Prevention Services										
Routine HIV Testing in Healthcare Settings	7	$0	0%	$0	0%	$440,263	100%	$0	0%	$440,263
Targeted HIV Testing at Non-Healthcare Settings	7	$0	0%	$0	0%	$401,405	100%	$1,000	0%	$402,405
Partner Services	16	$0	0%	$0	0%	$116,700	100%	$0	0%	$116,700
Evidence-Based Behavioral Interventions	16	$0	0%	$348,000	41%	$500,000	59%	$0	0%	$848,000
Health Care/Treatment Services										
Outpatient Medical Care	1	$2,019,759	23%	$727,350	8%	$5,453,145	61%	$700,000	8%	$8,900,254
State ADAP	2	$0	0%	$0	0%	$27,520,191	100%	$0	0%	$27,520,191
Medications Assistance	2	$3,900	0%	$0	0%	$11,729,833	100%	$0	0%	$11,733,733
Health Insurance Premium & Cost Sharing Assistance	2	$11,100	100%	$0	0%	$0	0%	$0	0%	$11,100
Oral Health Care	3	$403,629	80%	$0	0%	$52,803	10%	$50,000	10%	$506,432
Mental Health Services	4	$263,399	82%	$56,037	18%	$0	0%	$0	0%	$319,436
Home Health Care	8	$135,000	5%	$0	0%	$2,333,801	95%	$0	0%	$2,468,801
Substance Abuse Treatment	12	$6,344	2%	$258,264	98%	$0	0%	$0	0%	$264,608
Access Services										
Medical Case Management	5	$1,244,048	67%	$51,302	3%	$531,237	28%	$41,952	2%	$1,868,539
Benefits Counseling	5	$165,000	100%	$0	0%	$0	0%	$0	0%	$165,000
Client Advocacy	5	$125,691	81%	$28,788	19%	$0	0%	$0	0%	$154,479
Early Intervention Services	7	$50,000	100%	$0	0%	$0	0%	$0	0%	$50,000
Transportation Services	11	$255,000	70%	$0	0%	$96,000	26%	$13,984	4%	$364,984
Legal Services	13	$88,745	100%	$0	0%	$0	0%	$0	0%	$88,745
Care Outreach	15	$0	0%	$0	0%	$123,000	100%	$0	0%	$123,000
Sustaining Services										
Housing Services	6	$126,629	19%	$529,736	81%	$0	0%	$0	0%	$656,365
Food Pantry	9	$99,000	100%	$0	0%	$0	0%	$0	0%	$99,000
Home Delivered Meals	9	$50,000	100%	$0	0%	$0	0%	$0	0%	$50,000
Nutritional Supplements	10	$57,584	100%	$0	0%	$0	0%	$0	0%	$57,584
Independent Living Skills	14	$0	0%	$12,964	100%	$0	0%	$0	0%	$12,964
TOTAL FUNDS		$5,104,828	9%	$2,012,441	4%	$48,858,115	86%	$806,935	1%	$56,782,319

The following is a summary of the continuum of HIV services and providers in Orange County:

Summary of Orange County Continuum of Services and Providers

	Healthcare Organization			County of Orange Programs							Community-Based Organizations							Housing Programs				Other	
Services	Alta-Med Medical Centers	Laguna Beach Community Clinic	UCI Medical Centers	17th Street Testing, Treatment, and Care	Correctional Medical	Environmental Health	Family Health Clinics	Dental Clinic	Pulmonary Diseases Clinic	REACH Program	AIDS Services Foundation	APAIT Health Center	Delhi Center	OC Bar Foundation	Public Law Center	Shanti Orange County	The Gay & Lesbian Center	Mercy House	Casa Alegre	Hagan Place	Straight Talk Clinic, Inc.	Faith-Based Organizations	State ADAP
Prevention Services																							
Routine HIV Testing in Healthcare Settings	x		x	x	P		P		P														
Targeted HIV Testing at Non-Healthcare Settings										x	x	x		x			x						
Partner Services				x						x	x	x	x			x							
Evidence-Based Behavioral Interventions for HIV-Positive Individuals										x	x												
Evidence-Based Behavioral Interventions for High-Risk Populations											x	x		x			x						
Condom distribution				x						x	x	x					x						
Syringe education and services						x				x													
Social Marketing, Media, and Mobilization				x							x	x	x			x	x				x	x	
Health Care/Treatment Services																							
Outpatient Medical Care	x	x	x	x																			
Medications Assistance											x												x
Health Insurance Premium & Cost Sharing Assistance											x												
Oral Health Care								x															
Mental Health				x							x	x				x							
Home Health Care											x												
Hospice Care											x												
Rehabilitation											x												
Substance Abuse Treatment										x											x		
Treatment Adherence Education		x		x												x							
Access Services																							
Medical Case Management				x						x	x		x			x							
Benefits Counseling											x												
Client Advocacy											x					x							
Early Intervention Services	x		x	x																			
Transportation Services										x	x												
Legal Services															x								
Care Outreach				x																			
Sustaining Services																							
Housing Services											x	x						x	x	x	x		
Food Pantry											x												
Home Delivered Meals																x							
Nutritional Supplements											x												
Independent Skills											x												
Complementary Therapies/Supportive Services											x		x			x						x	

P= Services were being piloted at time of publication.

Appendix B: Other Publications

For additional information regarding HIV/AIDS services in Orange County, please refer to the following publications:

Client Handbook (for Clients in the Orange County Ryan White Act System)
(last updated in 2012 at time of publication)
Orange County Health Care Agency
HIV Planning and Coordination
1725-B W. 17th Street, P.O. Box 6099, Building 50, Santa Ana, CA 92706
Phone: (714) 834-8711
English: http://ochealthinfo.com/docs/AgcyPubs/phs/Client_Handbook-en.pdf
Spanish: http://ochealthinfo.com/docs/AgcyPubs/phs/Client-Handbook-SP.pdf

HIV Disease Surveillance Statistics 2010
Orange County Health Care Agency
HIV/AIDS Surveillance and Monitoring Program
1725-B W. 17th Street, P.O. Box 6099, Building 50, Santa Ana, CA 92706
Phone: (714) 834-8711
Website: http://www.ochealthinfo.com/docs/public/hiv/2010-Surveillance-Statistics-Report.pdf

Orange County Community Indicators
(last updated in 2011 at time of publication)
Orange County Community Indicators Project
17320 Redhill Avenue, Suite 200, Irvine, CA 92614
Phone: (714) 834-7257
E-mail: ocindicators@ocgov.com
Website: http://www.ocgov.com/ceocommunity.asp

Orange County HIV/AIDS Housing Plan
(last updated in 2005 at time of publication)
City of Santa Ana, Community Development Agency
20 Civic Center Plaza, M-25,
Santa Ana, CA 92701
Website: http://www.ci.santa-ana.ca.us/cda/

National HIV/AIDS Strategy for the United States
(signed July 2010)
The White House Office of National AIDS Policy
Phone: (202) 456-4533
Email: AIDSpolicy@who.eop.gov
Website: www.whitehouse.gov/onap