Ryan White Part A Grant Application Fiscal Year 2019

Orange County Transitional Grant Area

health CARE AGENCY

Disease Control and Epidemiology
HIV Planning and Coordination

Table of Contents

OMB Number: 4040-0004
Expiration Date: 12/31/2019

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: 09/19/2018

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier: H89HA0019

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: Orange County Health Care Agency

* b. Employer/Taxpayer Identification Number (EIN/TIN): 1956000928

* c. Organizational DUNS: 1361055120000

d. Address:

* Street1: 1725 W17th St.

Street2:

* City: Santa Ana

County/Parish: Orange

* State: CA: California

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 92706-099

e. Organizational Unit:

Department Name: HIV Planning and Coordination

Division Name: Disease Control & Epidemiology

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Dr.

* First Name: Tamarra

Middle Name:

* Last Name: Jones

Suffix:

Title: Administrative Manager II

Organizational Affiliation: Orange County Health Care Agency

* Telephone Number: 714-834-8798

Fax Number:

* Email: tjones@ochca.com

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources and Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-19-033

* Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

13. Competition Identification Number:

HRSA-19-033

Title:

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Ryan White HIV/AIDS Program Part A HIV Emergency Relief Grant Program-See attached abstract

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CA-039 * b. Program/Project: CA-039

Attach an additional list of Program/Project Congressional Districts if needed.

1247-Attachment - Additional Congressional | Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 03/01/2019 * b. End Date: 02/29/2020

18. Estimated Funding ($):

* a. Federal	6,526,898.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	1,114,665.00
* g. TOTAL	7,641,563.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Mr. * First Name: Scott

Middle Name:

* Last Name: Price

Suffix:

* Title: Administrative Manager II

* Telephone Number: 714-834-5063 Fax Number:

* Email: sprice@ochca.com

* Signature of Authorized Representative: Scott Price * Date Signed: 09/19/2018

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1235-Attachment 1 - Staffing	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	1236-Attachment 2- FY 2019 Ag	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	1237-Attachment 3 - HIVAIDS D	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	1238-Attachment 4 - Co-occuri	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	1239-Attachment 5 - Coordinat	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6	1240-Attachment 6 - Letter of	Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7	1241-Attachment 7 - HIV Care	Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8	1242-Attachment 8 - Service C	Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10	1243-Attachment 10 - Organiza	Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11	1244-Attachment 11 - MOE .pdf	Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12	1245-Attachment 12 - Federall	Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Project/Performance Site Location(s)

Project/Performance Site Primary Location

☒ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Orange County Health Care Agency

DUNS Number: 1361055120000

* Street1: 1725 W17th St.

Street2:

* City: Santa Ana County: Orange

* State: CA: California

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 92782-0099 * Project/ Performance Site Congressional District: CA-039

Project/Performance Site Location 1

☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** 1248-FY19 Part A Project Narrative.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure of Lobbying Activities,'' in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION	Orange County Health Care Agency
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Prefix:	Mr.
* First Name:	Scott
Middle Name:	
* Last Name:	Price
Suffix:	
* Title:	Administrative Manager II
* SIGNATURE:	Scott Price
* DATE:	09/19/2018

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** 1234-Attachment 13 - Budget Narrative and Justifica

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
Scott Price	Administrative Manager II
APPLICANT ORGANIZATION	DATE SUBMITTED
Orange County Health Care Agency	09/19/2018

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BUDGET INFORMATION - Non-Construction Programs

OMB Number: 4040-0006
Expiration Date: 01/31/2019

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Part A and MAI Administration	93.914	$	$	$ 580,436.00	$	$ 580,436.00
2. Part A and MAI Clinical Quality Management	93.914			291,288.00		291,288.00
3. Part A and MAI HIV Services	93.914			5,655,174.00		5,655,174.00
4.						
5. Totals		$	$	$ 6,526,898.00	$	$ 6,526,898.00

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SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Part A and MAI Administration	(2) Part A and MAI Clinical Quality Management	(3) Part A and MAI HIV Services	(4)	Total (5)
a. Personnel	$ 335,914.00	$ 161,086.00	$ 0.00	$	$ 497,000.00
b. Fringe Benefits	166,311.00	79,754.00	0.00		246,065.00
c. Travel	8,700.00	2,500.00	0.00		11,200.00
d. Equipment	0.00	0.00	0.00		0.00
e. Supplies	14,561.00	15,675.00	0.00		30,236.00
f. Contractual	0.00	0.00	5,655,174.00		5,655,174.00
g. Construction	0.00	0.00	0.00		0.00
h. Other	16,550.00	9,000.00	0.00		25,550.00
i. Total Direct Charges (sum of 6a-6h)	542,036.00	268,015.00	5,655,174.00		$ 6,465,225.00
j. Indirect Charges	38,399.00	23,274.00	0.00		$ 61,673.00
k. TOTALS (sum of 6i and 6j)	$ 580,435.00	$ 291,289.00	$ 5,655,174.00	$	$ 6,526,898.00
7. Program Income	$ 0.00	$ 0.00	$ 1,114,665.00	$	$ 1,114,665.00

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Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Part A and MAI Administration	$	$	$	$
9. Part A and MAI Clinical Quality Management				
10. Part A and MAI HIV Services				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Part A and MAI Administration	$	$	$	$
17. Part A and MAI Clinical Quality Management				
18. Part A and MAI HIV Services				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges: $6,465,225

22. Indirect Charges: $61,673

23. Remarks:

Key Contacts Form

*** Applicant Organization Name:**

Orange County Health Care Agency

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Program Manager

Prefix:	
* First Name:	Tamarra
Middle Name:	
* Last Name:	Jones
Suffix:	
Title:	Administrative Manager II

Organizational Affiliation:

Orange County Health Care Agency

* Street1:	1725 W17th St.
Street2:	
* City:	Santa Ana
County:	Orange
* State:	CA: California
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	92706-0099
* Telephone Number:	714-834-8798
Fax:	
* Email:	tjones@ochca.com

Project Abstract

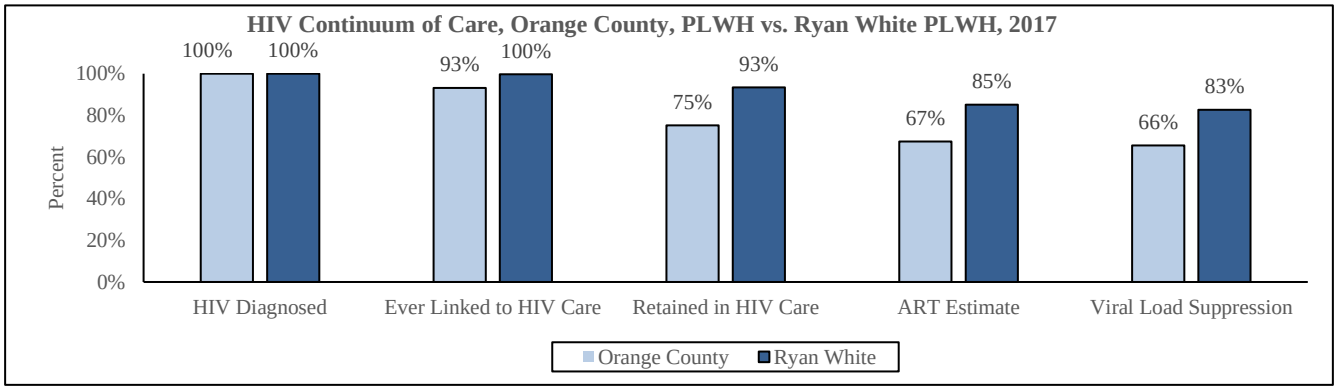
- **Project Title:** FY 2019 Part A (TGA) HIV Emergency Relief Grant Program
- **Applicant Organizational Name:** County of Orange
- **Address:** 1725 W. 17th St., P.O. Box 6099, Santa Ana, CA 92706-0099
- **Project Director:** Tamarra Jones, DrPH
- **Phone:** (714) 834-8798 **Fax:** (714) 834-8270 **Email:** TJones@ochca.com **Website:** N/A
- **HRSA Grant Number:** H89HA00019

For FY 2019, the Orange County TGA is requesting $6,526,898 ($6,101,131 Part A and $425,767 MAI), an increase of 5.00% from the current Part A/MAI funding level.

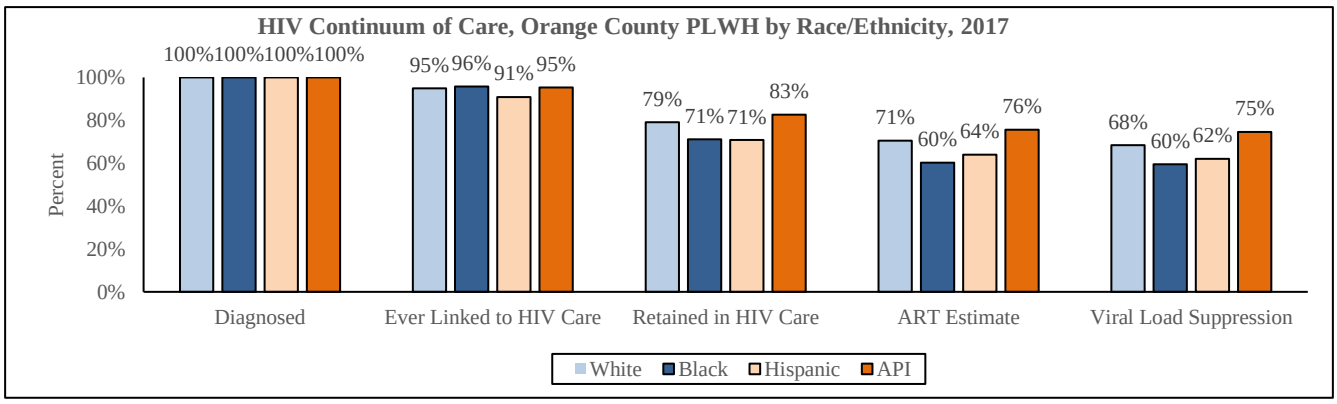
- **General Demographics:** Comprising 798 square miles between Los Angeles and San Diego in Southern California, Orange County is the sixth largest county in the United States. It includes 34 cities and an estimated 3.2 million people. Since 1980, the county population increased by 65%, largely due to immigration. The ethnic distribution has shifted from predominately White (78%) in 1980 to a White minority (42%) in 2017. The population for other ethnicities in 2017 was 35% Latino, 18% Asian/Pacific Islander (API), and 2% Black.
- **Demographics of HIV Population:** As of December 2017, a total of 3,353 individuals were living with AIDS and 3,358 were reported to be living with HIV, totaling 6,711 persons living with HIV (PLWH). An additional 941 persons are estimated to be living with HIV but unaware of their status, this estimate has increased from prior years due to changes in the Centers for Disease Control and Epidemiology back calculation method. Of prevalent cases, 87% are men, 12% are women, 39% are White, 46% Latino, 6% African-American, and 8% API. Men who have sex with men account for 74% of cases, followed by persons reporting heterosexual transmission (12%), and injection drug users (7%).
- **Geography of Epidemic:** Orange County cases are widely distributed throughout the county with the highest concentration of cases being in the central to northern region. By residence at diagnosis, the majority of PLWH were residing in Santa Ana, an urban area with a disproportionately high population of Hispanic and low-income residents. Five of the seven service providers are located in this region of the county.
- **System of Care:** Orange County's continuum of care (COC) encompasses core medical services, including outpatient medical care, early intervention services (EIS), oral health care, health insurance premium program, home health care, mental health services, medical nutrition therapy, and medical case management. The COC also funds non-medical case management, outreach, housing, medical transportation, and legal services that increase access to and maintenance in care. In 2016, case management services were modified into tiers to better address the needs of all PLWH in Orange County. The new tiers include Linkage to Care (utilizing the ARTAS Evidenced-Based Intervention) to facilitate linkage to health care services for individuals newly diagnosed, being brought back into care, or transitioning health care coverage; Medical Retention Services for those who are medically compromised or unstable; and Client Support Services for individuals who are medically adherent but need supportive services assistance. The TGA also funds the tiers of case management with Minority AIDS Initiative (MAI) funding. Early intervention services and outreach services have been expanded to improve access to care and re-engagement in care utilizing HIV surveillance data to guide efforts. With the implementation of the Affordable Care Act (ACA), the coordination of care has expanded to help individuals apply for and access services through public and private insurances. Case managers and eligibility workers have provided the majority of coordination assistance to clients to ensure access to all available resources within the TGA.

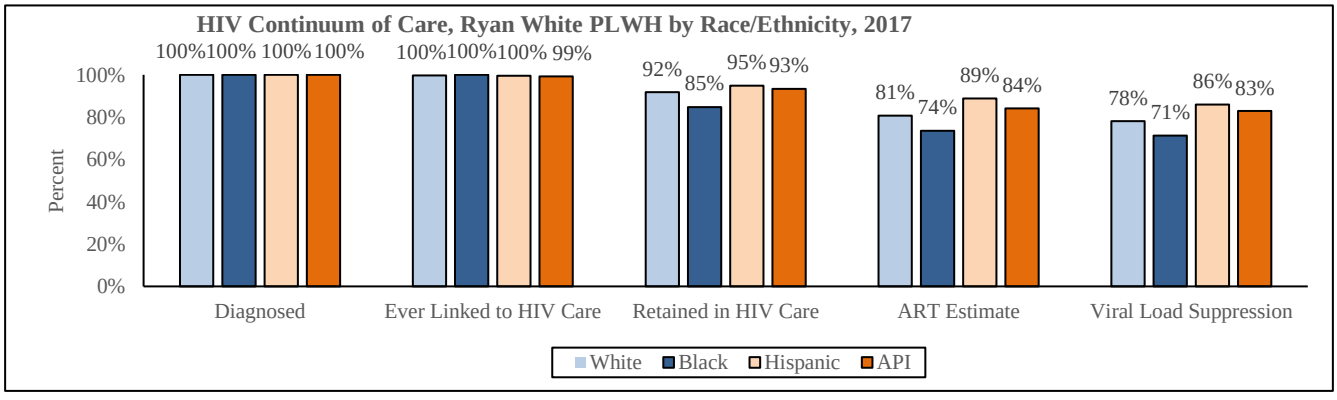
- As of December 2017, the HIV viral load suppression rate for all Orange County residents diagnosed living with HIV was 65.5% compared to 82.7% among Ryan White clients.

	Diagnosed	Ever Linked to HIV Care		Retained in Care		ART Estimate		Viral Load Suppression	
Orange County	6,711	6,252	93.2%	5,046	75.2%	4,526	67.4%	4,399	65.5%
Ryan White	2,330	2,322	99.7%	2,176	93.4%	1,986	85.2%	1,926	82.7%



- As shown in the figures below, Blacks have the greatest disparities in Orange County and in the Ryan White system followed by Hispanics along the stages of the continuum. Comparing the total numbers (368 Blacks diagnosed to 3,101 Hispanics diagnosed), the most disproportionately impacted subpopulation in Orange County is Hispanics. However, as shown, in the Ryan White system, they have far better outcomes with the viral load suppression of 86.0% in Ryan White compared to 62.0% for Orange County.





INTRODUCTION

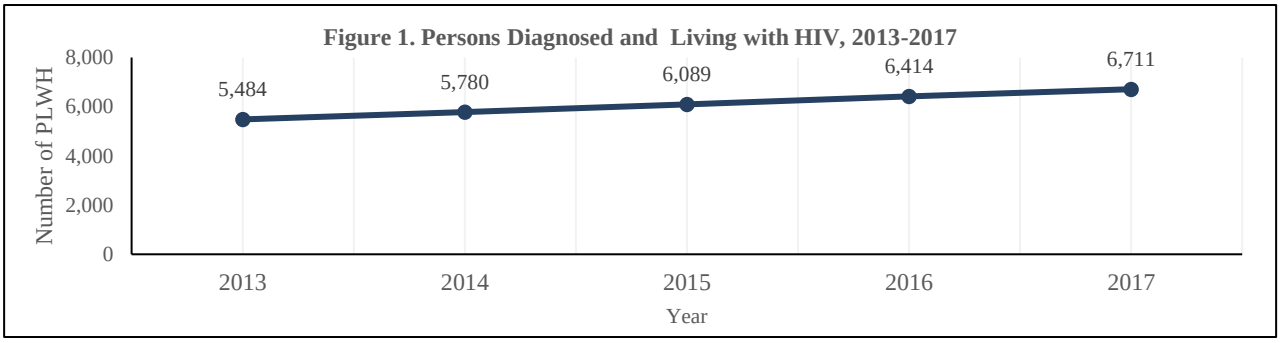
NEEDS ASSESSMENT

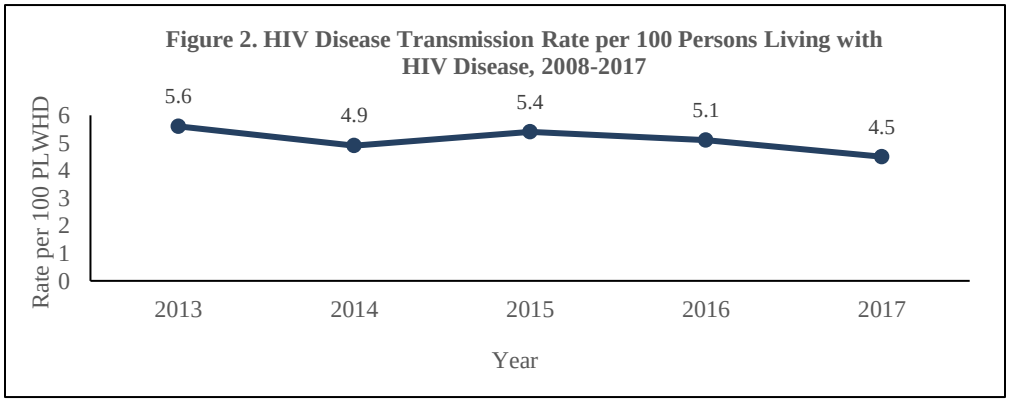
A. Demonstrated Need

1) Epidemiologic Overview

a) Summary of HIV Epidemic in TGA

Over the last five years, Orange County's epidemic has seen trends that include increases in the number of people living with HIV (PLWH), decreases in the HIV transmission rate, decrease in concurrent HIV/AIDS diagnosis, and improvements in the HIV Care Continuum. The number of PLWH in Orange County has increased by 1,227 over the last five year between 2013 and 2017 as shown in Figure 1[1]. This represents an average increase of 245 individuals a year. This number does not include individuals that have passed away or have been confirmed to have moved outside of Orange County. As the number of PLWH has increased each year, the transmission rate has decreased from 5.6 to 4.5 during the same five year time period. As shown in Figure 2[2] below, the overall transmission rate has decreased from 8.1 to 4.5 over the last 10 years.





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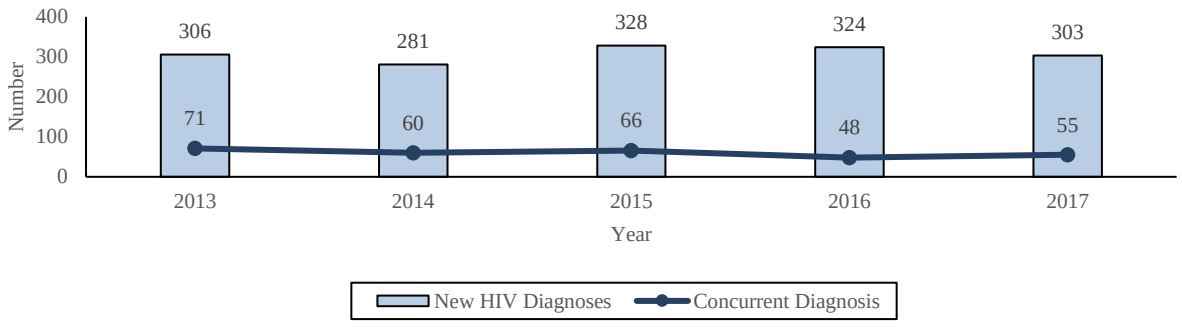
[1] HIV/AIDS Case Registry, PLWH as of January 31, 2018
[2] HIV/AIDS Case Registry, PLWH as of January 31, 2018

The number of concurrently diagnosed individuals has decreased by 23 percent as shown in Figure 3[3]in the past five years. The decreasing number of concurrently diagnosed individuals that are newly diagnosed individuals that were diagnosed with HIV and AIDS within the same month, may be due to a number of factors including, improved testing efforts to target individuals with the highest risk and increased efforts for routine HIV testing in medical care settings. Figure 3, shows the number of concurrently diagnosed by year of diagnosis as well as the number of newly diagnosed individuals, indicating the number of individuals that are tested late (concurrently diagnosed with HIV and AIDS).

Figure 3. Number of New HIV Diagnoses and Number of Those Concurrently Diagnosed with AIDS by Year of HIV Diagnosis, 2013-2017



The following outlines trends in the Orange County epidemic over the last five years (2013-2017):

- The rate of infection based on gender for Males and Females has seen small changes from 87.6% to 89.1% and 11.1% to 9.6% for males and females, respectively.
- The transmission rate has decreased by nearly 20% from 5.6 per 100 PLWH in 2013 to 4.5 per 100 PLWH in 2017.
- The percentage of Transgender individuals that are newly diagnosed has been a stable 1.3% from 2013 to 2017.
    - The TGA tested a higher percentage of Transgender individuals from 3.2% in 2013 to 3.7% in 2017.
- By race/ethnicity the rate of infection per 100,000:
    - Blacks[4] has increased from 23.7 in 2013 to 27.0 in 2017.
    - Hispanics[5] has decreased from 14.2 in 2013 to 11.1 in 2017.
    - Whites increased from 6.9 in 2013 to 8.8 in 2017.
    - Asian/Pacific Islander (API) remained the same for both years (7.4 per 100,000).

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[3] HIV/AIDS Case Registry, PLWH as of January 31, 2018
[4] Black and African American are used interchangeably.
[5] Hispanic and Latino are used interchangeably.

- When reviewing the rate of infection based on age:
    - 19-25 year olds have seen an increase from 19.4 in 2013 to 22.2 in 2017.
    - 26-35 year olds have seen an increase from 23.7 in 2013 to 27.2 in 2017.
    - 36-45 year olds have seen a decrease from 16.8 in 2013 to 12.4 in 2017.
    - 46-55 year olds have seen a decrease from 10.4 in 2013 to 8.2 in 2017.
- When reviewing the rate of infection based on the Mode of Exposure or Risk Factor:
    - The rates for Men who have Sex with Men (MSM) has decreased from 75.8 in 2013 to 68.0 in 2017.
    - The rate for heterosexuals has decreased from 9.8 in 2013 to 9.6 in 2017.
    - The rates for Persons who Inject Drugs (PWID) has increased from 4.9 in 2013 to 5.0 in 2017.
    - The rates for MSM/PWID has decreased from 4.2 in 2013 to 2.0 in 2017.
- Over the last five years, with the implementation of ACA, expanding Medicaid (Medi-Cal in California), and private insurance through the health care exchange, the number of PLWH utilizing Ryan White services has decreased for core medical services and increased for case management which assist PLWH with ACA navigation.
    - In 2017, a total of 2,307 PLWH utilized Ryan White services compared to 2,450 in 2013.
    - Ryan White clients utilizing Outpatient Ambulatory Health Services have decreased from 1,660 in 2013 to 814 in 2017.
    - The numbers of people accessing Mental Health Services have decreased from 271 in 2013 to 108 in 2017.
    - Case Management Service (including Medical Case Management and Non-Medical Case Management) utilization have increased from 1,969 in 2013 to 2,280 in 2017.

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b) Description of socio-demographic characteristics of newly diagnosed, PLWH, and high-risk populations in the service area

i. Demographic data

The Table 1 shown below, provides the 2017 demographic detail for all newly diagnosed individuals, PLWH, and high-risk populations that received a State Office of AIDS funded HIV tests. The demographic detail includes gender, race/ethnicity, age at diagnosis, and risk factor. A comparison of newly diagnosed to those living with HIV shows an increase among the following populations: 1) Male; 2) Transgender; 3) Asian/Pacific Islander; 4) Individuals under the age of 35; 5) Heterosexual Contact; and 6) Other/Unknown/Not Reported.

Table 1: Demographic Detail for
2017 Newly Diagnosed Individuals[6], PLWH[7], and High-Risk Populations[8]

	2017		PLWH		High-Risk Populations	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Total Number of Cases	**303**	**100.0%**	**6,711**	**100.0%**	**5,287**	**100.0%**
Gender/Sex						
Male	270	89.1%	5,833	86.9%	4,864	92.0%
Female	29	9.6%	799	11.9%	220	4.2%
Transgender	4	1.3%	79	1.2%	193	3.6%
Unknown	0	0.0%	0	0.0%	10	0.2%
Race/Ethnicity						
Black	13	4.3%	368	5.5%	159	3.0%
Hispanic	126	41.6%	3,101	46.2%	2,880	54.5%
White	118	38.9%	2,638	39.3%	1,174	22.2%
Asian/Pacific Islander (API)	43	14.2%	516	7.7%	929	17.6%
Other/More than One Race/ Unknown	3	1.0%	88	1.3%	145	2.7%
Age at Diagnosis						
0-18 Years	5	1.7%	28	0.4%	111	2.1%
19-25 Years	74	24.4%	301	4.5%	1,583	29.9%
26-35 Years	107	35.3%	1,146	17.1%	2,010	38.0%
36-45 Years	51	16.8%	1,440	21.5%	859	16.2%
46-55 Years	38	12.5%	2,014	30.0%	489	9.2%
56 Years and Older	28	9.2%	1,782	26.6%	216	4.1%
Unknown	0	0.0%	0	0.0%	19	0.5%
Risk Factor/Transmission Category						
Men Having Sex With Men (MSM)	213	70.3%	4,930	73.5%	4,541	85.9%
Heterosexual Contact	38	12.5%	777	11.6%	139[9]	2.6%
Persons who Inject Drugs (PWID)	16	5.3%	449	6.7%	341	6.4%
MSM/PWID	6	2.0%	313	4.7%	73	1.4%
Other/Unknown/Not Reported	30	9.9%	242	3.6%	193	3.7%

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[6] HIV/AIDS Case Registry, PLWH as of January 31, 2018
[7] HIV/AIDS Case Registry, PLWH as of January 31, 2018
[8] California State Office of AIDS, Local Evaluation Online, High-Risk Testers as of March 15, 2018
[9] Heterosexual contact includes sexual contact with a partner who is HIV positive and/or a sex worker.

ii. Socioeconomic data

Table 2 below shows available socioeconomic data for individuals that were newly diagnosed in 2017, PLWH in the Ryan White system, and high-risk populations that received State Office of AIDS funded HIV testing in 2017. Currently, there is no reliable way to obtain data about language barriers and levels of education. Income, federal poverty level, and health insurance status is shown below when available.

Table 2: Socioeconomic Detail for
2017 Newly Diagnosed Individuals, Ryan White, and High-Risk Populations

	2017		Ryan White		High-Risk Populations	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Total Number of Cases/Tests	**303**[10]	**100.0%**	**2,307**	**100.0%**	**5,287**	**100.0%**
Federal Poverty Level (FPL)						
Under 100% FPL	49	16.2%	1,011	43.8%		
101-138% FPL	16	5.3%	305	13.2%		
139-200% FPL	20	6.6%	445	19.3%		
201-250% FPL	4	1.3%	207	9.0%	Data is not	
251-400% FPL	15	5.0%	266	11.5%	available	
401-500% FPL	2	0.7%	52	2.3%		
501% FPL and above	1	0.3%	11	0.5%		
Not Reported[11]	196	64.7%	10	0.4%		
Health Insurance Status						
Private Insurance	132	43.6%	245	10.6%	1,392	26.3%
Medi-Cal/Medicare	75	24.8%	1,222	53.0%	1,012	19.1%
No Insurance	86	28.4%	685	29.7%	2,368	44.8%
Other Public[12]	4	1.3%	155	6.7%	246	4.7%
Unknown	6	1.9%	0	0.0%	269	5.1%

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[10] The FPL and insurance numbers for newly diagnosed individuals is limited to individuals that entered the Ryan White system or information self-disclosed at the time of diagnosis.

[11] Not Reported are newly diagnosed individuals that did not enter the Ryan White system of care and income information is not available.

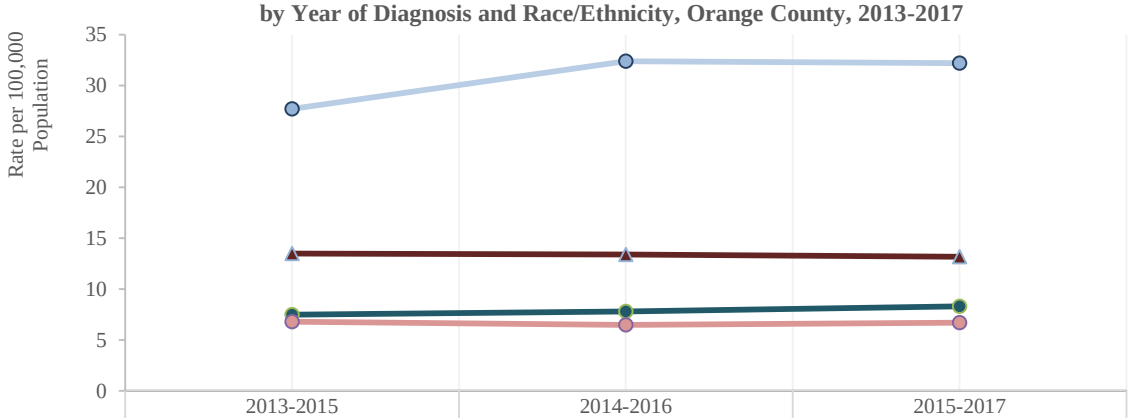
[12] Other public insurance may include military coverage, Family PACT, Indian Health Services, and other public programs.

c) Description of rates of increase in HIV diagnosed within new and emerging populations including disproportionally impacted subpopulations

There are no new emerging communities represented in the Orange County epidemic that have not been previously included in the HIV Emergency Relief Grant application. However, there are subpopulations that are disproportionally impacted by HIV. Those populations include Blacks, Hispanics, and Men who have Sex with Men (MSM).

Based on 2017 U.S. Census population estimates, Blacks make up 1.6%[13] of the population in Orange County. When comparing the percentage to all people living with HIV (PLWH) in Orange County that percentage is 5.5%. In addition, Figure 4 below shows the rate of infection for race/ethnicity on a rolling three years of rates in order to eliminate peaks and valleys in data for the last five years. As shown in Figure 4, the rate for Blacks has increased. This trend will continue to show that Blacks are disproportionally impacted by HIV. The rates for Hispanics has remained stable since 2013; however, based on the 2017 Census data, Hispanics made up 34.2% of the population, but among PLWH Hispanics made 46.2%. The percent of Hispanics among PLWH will continue to grow the disproportion because Hispanics made up 41.6% of new infections and over half (54.5%) of the high-risk individuals tested for HIV in 2017.

Figure 4. Rolling Three Year Average Rate per 100,000 Population of HIV Disease Cases by Year of Diagnosis and Race/Ethnicity, Orange County, 2013-2017



	2013-2015	2014-2016	2015-2017
Black	27.7	32.4	32.2
Hispanic	13.5	13.4	13.2
White	7.5	7.8	8.3
API	6.8	6.5	6.7

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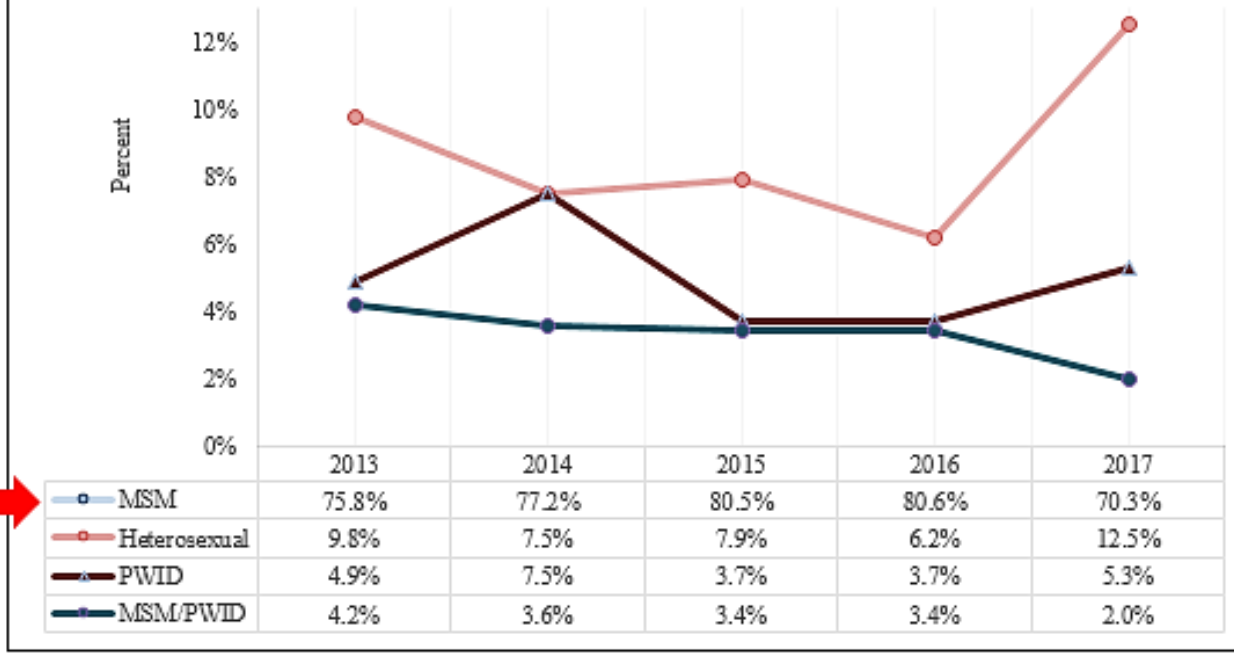
[13] U.S. Census, 2017. American Fact Finder. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2017_PEPSR6H&prodType=table

The last subpopulation that is disproportionally impacted is MSM. The number of all PLWH that identified as MSM in 2017 was 73.5%. That percentage may actually be higher than reported because Hispanics born outside of the US account for a higher percent of new infections among Hispanics and are less likely to identify as MSM due to cultural norms, beliefs, language, and levels of acculturation[14]. Increases of MSM among new positives and high-risk testers continue to show MSM are disproportionally impacted by HIV. In addition, the graph below shows the rate of infection based on the Mode of Exposure or Risk Factor. MSM percentages are not shown in Figure 5 below because the percentages are so high compared to the other risk categories. The line graph below shows the changes among Persons who Inject Drugs (PWID), heterosexual contact, and MSM/PWID. The MSM case percentage is provided for each year and demonstrates a continued increase among MSM (see row with arrow below). In addition, increases in heterosexual mode of exposure from 6.2% in 2016 to 12.5% in 2017 may be a result of individuals not being comfortable stating risk factors such as MSM or PWID. The increase of will be monitored by the Planning Council and subcommittees moving forward to determine if there is a continued increase or if it deceases to percentages seen in the previous five years.

Figure 5. Percent of HIV Disease Cases by Year of Diagnosis and Mode of Exposure, Orange County, 2013-2017



	2013	2014	2015	2016	2017
MSM	75.8%	77.2%	80.5%	80.6%	70.3%
Heterosexual	9.8%	7.5%	7.9%	6.2%	12.5%
PWID	4.9%	7.5%	3.7%	3.7%	5.3%
MSM/PWID	4.2%	3.6%	3.4%	3.4%	2.0%

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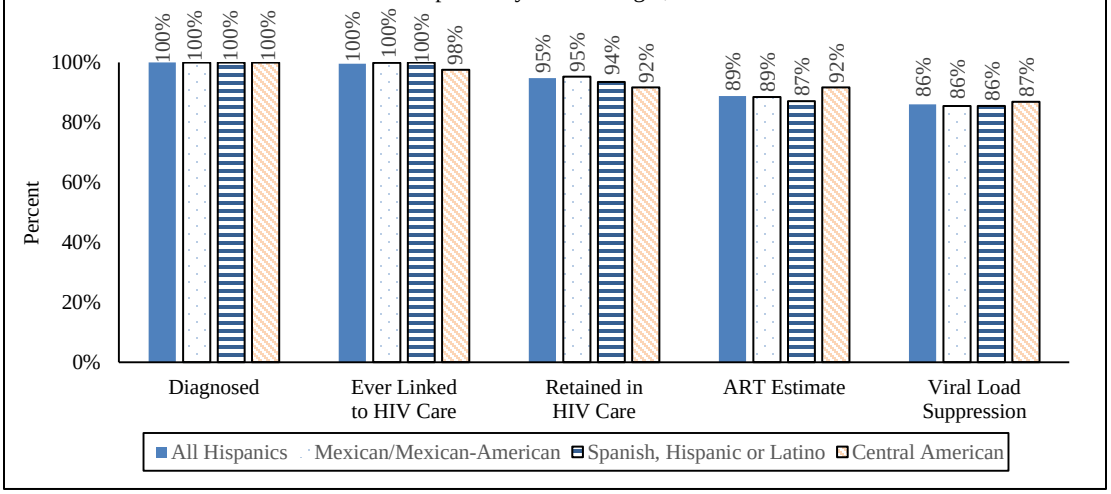
[14] David Garcia, Gabriela Betancourt, Luis Scaccabarrozzi, & Jacinto, 2016, *The HIV Crisis among Hispanics/Latino MSM.* New York, Latino Commision on AIDS.

i. Identification of emerging populations including challenges and estimated costs

All communities represented in the Orange County epidemic have previously been included in the HIV Emergency Relief Grant application. However, the Planning Council and its subcommittees Priority Setting, Allocations, and Planning (PSAP) committee as well as the Integrated Plan Committee (formerly the Prevention and Care Strategies Committee) review data of newly identified positives and high-risk populations each year to determine if there are new emerging populations as part of the planning process. A review was conducted of subpopulations such as Hispanic subpopulations. Bases on that analysis (shown below in Figure 6) PLWH who receive Ryan White Services, and the Continuum of Care does not show a disparity.

Figure 6. HIV Continuum of Care, Orange County, Ryan White PLWH: Hispanics by Ethnic Origin, 2017

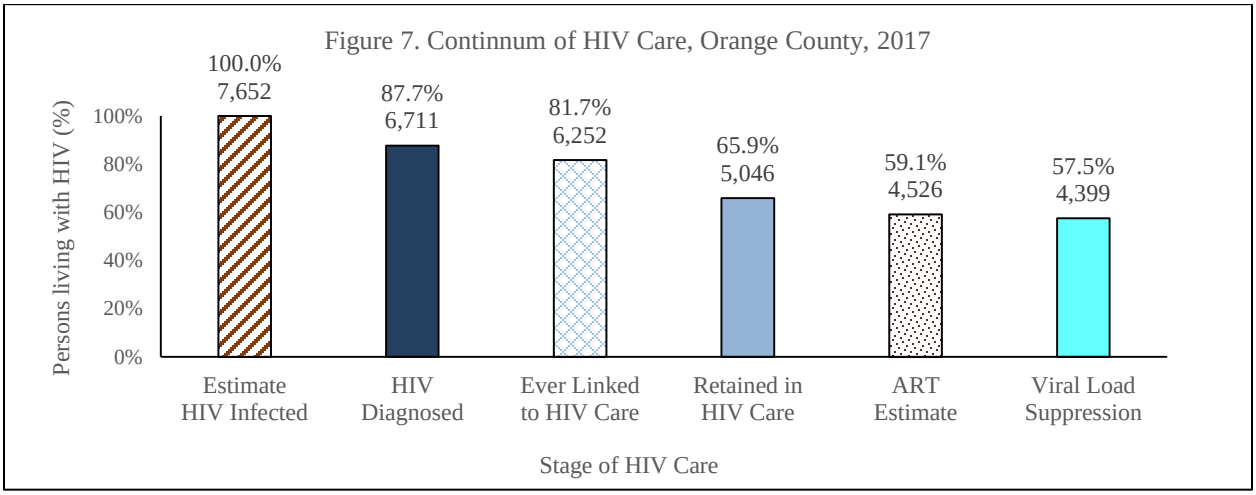


ii. Description of increasing need of HIV-related services

There was a decrease in the number of new HIV infection in 2017 compared to 2016. In 2016, there were 320 new HIV diagnoses and in 2017 there were 303 new HIV diagnoses which is a decrease of 5.6%. Despite a decrease in cases, newly diagnosed have an increased need for services as indicated in the results of the client needs survey and service utilization rates. The increased need for services in Orange County are from newly diagnosed individuals. Based on the 2017 needs survey that was completed by 21 individuals who were diagnosed between 2013 and 2017, 11% (21 of 197) of all respondents, stated they needed the following services Medical Care, ADAP, Non-Medical Case Management, Linkage to Care, and Dental Care. The top five most needed services are similar to the responses from the all PLWH except for the Linkage to Care. This level of case management assists newly diagnosed navigate the healthcare system, engage in care, and start anti-retroviral medication. This service is rarely used by people who have been living with HIV for an extended period of time and have been engaged in care. Additionally, newly diagnosed stated that the following five services were the most important ADAP, Medical Care, Prevention Services, Non-Medical Case Management, and Emergency Financial Assistance for Medications. The most important services differ from all PLWH which listed Medical Care, Dental, ADAP, Case Management, and Housing. The biggest difference is the inclusion of Prevention Services among the newly diagnosed. The importance of this service may be linked to the new diagnosis, lack of education on the safer sex practices, and/or the desire to not infect others with HIV.

2) HIV Care Continuum

The graph below (Figure 7) shows the HIV Care Continuum for all estimated PLWH in Orange County.



1. **HIV Infected**: This is the Centers for Disease Control and Prevention (CDC) estimate that includes those who know their HIV status and those who are HIV-positive but unaware of their HIV status;

2. **HIV Diagnosed**: This is the percent of individuals who are HIV-positive and aware of their status compared to the estimate of all individuals living with HIV in Orange County;

3. **Ever Linked to HIV care**: This is the percent of HIV-positive individuals who have been linked to HIV medical care (as indicated by having at least one viral load and/or CD4 count blood test after the month and year of diagnosis);

4. **Retained in HIV care**: This is persons diagnosed with HIV and whose most current address was in Orange County as of December 31, 2017 who had at least two CD4 or viral load results with at least three months in-between the first and last result. For persons diagnosed prior to 2017, the two results occurred in 2016 and/or 2017. For persons diagnosed in 2017, the results occurred between January 2017 and July 2018.
5. **Antiretroviral Therapy (ART) Estimate**: This is the estimated percent of HIV-positive individuals who are taking antiretroviral medications. Because this data is not available for Orange County, a proxy measure has been used (persons with a viral load under 200 copies/mL at their last test in 2017 and persons whose viral load has declined between the last test in 2017 and the previous test); and

6. **HIV Viral Load Suppression**: This is the percent of individuals with a HIV viral load of less than 200 copies/mL.

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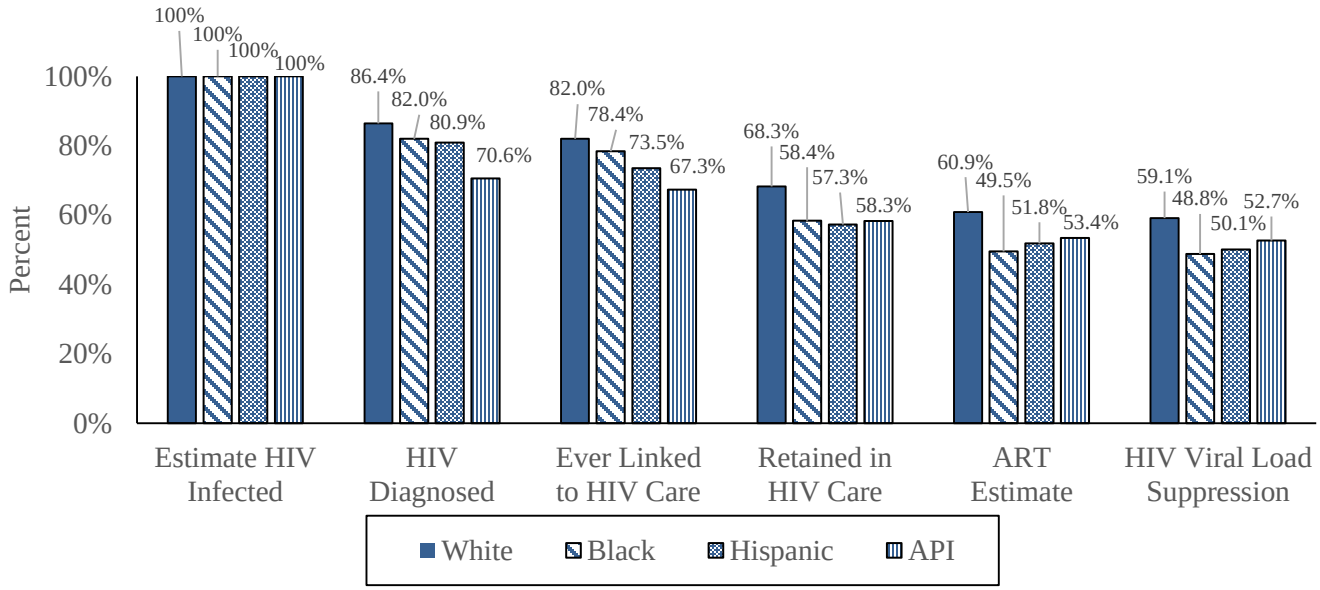
The table below (Figure 8) illustrates the HIV Care Continuum by race/ethnicity.

Figure 8. HIV Continuum of Care, Orange County, Orange County PLWH by Race/Ethnicity, 2017



As shown above, in comparing disproportionately impacted minority populations with White people living with HIV; Blacks, Hispanic, and Asian/Pacific Islander populations have lower outcomes at every step of the care continuum. Minority populations are diagnosed at lower rates, linked to care at lower rates, and eventually have between six and 10 percent lower viral load suppression rates compared to White populations. The health disparities among minority populations are clear and the Orange County TGA has begun to work with the Center for Quality Improvement and Innovation (CQII) on the end+disparities ECHO Collaborative to reduce health disparities among Men who Have Sex with Men (MSM) of color.

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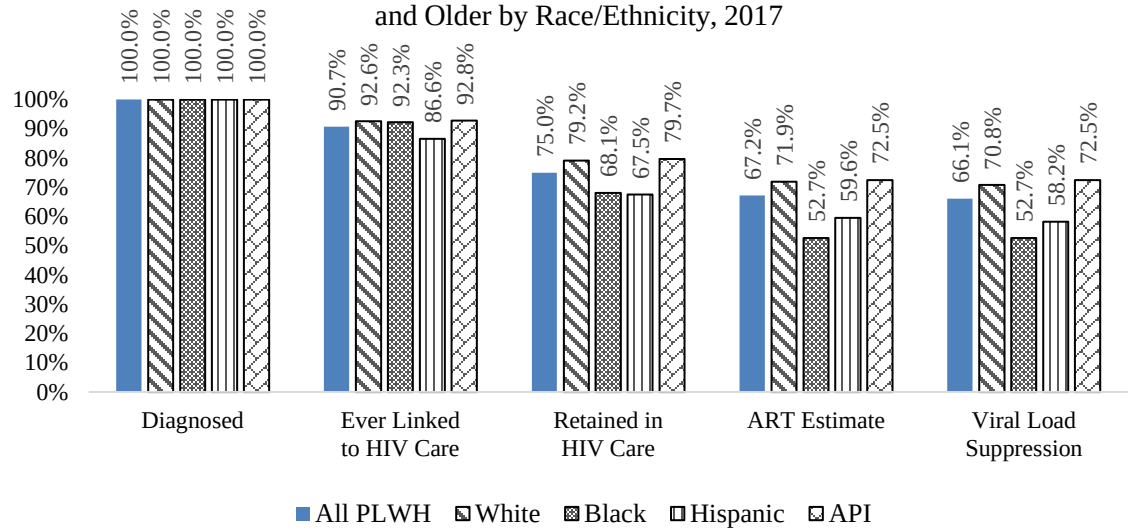
In addition, when reviewing subpopulations by age and Hispanic subpopulations, a disparity exists with older Black and Hispanic populations. In Figure 9 below, Blacks 56 years and older achieved a viral load suppression of 52.7% and Hispanic populations of the same age achieved a viral load suppression of 58.2%. These percentages are much lower compared to Whites and API populations 56 years and older that achieved viral load suppression a 70.8% and 72.5%, respectively. As Orange County works on improving viral load suppression among MSM populations of color, older populations will need to be a large part of the target population.

Figure 9. HIV Continuum of Care, Orange County, PLWH Age 56 Years and Older by Race/Ethnicity, 2017



3) Co-occurring Conditions

See **Attachment 4** for table of co-occurring conditions including Hepatitis C, STIs, mental illness, substance use disorders, homelessness, and former incarceration.

4) Complexities of Providing Care

a) Impact and response to a reduction in funding

i. Impact

In FY 2018, Orange County received a decrease in formula funding of $35,500 compared to FY 2017 (0.9% decrease). There was an overall decrease of 1.76% in total funding in FY 2018 ($6,216,093) compared to FY 2017 ($6,327,196). Based on the small decrease there were no specific services eliminated or reduced as other funding sources were available to address the identified needs in Orange County.

ii. Response

There were no cost containment measures implemented in FY 2018 because other funding sources including Ryan White Part B and Housing Opportunities for People with AIDS (HOPWA) funding was used to address the identified needs in Orange County.

b) Estimates on poverty and health care coverage status of PLWH in jurisdiction

Poverty and health care coverage estimates as of 12/31/2017:

Health Coverage	Total	Percent of total diagnosed PLWH
Estimate of PLWH who have Medicaid health insurance	1,111	17% (1,111 of 6,711)
Estimate of PLWH who have other public or private health insurance including Medicare	3,516	52% (3,516 of 6,711)
Estimate of PLWH who are uninsured	839	13% (839 of 6,711)
Estimate of PLWH living at or below 138 percent (only available for PLWH in the Ryan White system)	1,316	20% (1,316 of 6,711)
Estimate of PLWH living at or below 400 percent (only available for PLWH in the Ryan White system)	2,234	33% (2,234 of 6,711)
Percentage of FPL used to determine RWHAP eligibility	Not Applicable	Not Applicable

The HIV Planning Council (Council) in Orange County has not placed an income restriction to determine eligibility for Ryan White services. However, service qualifications have been placed on specific services to best meet the needs of the population. For example, medical transportation has an income restriction of 150% of federal poverty level (FPL). The restriction allows the Council to prioritize a population that may face a financial hardship paying for medical related transportation. The cost containment measure allows the Council to allocate funding to other services. In addition, The California State Office of AIDS, which oversees the implementation of Ryan White Part B funded services, will be implementing an income eligibility requirement limit of 500% of FPL. Orange County will implement the 500% FPL for all service categories funded by Part B. This will result in a change to the Part A eligibility criteria for Outpatient Ambulatory Care, Case Management Services, Oral Health Care, and Medical Nutrition Therapy.

c) Relevant factors that limit access to health care including service gaps

Health care coverage for HIV health services is available to everyone in Orange County; however, availability does not mean all PLWH select to use their coverage or are aware services are available. With the implementation of the Affordable Care Act (ACA), including the expansion of Medicaid, the healthcare exchange, and health insurance premium assistance, PLWH have multiple options for health care. Geographic location does not appear to be a barrier to care because on the 2017 client needs survey only 3.6% (7 of 197) of respondents stated that transportation was a challenge to receiving medical care. However, review of infectious disease specialist that are contracted with Medi-Cal and/or medical groups show that a small number of doctors (22) are available to provide care to the estimated 1,111 PLWH who have Medi-Cal. This estimate assumes that medical providers are accepting new patients. In Orange County providers have closed enrollment to patients as the number of clients enrolled at providers surpasses capacity. These providers may not be following HRSA HIV treatment

recommendations or have the capacity to serve clients who do not speak English. These barriers can make it difficult for PLWH to reach viral load suppression. In addition, for those not in care barriers and service gaps may exist such as insurance systems, the practicality of getting to medical appointments and taking medications, and financial issues[15]. Some of those challenges include the clients transitioning out of the Ryan White medical care system or through the various medical groups, and payer sources. Clients who have trouble navigating their new system of care may not be seeing their doctor on a regular basis. The Ryan White system has developed and implemented some tools that assist PLWH who have difficulty transitioning health systems, falling out of care, and those PLWH not in care. The tools include the use of Linkage to Care using the Anti-Retroviral Treatment and Access to Services (ARTAS) intervention, Outreach Services for those who have fallen out of care, and Early Intervention Services for those newly diagnosed and their partners. Additionally, newsletters and flyers are used to help support individuals by providing information and resources that may assist them in linking to or staying in care. Lastly, the Ryan White Quality Management Committee and Planning Council have approved the implementation of a peer model unitizing a community health worker model that will be used to address those individuals that are having difficulty staying in care and engaging those who are out of care.

B. Early Identification of Individuals with HIV/AIDS (EIIHA)

1) Planned EIIHA Activities for 2019 Project Period

a) Primary activities

Orange County's strategies to identify individuals who are unaware of their HIV status include:

1) Promoting HIV and STD testing as part of routine health care
2) Offering targeted HIV testing of high-risk populations in non-healthcare settings
3) Providing Partner Services (assisting HIV-positive individuals with disclosing status to sex or needle-sharing partners to promote HIV testing of partners) utilizing surveillance-based and venue-based referrals
4) Conduct Early Intervention Services (EIS) and Outreach services
5) Routine HIV and STD testing of high-risk populations that are enrolled in the county's PrEP program

Strategies 1, 2, 3, and 5 focus on identifying and informing individuals who are HIV unaware. Strategy 5, requires testing at enrollment and on-going testing every three months to diagnose an acute infection. Strategy 4, services include the use of HIV surveillance data to 1) initiate cases for Partner Services follow-up among identified partners of individuals newly diagnosed with HIV), and 2) to identify individuals who appear to have never linked to HIV care following diagnosis.

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[15] Dombrowski, Julia C. et al. "Barriers to HIV Care and Treatment Among Participants in a Public Health HIV Care Relinkage Program." *AIDS Patient Care and STDs* 29.5 (2015): 279–287. *PMC.* Web. 24 Aug. 2018.

b) Major collaboration with HIV related programs and agencies

Orange County has developed major collaborations with various programs and agencies to implement or expand some of the strategies listed above. Some of the collaborations include implementing routine HIV testing (Strategy 1) in partnership with Orange County Jails. The Health Care Agency (HCA) also partnered with UCI (AIDS Education Training Center for the Southern California region) and developed a toolkit for medical providers to implement routine HIV testing. The Orange County Medical Association (OCMA) has also promoted routine HIV testing by having a banner on its webpage with a link to toolkit information. In addition, Orange County is currently finalizing a request for applications to assist medical providers with implementation of routine HIV testing by assisting with infrastructure development. Community based HIV testing providers have built strong alliances to offer HIV testing in areas where high-risk individuals congregate including gay bars, sex parties, syringe service programs, and night clubs (Strategy 2). Strategy 3 (Partner Services) collaborate with high volume STD and HIV medical sites to refer individuals with positive screenings in order to solicit partners that are at high-risk for HIV and/or STDs. In addition, implementation of surveillance-based activities required extensive teamwork with surveillance staff to implement effective coordination of case assignments. To facilitate streamlined surveillance activities, Sr. Public Health Investigators (PHI) now conduct HIV/AIDS case reporting as well as follow-up with newly diagnosed for initiation of Partner Services. Early Intervention Services are carried out utilizing a multidisciplinary approach. Ryan White providers, and PHI staff work collaboratively to implement strategy 4.

c) Anticipated outcomes of the overall EIIHA strategy

The overall outcomes for EIIHA include the reduction of HIV transmission; an increase in individuals who know their HIV status (positive or negative); and, for individuals who are HIV-positive, EIIHA activities will result in early diagnosis, linkage to care, and ultimately viral load suppression. Listed below are some of the expected outcomes in 2019 related to EIIHA activities.

Activities	Anticipated 2019 Outcomes
Routine HIV testing at Orange County jails	• 0.15% positivity rate
HIV testing in non-healthcare settings	• 1% positivity rate • 95% of newly identified HIV positive individuals will be informed of their test results • 85% of newly identified HIV positive individuals will have a documented Verified Medical Visit within 30 days of diagnosis
Early Intervention Services	• Orange County is currently measuring the number of elicited contacts from newly diagnosed individuals that are tested for HIV to determine a goal for 2019.

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2) Description of Efforts to Remove Legal Barriers, State Laws, and Routine HIV Testing

The EIIHA strategy also includes efforts to enhance awareness and enforce state legislation that has been put in place to reduce barriers to routine HIV testing in healthcare settings. In 2008, two bills were passed and are consistent with CDC's revised 2006 guidelines recommending routine HIV screening. Assembly Bill 682 eliminated the requirement for written consent for an HIV test when ordered by a medical care provider and Assembly Bill 1894 required medical plans and insurers to cover routine HIV testing. In addition, to assist medical providers in implementing routine HIV testing, Orange County worked with the AIDS Education Training Center to create an online toolkit to implement for healthcare settings. The toolkit includes sample policies, billing examples, scripts for disclosing test results, and various materials for promoting routine opt-out testing. Orange County is currently finalizing a request for applications to implement the routine opt-out testing toolkit and assist medical providers with implementation of routine testing by developing infrastructure development around testing procedures, billing, and patient navigation to HIV care.

3) Description of Three Target Populations for the 2019 Project Period EIIHA Plan

Orange County's EIIHA target populations are MSM, substance users, and incarcerated individuals. The narrative below describes data supporting the need to target these populations for EIIHA strategies, challenges and opportunities in working with these populations, and strategies aimed at improving outcomes for these groups.

MSM

- **Supporting Data:** According to epidemiological data MSM made up 70.3% of new Orange County HIV cases in 2017. Over the last five years, 76.9% of new infections is attributed to this risk population.
- **Challenges and Opportunities:** Some of the challenges when targeting this population include MSM who do not understand the risk of HIV, may not be concerned about HIV transmission if they use condoms or have one partner, fear of the stigma associated with testing or finding out one's status, and more specifically in the Latino MSM community there is also stigma and fear, language barriers, legal status issues, and lack of knowledge related to HIV transmission[16]. With the implementation of Pre-Exposure Prophylaxis (PrEP) programs; there is an opportunity to increase efforts to reach MSM and provide comprehensive HIV prevention services.
- **Activities:** HIV testing for MSM unaware of their status including STD screening for Gonorrhea, Chlamydia, and Syphilis. Routine testing in the medical care settings provide an opportunity to test MSM that may be afraid to go to traditional HIV testing sites. The following will be completed by December 2019 in order to achieve EIIHA goals for MSM:
    - HIV testing for 3,000 MSM unaware of their status and linkage to care for those testing HIV-positive. Additional tests may be conducted as an STD testing media campaign is currently in development.

[16] Brooks, R. A., Etzel, M. A., Hinojos, E., Henry, C. L., & Perez, M. (2005). Preventing HIV among Latino and African American Gay and Bisexual Men in a Context of HIV-Related Stigma, Discrimination, and Homophobia: Perspectives of Providers. *AIDS Patient Care and STDs*, *19*(11), 737–744. http://doi.org/10.1089/apc.2005.19.737

- Provide PrEP education to 600 MSM
- The continuation of Orange County's campaign "HIV, it's a human thing" designed to create awareness of and decrease stigma about HIV (one example of the logo is shown on the right). Orange County has recently secured funding to expand the campaign and use the logo with various taglines on digital platforms, buses, and bus shelters.

Substance Users

- **Supporting Data:** Persons who Inject Drugs (PWID) made up 5.3% of new infections in 2017, an increase of 3.1% compared to 2016. If combined with the MSM/PWID population, that percentage increases to 7.3%. This combined group made up the third largest number of new infections behind MSM and those who stated heterosexual contact as their risk factor in 2017. Additionally, 24.4% (43 of 176) of respondents of the 2017 Client Needs Survey stated that they had used a recreational street drug such as marijuana, cocaine, meth, or heroin in the past 12 months.
- **Challenges and Opportunities:** Some of the challenges reaching this population include the fact that PWID are found within homeless, incarcerated, and impoverished communities. These communities are difficult to gain access to if there are no established linkages or gatekeepers that can facilitate access. Furthermore, substance users are less likely to access healthcare or HIV testing when dealing with addiction, homelessness, or extreme poverty. Some PWID believe sharing needles with a small circle of friends will prevent the transmission of HIV. Without appropriate education related to risk reduction techniques, these beliefs could actually lead to increased transmission. Lastly, use of drugs can cloud judgment and increase risky behaviors. As indicated in the results of the Needs Survey, individuals want increased access to substance use services. However, currently there is no waiting list for treatment. There may be a lack of knowledge about available treatment services. As targeted testing is conducted with this population, there is an opportunity to address the needs of this population.
- **Strategies:** In order to reach this population and achieve the goals of the EIIHA Plan, efforts are focused on opt-out testing in community clinics and emergency rooms that treat the uninsured and Medicaid populations. This will hopefully increase HIV testing for PWID that have sought out medical care for a variety of conditions. This group may include individuals who are currently using drugs and have not been engaged into treatment. In order to achieve these goals, the following activities are directed at PWID for the 2019 calendar year:
  - HIV testing for 350 PWID that unaware of their status and linkage to care for those testing HIV-positive

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Incarcerated Individuals

- **Supporting Data:** Individuals that are frequently incarcerated can fall through the cracks in the health care system. Individuals that are incarcerated can also have difficulties restarting their lives upon release from jail. Since 2012, the state of California has shifted the burden of housing non-violent offenders on to the local jails instead of state prisons; this has caused a dual system at the local level that has some offenders incarcerated for years at the local jail instead of simply transitioning through local jails to prison. In addition, some offenders are spending less time incarcerated than in the past because open beds are used for more violent crimes with offenders staying in the local jails for extended periods. Medical care inside of jails now requires that systems are in place to treat long term chronic illnesses. In 2015 and 2016, three percent (3%) and five percent (5%), respectively, of all new HIV-positive tests occurred in correctional facilities. In 2017, the percentage increased to 6% (17 of 303). In the six years that routine testing has occurred in the five Orange County jails, there have been just over 23,000 tests conducted with an average positivity rate of 0.28%. This rate is much higher than the goal for routine HIV testing in healthcare settings of 0.1%. In 2017, 19% (3 of 17) of the newly identified HIV-positive individuals identified in the jails reported being a PWID.
- **Challenges and Opportunities:** Some of the challenges working with this population involve stigma by fellow inmates. An individual might be hesitant to take an HIV test because of fear of being ostracized. In addition, incarcerated individuals who are currently using drugs may not want to be involved with the medical care system to avoid detection. Within the incarcerated population individuals who do not identify as MSM, but engage in MSM activities, may refuse testing so as not to be associated with this population. Engaging in activities that are stigmatized (i.e., homosexual behavior) may prevent individuals from seeking HIV testing as finding out one's HIV status may reduce one's social standing. As presented in the data above, testing in the jails has been a very effective strategy in identifying individuals who are HIV positive but were unaware and individuals who have fallen out of care. Jail testing provides the opportunity to inform individuals of their status and link or re-engage individuals in care.
- **Strategies:** Routine HIV testing and standardized procedures to diagnose, evaluate, and treat sexually transmitted infections including Chlamydia, Gonorrhea, Syphilis, and Hepatitis C. Screening inmates for STIs, will hopefully identify those individuals that would not normally take an HIV test, but may be a higher risk for HIV.

  In order to increase the number of incarcerated individuals aware of their HIV status by the end of 2019:
  - 5,000 inmates will be tested throughout the five local county jails and HIV-positive individuals identified will be linked to care

C. AIDS Pharmaceutical Assistance (LPAP)

Orange County does not fund a Local Pharmacy Assistance Program; therefore, this section of the application is not applicable.

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METHODOLOGY

A. Impact of Changing Health Care Landscape

1) Description of Health Care Coverage Options in the Jurisdiction

a) Description of how coverage options negatively or positively influence access to health care services and outcomes

In Orange County, persons living with HIV (PLWH) access HIV medical care utilizing the following coverage options:

- Medicaid (Medi-Cal in California) or Medicare: Approximately 48% of those who access health care services have Medicaid. Nearly 5% of the population utilized Medicare.
- Private Insurance: Almost 11% of PLWH have private insurance.
- Grant-funded Care: 35% of PLWH utilize Ryan White (Parts A, B, or C) to access medical care.

Expansion of options for care via the Affordable Care Act (ACA) has positively influenced access to care. It has led to increased options for care for a significant proportion of the population. Ryan White care is limited to outpatient HIV care and therefore, individuals who obtain Medicaid or private insurance have expanded access to health care services including coverage for hospitalization, non-HIV related care, and access to urgent care services when needed. However, one negative impact of coverage is that individuals in public and private care continue to have worse health outcomes compared to their Ryan White counterparts. Public and private insurance often require significant navigation to access services, including access to an HIV specialist. This may result in barriers to care for individuals, especially those who have previously accessed services under Ryan White. Ryan White services offer one-stop services where an individual can see their primary care/HIV specialist, access case management services, and are screened for service eligibility in one location. Ryan White services also offer an expansive support continuum to help individual stay engaged in care. Public and private health care providers may be unaware of the comprehensive services available for their patients. The AIDS Education Training Center and Medical Director for Orange County Ryan White services continue to work with community medical providers to educate and support improvements in health care delivery to improve health outcomes for all PLWH in Orange County.

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2) Description of the Impact of the Changing Health Care Landscape

a) Service provision and the complexity of providing care to PLWH in the TGA

Enrollment in ACA expansion continues to increase in Orange County. Before 2017 open enrollment, 359,480 individuals had signed up for private insurance plans through Covered California (health care exchange in California) statewide. In Orange County, based on information from Covered California, 40,440 individuals enrolled for health insurance for 2018 in Orange County.[17] Individuals obtained various insurance plans under insurance providers as detailed below:

- Blue Shield of California: 13,980
- Health Net: 12,980
- Kaiser Permanente: 8,070
- Molina Healthcare: 930
- Oscar Health: 4,480

As successful as the healthcare exchange and Medicaid (Medi-Cal in California) have been in enrolling individuals for healthcare coverage, it has placed a strain on the limited number infectious disease physicians or HIV specialists. The complexity of providing care under insurance plans is that various doctors or networks have stopped accepting new enrollees or have discontinued contracts with networks to see patients. These changes appear to occur more with clients with Medicaid coverage. These changes place the burden on PLWH to find new medical care and transition through different networks and medical providers. The difficulty of this navigation can lead to a higher number of PLWH falling out of care. In order to support PLWH, the case management system has been revised to allow more assistance in helping navigate the health insurance landscape. Case managers have increased their understanding of the healthcare networks, availability of HIV specialists, and have assisted PLWH in picking a health plan that works for them. In addition, some of the case management agencies are certified enrollment entities for the healthcare exchange to further facilitate the enrollment process.

In 2018, there has been increased concern about health care options due to the uncertainty of ACA. These concerns may significantly impact the 2019 Open Enrollment process. To help mitigate these concerns, additional staffing is being trained to assist with insurance enrollment and answer any concerns clients may have.

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[17] Covered California (2018, February, 4). *Covered California: 2018 Open Enrollment Profile.* Retrieved from The California Health Benefit Exchange http://hbex.coveredca.com/data-research/

b) Changes in Part A allocations, including activities related to health insurance premiums and cost sharing assistance

There have been four significant changes in Part A allocations since the implementation of ACA:

1. Funding for Outpatient Ambulatory Health Services has decreased by over 7% from $1,433,007 in FY 2014 to $1,328,173 in FY 2018.
2. Funding for Mental Health Services have decreased from $192,092 in FY 2014 to $55,000 in FY 2018, signifying a 71% decrease.
3. Funding for the range of Case Management Services has increased to better assist with navigation and help reduce those falling out of care. The total allocation increased by 9% from $1,721,049 in FY 2014 to $1,878,014 in FY 2018. However, the total allocation does include a significant increase in HOPWA funding. The FY 2018 Part A allocation is only $1,603,983.
4. Funding for Health Increase Premium Cost Sharing Assistance initially increased after the full implementation of ACA but has recently decreased. The service provides temporary assistance to individuals who are applying for the State program (Office of AIDS-Health Insurance Premium Payment [OA-HIPP] Program). In FY 2014, the allocation was $97,010 compared to $85,000 in FY 2018, representing a 12% decrease in funding. The decrease in funding is a result of the expansion of OA-HIPP and the decreased timeframe by which an individual can be screened for and enroll in OA-HIPP. In FY 2018, Office of AIDS (OA) has expanded coverage for AIDS Drug Assistance eligible clients to provide Employer-Based HIPP to cover the client (employee's) portion of their employer-based insurance premiums. The OA Medicare Part D Premium Payment Program pays monthly premiums and Medigap payments for eligible clients. Eligible individuals may also receive assistance to pay for medical out-of-pocket expenses.

In addition, in January 2018, Medicaid reinstated Adult Dental coverage. This expansion may have a positive impact on Ryan White funding and decrease the level of funding currently allocated to Oral Health Care under Ryan White. However, it is too soon to know the impact of the expansion of coverage as a review of the first six months of 2018 does not show savings.

The Grant Recipient also continues to submit annual requests for the waiver to the Core Medical Services allocation to allow flexibility in allocation funds to the areas of greatest need that also have the potential to make the best impact on improving Orange County's HIV Care Continuum.

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B. Planning Responsibilities

1) Planning and Resource Allocation

a) Description of Community Input Process

i. Involvement of PLWH in the planning and allocation processes

The HIV Planning Council (Council) places PLWH at the forefront of decision and policy making. The Council and the Priority Setting, Allocations, and Planning (PSAP) Committee are composed of a diverse group of individuals, many of whom represent historically underserved populations. The Council ensures participation of PLWH members in all of its processes. During the majority of the planning process, four (29%) of the 14 voting members of the Council were unaligned consumers. The Planning Council has an Affiliate Program that helps mentor individuals. Affiliates are consumers who are able to comment and participate like a regular member. Affiliates may also vote on Council issues when PLWH members are absent from meetings. The affiliate seats provide an opportunity for PLWH to become comfortable with the planning process before undertaking the commitment to be a member. The PSAP Committee, responsible for priority setting and resource allocations, consists of seven members, two (29%) of whom are PLWH. The HIV Client Advocacy Committee (HCAC), another subcommittee of the Council consists of seven members who are all PLWH, also met to recommend its priorities for FY 2019 to the PSAP Committee and Council. HCAC involvement is an important component that allows for stronger consumer feedback on services that are vital to the health of PLWH.

All officers (3 of 3) of the Council are PLWH. One of the two PSAP officers is a PLWH. All officers are sensitive to the range of experiences of members and make every effort to explain terms, processes, and decision-making protocols at each meeting. Furthermore, the Grant Recipient offered tutorials prior to Council meetings and conducted trainings during the meetings to help members better understand the epidemiological, expenditure, and utilization data presented so that all members could more fully and actively participate in the priority setting and allocation process. Tutorials and trainings help ensure that all members of the committee, especially PLWH, who may be less comfortable with the complexities of data and information presented, have the opportunity to learn and better understand data required in determining priorities and allocating funds.

Participation of PLWH on the Council, PSAP, and HCAC helps to ensure involvement of PLWH in the planning and allocation process. The review of data from client needs surveys, satisfaction surveys, focus groups, and interviews also helps to ensure PLWH priorities are considered in planning.

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ii. Consideration of community input process including addressing changes in Part A award

Community input is gathered in multiple ways. All Council and committee meetings are open to the public. There is an extensive guest list for all meetings to ensure interested community members have the opportunity to attend and provide input at meetings. All meeting agendas have two public comment sections: 1) public comment at the beginning of the agenda which provides dedicated time for the public to speak on any subject, ask questions, or make general recommendations and 2) public comment prior to taking a vote on any action item on the agenda. Public comment for action items allows the public a time to provide input and recommendations for consideration prior to the committee or Council voting on the item.

Upon receipt of the Part A Notice of Full Grant Award, a memo is distributed to Council and subrecipients to inform them of any increase or decrease in funding. Based on award, the Council will review and approve reallocations that reflect changes in need or service utilization. Prior to the reallocation process, subrecipients have the opportunity to request reallocations based on service and expenditure trends. The PSAP Committee is traditionally first to review the proposed revisions. Based on PSAP's recommendations, the proposed reallocations are reviewed by the Executive Committee prior to being forward to Council for final approval. Community members have the opportunity to provide input at any or all of the committee meetings. In addition to considering Part A awards, the reallocation process considers how other funding sources (e.g., Part B, Part C, HOPWA, and public/private insurance) support costs for service delivery.

iii. Consideration of MAI funding during planning process to enhance services to minority populations

MAI funding has traditionally funded programs geared at meeting the unique needs of minority populations in Orange County. MAI funding contributes to the Medical Case Management and Case Management: Non-Medical allocation which funds staff who provide culturally and linguistically appropriate care for Hispanics and African Americans. The Council has traditionally utilized MAI for case management services because the navigation and support needs of minority populations are best met by having a dedicated case manager. The MAI allocation was considered in the annual planning process. Outcomes associated with MAI services were reviewed and continue to support the effectiveness of MAI programs.

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iv. Description of use of data to increase access to core medical services and reduce disparities

The following provides a brief overview of the data sources reviewed and how they are used for annual planning:

Data Type	Use of Data
Epidemiological	Data used to identify trends in epidemic including any emerging populations or disproportionately impacted communities
Unmet Need	Data used to: • Identify successes/failures in keeping individuals in care • Identify priority populations for care engagement and retention activities
Early Identification of Individuals with HIV/AIDS (EIIHA)	Data used to: • Identify successful strategies in identifying and informing individuals of their HIV status • Identify priority populations for Early Intervention Services activities • Prioritize future funding for EIIHA activities
HIV Care Continuum	Data used to: • Identify successes and gaps in improving outcomes along the Continuum • Prioritize future funding and targeted intervention/services
Service Utilization and Cost	Data used to: • Identify trends in service utilization by demographics, including WICY and minority populations • Identify increase, decrease, or gaps in service need • Identify trend in costs by service categories • Prioritize future funding for service categories
Needs Assessment	Data used to: • Identify real and perceived needs • Identify service gaps • Prioritize future funding for service categories
Prior Resources	Data used to: • Identify other funding sources available to meet needs of PLWH • Prioritize future funding for service categories

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v. Significant changes in the prioritization and allocation process and rationale for making changes

There has been increased efforts and activities to help ensure the Council and its committees make data-based decisions. Beginning with the FY 2017-18 priority setting process, a spreadsheet was created that included data on the following:

- Percent of those retained in care for each service category that retention in care data was measured
- Percent of those virally suppressed for each service category that viral load suppression data was collected
- Prior year service utilization to see how many individuals utilized each service category
- Top 10 most important services as indicated in the 2015 and 2017 Client Needs Survey
- The number of estimated individuals unaware of their HIV status and the fact that 30% of new HIV infections are attributed to those who are unaware of their status
- The number of individuals who are out of care and the fact that individuals who are aware of their HIV status but out of care are estimated to be responsible for 61% of new infections
- The estimate number of individuals living in Orange County who are not virally suppressed

During the FY 2019-20 priority setting process, PSAP members participated in a data musical chairs activity. The activity included the review of data cards that included information regarding those not retained in care and the percent virally suppressed for multiple service categories, but the service category information was missing. Based on the data, members were to score the card as follows: 1) unknown if the service improves health of PLWH, 2) Doesn't improve health of PLWH (viral load suppression percent for service is 60% or under), 3) Slightly improves health of PLWH (viral load suppression percent for service is 61%-70%), 4) Moderately improves health of PLWH (viral load suppression percent for service is 71%-80%), and 5) Significantly improves health of PLWH (viral load suppression percent for service is 81% or higher. This activity was implemented to reduce the tendency for committee members to rate a service category a higher priority because either the PLWH needs the service or the service provider offers the service. Once the ranking was completed, members were provided with information on the actual service categories based on their anonymous ranting and were given the opportunity to discuss differences in service priority ranking based on data alone.

The decrease funding scenario is the most difficult allocation scenario to create. Last year, the PSAP committee participated in an activity that reviewed cost per client and cost per unit data and based on the cost alone, members were asked to indicate if the costs increased, decreased, or remained unchanged compared to the prior year. Based on the expenditure data, members indicated if there should be a decrease in a service category funding.

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For the FY 2019-20 decrease funding scenario, a different activity was conducted. This activity tasked members with ranking the following criteria (with 1 indicating that the data should be considered first in decreasing funding and 6 indicating that the information should be considered last in a reduction scenario): 1) Other funding available for the service, 2) Expenditure trends for the past two years, 3) if the service is a core service or support service, 4) If the service category has a proposed increase in funding for FY 2019-20, 5) The ability to reallocate funds based on identified need, and 6) The number of clients that have accessed the service. Once the criteria was ranked, members were given a spreadsheet with the data for consideration for each service category. They used the data and the ranking criteria to propose the FY 2019-20 decrease funding scenario.

Each year, the Grant Recipient has tried to identify different ways to look at data in helping to make service priority and allocation decisions. The rationale for these activities is that it reduces the likelihood that members will continuously make the same decisions as previous years and it promotes using data for the decision making process. While these activities may not result in significant changes in service priority or funding recommendations, this process allows for individuals to review data in different ways that support the decisions being made.

2) Administrative Assessment

a) Assessment of grant recipient activities to ensure timely allocation, contracting, and payments

The Orange County HIV Planning Council's Executive Committee which is comprised of leaders from the Planning Council (Council) and its subcommittees serve as the oversight body for the Assessment of the Administrative Mechanism. In 2017, the committee revised its process for conducting the assessment from previous years to ensure the review being conducted by the committee focused on assessing the Grant Recipient's activities for timely allocation of funds, contracting services, and reimbursement payments to subrecipients. To assess the activities, the committee reviewed a summary of records which included the following:

- **Contracting and amendment process**: This review included a timeline for the execution of contracts based on the Council approved level funding and any contract amendments based on approved reallocations. The average number of business days between Council's action and amended contracts was 21 business days.
- **Reimbursement process**: Contracts require payment of subrecipients no later than 21 days from the receipt of a correct invoice. The Council was given a report that outlined each provider (indicated as provider A, B, C, etc.) and each invoice received for the year. The date the original invoice was received, the date of returned invoices, if applicable, the date of corrected invoices received (which may be the same as the original invoice for some invoices), the date the invoice was submitted for payment, and the date the invoice was paid. The average number of business days for subrecipients to receive payment was eight business days. There were over 60 invoices paid during the period being reviewed and only five payments exceeded the 21 days. Details were provided regarding payment delays, most of which were due to the process of closing out the county fiscal year.

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In addition to the records review, Council members completed a survey regarding communication from the Grant Recipient about the process to ensure funds are rapidly allocated and disbursed. The survey was conducted on April 11, 2018. A total of nine of 11 (82%) Council members in attendance and served on the Council the previous year completed the survey. The following are highlights from the survey responses:

1. The Grant Recipient provided sufficient epidemiological data (i.e., number of living PLWHD, HIV Care Continuum, unmet need, etc.) to identify the populations and areas of greatest need in Orange County. The average rating for agreement was 3.44 of 4.00.
2. The Grant recipient provided adequate data (i.e., service utilization, client needs survey data, performance outcomes, cost data, etc.) for the priority setting and allocation process. The average rating for agreement was 3.56 of 4.00.
3. The Grant Recipient provided the Planning Council with an overview of the Priority Setting, Allocations, and Planning (PSAP) committee process used to develop priorities and funding allocations. The average rating for agreement was 3.50 of 4.00.
4. The Grant Recipient followed funding amounts to service categories that the Planning Council approved during the allocation or reallocation process. A total of eight respondents answered yes to this question (88.8%). One member indicated don't know.
5. The Grant Recipient provided reports on expenditures and client utilization quarterly. A total of eight respondents answered yes to this question (100.0%). One member did not respond to this question.
6. The Grant Recipient provided information on provider reimbursement timeframes to show providers were paid in a timely manner or provided an explanation of reason for delayed payments. A total of eight respondents answered yes to this question (100.0%). One member did not respond to this question.
7. The Grant Recipient provided information on the timeframe from Planning Council allocations or reallocations to amendments to provider contracts. The timeframe overview spreadsheet (also called records review) was provided and reviewed at the April 11, 2018 meeting. A total of eight respondents answered yes to this question (100.0%). One member did not respond to this question.

b) Overview of any corrective actions to address identified deficiencies and findings

There were no corrective actions required to address deficiencies or findings. The Executive Committee recommended a change to the allocations/reallocations report format to show the changes to the service category funding approved by the Council.

3) Letter of Assurance from Planning Council Chair

See **Attachment 6** for letter of assurance from the Planning Council Chair.

4) Resource Inventory

a) Coordination of Services and Funding Streams

i. Table of jurisdictional HIV resources

A table outlining Orange County's resources inventory is included as **Attachment 5.**

ii. Description identifying needed resources and/or services in the jurisdiction

The Council undertakes detailed priority setting and allocation processes in accordance with HRSA-recommended steps to ensure that HIV services are provided in a coordinated, cost-effective manner that ensures Ryan White is the payer of last resort, but also ensure that Part A funding is allocated to address service gaps in the community. These processes consider the availability and distribution of all funds for services including other Ryan White Act Programs (Ryan White Act Parts B and C, Minority AIDS Initiative funds, and ADAP) and other State, Federal, and County resources received within the TGA. The Orange County TGA does not receive funds from Part F-Special Projects of National Significance (SPNS), or the Dental Reimbursement program; this places further burden on Part A funding to maintain the continuum of care. In 2012, AltaMed Health Services, Orange County was awarded Part D funds to address the needs of women, infants, and youth living with HIV.

The Council continues to identify needs related to ensuring individuals are aware of their status, linked to services, and retained in medical care. Funding resources will always be limited and Orange County utilizes opportunities to apply for grant funding whenever it becomes available. Subrecipients are also utilizing 340B and other revenue streams to support Ryan White services. Furthermore, the Council continues to request a waiver to the requirement that 75% of Part A funds be allocated to Core Medical Services. The waiver allows the TGA flexibility in funding those services that help support and encourage retention in care.

WORKPLAN

A. HIV Care Continuum Table and Narrative

1) HIV Care Continuum Table

A table outlining Orange County's HIV Care Continuum is included as **Attachment 7.**

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2) HIV Care Continuum Narrative

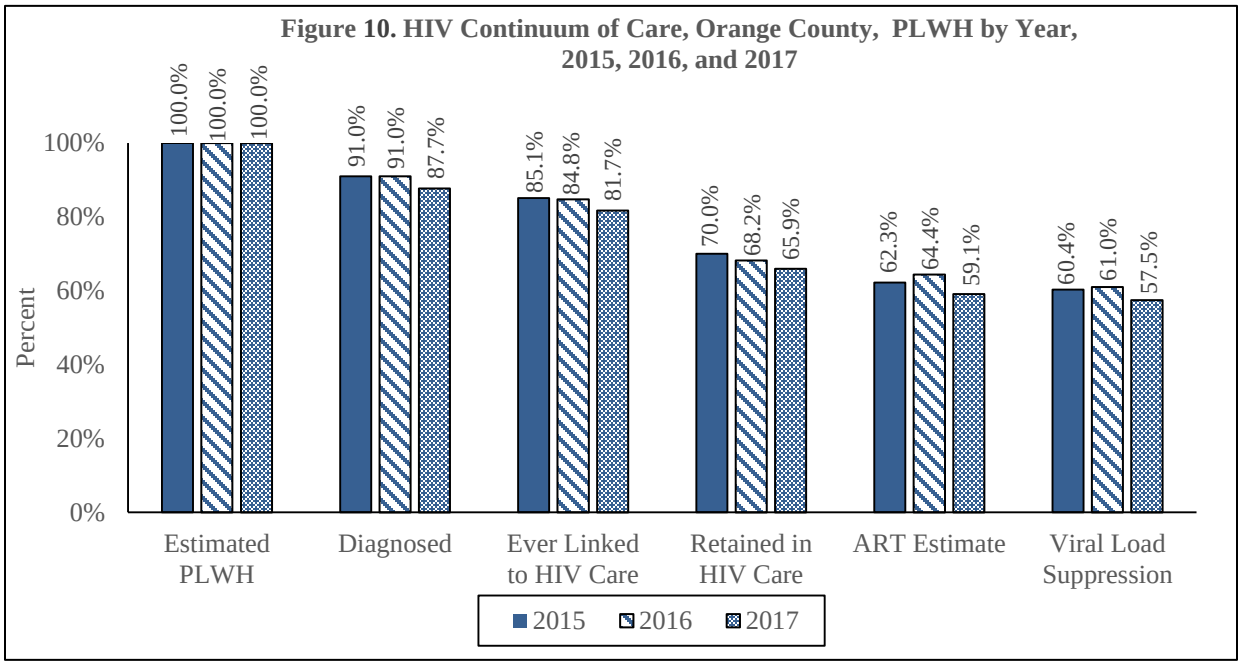
a) Utilization of HIV Care Continuum in planning, prioritizing, and monitoring the needs of PLWH

The Grant Recipient has worked closely with the HIV Planning Council (Council) and its subcommittees, the Priority Setting, Allocation, and Planning Committee (PSAP), Integrated Plan Committee (previously the Prevention and Care Strategies Committee), and the Ryan White Quality Management Committee to actively use the HIV Care Continuum in the planning and prioritizing of Part A funding, as well as being a tool utilized for monitoring available resources in the following ways:

Task	Activities
Planning	• An evaluation of testing site data (focused testing events, emergency room diagnosis, routine HIV testing, or newly confirmed positive tests from STD specialized clinics) was reviewed to develop strategies that would increase testing of those unaware of their HIV status. Data was reviewed on the demographics of newly diagnosed individuals to identify trends or emerging populations. • Data was reviewed for linked to and retained in care to ensure that diagnosed individuals are being appropriately linked to care and engaged in care. • Activities were conducted with committees on how to understand the Continuum which included identifying the number of clients who have fallen out of care at each step of the Continuum. In addition, Continuums based on demographics that show, for example, Hispanics and MSM populations in order to understand disparities among these subpopulations. • Linkage to care and retention in care data for each service category is also reviewed to identify services that support improving the care continuum.
Prioritizing	• The impact of services on the HIV Continuum was considered during the service priority process. For example, Early Intervention Services was ranked as service priority 7 in FY 2019 whereas in the previous year, it was ranked lower at number 11. This service was moved up in priority based on the fact that Early Intervention Services is one of the few Ryan White services that contribute to improving the HIV diagnosed stage of the continuum. This service would assist with the 941 individuals who are estimated to be living with HIV in Orange County but do not know their status. The impact of services on viral load suppression was also considered during the prioritization process. For example, viral load suppression for Ryan White Mental Health services was 93%, which demonstrates the ability to improve the care continuum, and was ranked as service priority 4. • In addition, committees' evaluated information from the FY 2017 client needs survey, FY 2018 health outcomes, service utilization data, as well as recommendations from the HIV Client Advocacy Committee to determine the importance of priority of services to increase the likelihood of improving engagement at each stage of the Continuum.
Monitoring	• The Ryan White Quality Management Committee will review data on linkage to care, retention in care, and viral load suppression on a quarterly basis. • Local and national Care Continuum data is presented to the Council annually to monitor progress. • Data is also monitored when reviewing strategies to address the National HIV/AIDS Strategy.

b) Changes in HIV care continuum from 2015-2017 and its impact on program

Figure 10 compares the care continuum from 2015-2017 for all PLWH in Orange County, which shows that the percentages of each stage of the continuum have remained stable (within 5 percentage points) in the past three years. In 2017, however, there was a decrease in the percentage of individuals diagnosed with HIV because the percentage was based on the updated Centers for Disease Control and Prevention (CDC) estimate. The decrease in percentage when there is an increase in the actual number relates to changes in the CDC back calculation for those estimated to be living with HIV. The new estimates has lowered the percent that was diagnosed from 91% to 87.7%, thus increasing the percentage estimated to be unaware of their HIV status.



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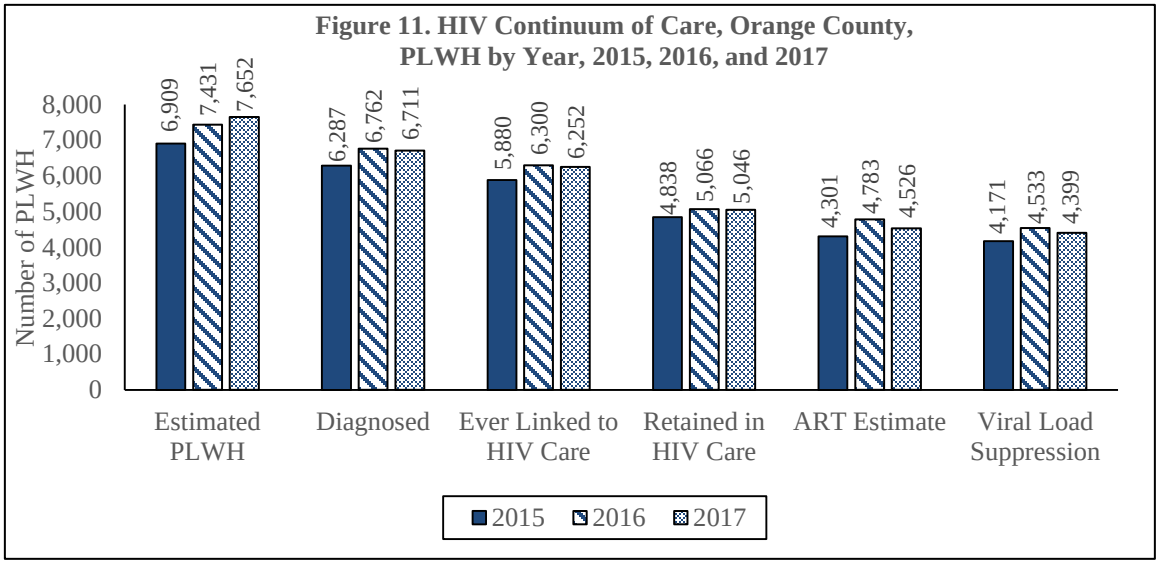
However, when reviewing the actual number of individuals in each stage of the continuum (see Figure 11), there has been an increase in individuals engaged in each stage of the continuum in from 2015 to 2016. In 2017, there was a slight decrease in the number of individuals along the continuum compared to 2016. The decrease in the number of individuals diagnosed is attributed to better access to data for individuals living with HIV. Orange County now has access to the state's HIV records, eHARS, which has helped with identifying clients who have moved out of the county or were deceased. The decrease in the number of individuals diagnosed also decreased the number of individuals in the subsequent stages of the HIV Care Continuum. Although there was a decrease in individuals along the continuum from 2016 to 2017, the number of individuals remains higher than 2015. For example, viral load suppression decreased from 60.4% in 2015 to 57.5% in 2017; however, there was actually a 5.5% increase (from 4,171 in 2015 to 4,399 in 2017) in the actual number of clients who were virally suppressed.



The figures above show that the largest gap in the Orange County HIV Care Continuum in the last three years continue to be between those who have ever linked to care and those who are retained in care. Based on this, the Council has ranked Outreach Services at service priority 8 for FY 2019 because of the potential impact in can have on retaining clients in HIV Care. This ranking is higher than the previous year, where it was ranked as service priority 10. The Ryan White Outreach Services Program focuses on identifying, finding, and engaging clients who have been out of Ryan White medical care back into care. Beginning in 2018, a component of this program also includes data to care outreach, which utilizes surveillance data (HIV viral load and/or CD4 labs) to identify individuals who: 1) has not been informed of their HIV-positive status, 2) has never linked to care after HIV diagnosis, or 3) has fallen out of care (no HIV lab reported in 18 months). Data to care outreach help clients engage with an HIV medical provider regardless of whether they receive their medical care from a Ryan White provider or an outside provider. To support these efforts, the Council has increased the allocation by 60%, from $50,000 in FY 2018 to $80,000 in FY 2019.

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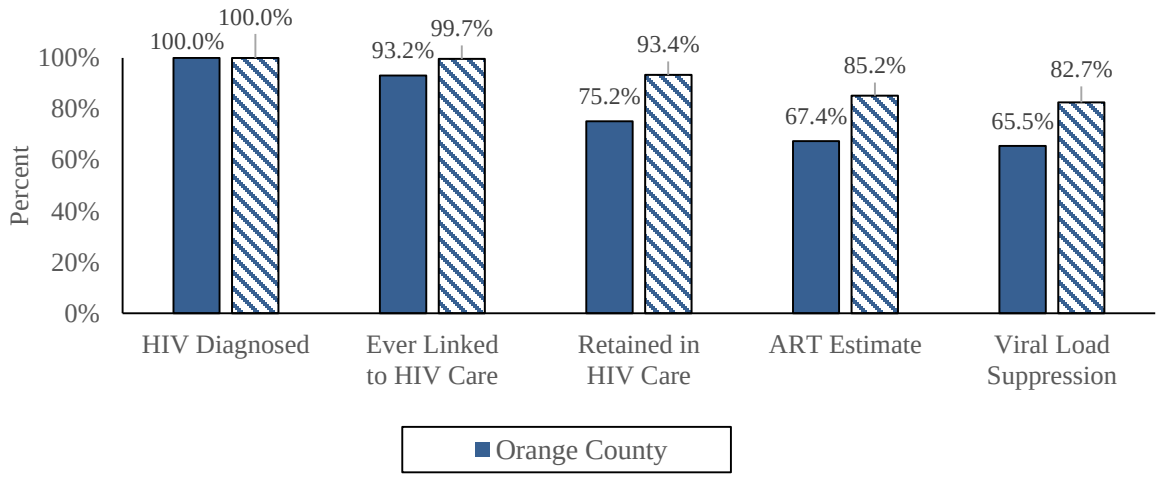
For FY 2019, the Council continued to rank Medical Case Management services at service priority 2 because of this service's ability to impact all of the stages of the HIV Care Continuum. As part of the Medical Case Management program in Orange County, the LTC program is based on a strengths-based intervention, Anti-Retroviral Treatment and Access to Services (ARTAS), and focuses on helping newly diagnosed clients link to a HIV medical care. To further increase the percentage of individuals living with HIV who are linked to HIV medical care, a LTC Peer Navigation program will be piloted in 2019. The peer navigator in this program will help clients link to care, stay in care, navigate and access services, and adopt health behaviors. To support the LTC Peer Navigation program, the Council has increased the allocation by 8.6%, from $466,117 in FY 2018 to $506,117 in FY 2019.

Furthermore, when comparing the HIV Care Continuum for the whole jurisdiction to the HIV Care Continuum for Ryan White clients, Ryan White clients have much higher outcomes along the continuum (see Figure 12). This demonstrates the impact of the Ryan White program on improving health for PLWH. To assess how the Ryan White program can address and improve the HIV Care Continuum for the whole jurisdiction, the Quality Management Committee reviews data on linkage to care, retention in HIV care, and viral load suppression on a quarterly basis for all Ryan White funded services. Depending on the data for each service category, the Quality Management Committee will develop initiatives for services in the Ryan White program that will improve the stages of the HIV Care Continuum.

Figure 12. **HIV Continuum of Care, Orange County, PLWH vs. Ryan White PLWH, 2017**



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B. Funding for Core and Support Services

1) Service Category Plan

a) Service category plan table

A table outlining Orange County's service category plan for RWHAP Part A and MAI for 2018 and 2019 is included as **Attachment 8.**

b) MAI service category plan narrative

Epidemiological and care continuum data show that Blacks, Latinos, and Asian/Pacific Islander populations continue to be disproportionately impacted by the HIV in Orange County. According to 2017 data from the United States Census Bureau, it is estimated that Latinos represents 34.2% of Orange County's population and African-Americans represents 2.1%. However, for the same year, Latinos represented 46.7% of the county's reported HIV cases. African-Americans represented 5.9% of HIV cases reported in the same time period. Comparison of HIV case rates (cases per 100,000) among each racial/ethnic group show that African-Americans have a significantly higher case rate than all other ethnic groups. Of HIV cases diagnosed between 2015-2017, the case rate for African-Americans was 32.2 per 100,000, much higher than Hispanics (13.2 per 100,000), Whites (8.3 per 100,000), and Asian/ Pacific Islanders (6.7 per 100,000). Because HIV disproportionately impacts Blacks and Latinos the most in Orange County, the MAI program will continue to focus on these two populations.

The Planning Council has allocated $425,767 in MAI funds for FY 2019. Of these funds, $229,203 will be used for the provision of Medical Case Management services for African Americans and Latinos[18] ($55,009 for African Americans and $174,194 for Latinos) and $132,700 ($17,251 for African Americans and $115,449 for Latinos) will be used for the provision of Non-Medical Case Management services. Additionally, $42,576 (10.0% of award) was allocated for Grant Recipient administration and $21,288 (5% of award) for Clinical Quality Management (CQM).

The following table shows the FY 2019 allocations of MAI funds:

	African Americans	**Latinos**	**Total**
Medical Case Management	$55,009	$174,194	$229,203
Non-Medical Case Management	$17,251	$115,449	$132,700
Grant Recipient Administration			$42,576
Clinical Quality Management			$21,288
Total			$425,767

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[18] African-American and Black are used interchangeably in this report. Additionally, Hispanic and Latino are also used interchangeably.

The Orange County Planning Council (Council) approved allocations for MAI Medical Case Management with the plan to serve 54 African American clients with 370 Medical Case Management units (15 minute face-to-face is considered one (1) unit) and 775 service coordination units (one (1) unit of service coordination equals 15 minutes of phone calls, referrals, follow-up, etc.). Additionally, 36 African American clients will receive 220 Non-Medical Case Management visits and 400 service coordination units.

The MAI program will also serve 169 Latinos clients with 640 Medical Case Management units and 5,255 service coordination units. Additionally, 240 clients will receive 1,930 Non-Medical Case Management units and 3,652 service coordination units.

Targeted activities to improve HIV-related health outcomes

Information from Orange County's Ryan White client database and the 2017 HIV Needs Assessment Survey show that Case Management services continue to be reported as one of the top five important services for African-Americans and Latinos in Orange County. Case Management services are key to helping clients access medical care services and community resources to support optimal health. Orange County's Ryan White Case Management system is comprehensive and includes multiple tiers to better address specific needs for each client. These tiers are meant to better support client with varying needs. The service levels focus on linkage and retention in medical care versus a client's on-going need for supportive services such as housing and nutrition services. The tiers are as follows:

Medical Case Management:

- Linkage to Care (LTC): Use of the Anti-Retroviral Treatment and Access Services (ARTAS) evidence-based intervention to facilitate linkage to care for those who are newly diagnosed or have been out-of-care and need assistance re-engaging in care
- Medical Retention Services (MRS): Intensive case management for individuals who are not virally suppressed, HIV medically adherent, or medically compromised

Non-Medical Case Management:

- Client Support Services (CSS): Case management assistance to those who are medically stable but need assistance accessing support services and may have barriers to care
- Client Advocacy (CA): The provision of basic information and referrals to individuals who can navigate the system without on-going case management

Based on the client's need, they will be placed in the MAI case management program, as appropriate.

Activities that reduce existing racial and ethnic health disparities

With the funding, the program will provide comprehensive case management services, which will include the coordination and follow-up of medical appointments and treatment to ensure timely and coordinated access to medically appropriate levels of health and support services. Of primary importance is assistance in accessing specialized medical care services and maintaining medical appointments. Additionally, case managers help the clients access a variety of services both at the provider agency and other community agencies. The needs of clients are assessed on an ongoing basis through regularly scheduled contacts, which may occur by phone, an onsite visit, or a visit at the client's home.

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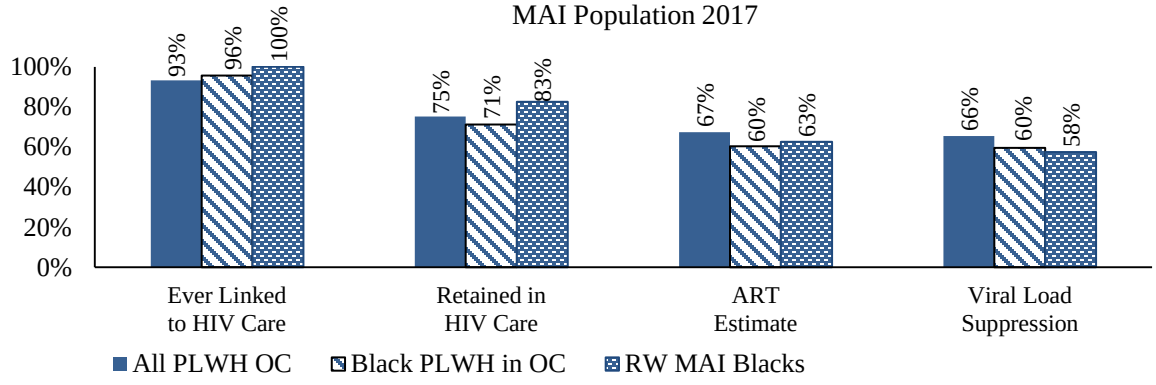
Case managers provide regular follow-up with all clients to assure that they are able to maintain appropriate care. The needs of the clients are assessed on an ongoing basis through regularly scheduled contact.

Impact of Case Management on improving HIV Care Continuum

The Case Management tiers are intended to improve the HIV Care Continuum by having dedicated and appropriately trained staff that meet the medical and support needs of clients. The graph below (Figure 13) compares the HIV Care Continuum between Ryan White (RW) MAI African Americans, compared to all African Americans in Orange County, and the total of PLWH in Orange County[19]. The second graph below (Figure 14) compares the HIV Care Continuum between Ryan White (RW) MAI Latinos, compared to all Latinos in Orange County, and the total of PLWH in Orange County[20]. The graph also shows the impact of the RW MAI program on African American and Latino clients. As shown, African American and Latino PLWH are less likely to be engaged along the Continuum of Care compared to all PLWH in Orange County. However, those participating in the Ryan White MAI program have better outcomes along the Continuum of Care. The exception is Viral Load Suppression among RW MAI Blacks, which is slightly lower than the Black PLWH population. A total of 64% (60 of 94) Blacks who used RW case management in 2017, utilized LTC and MRS services. Case management tiers that focus on assisting clients with new diagnosis, medically compromised, and those not virally suppressed. Based on this information it makes sense that RW MAI Blacks would have lower viral suppression. Orange County will continue to monitor this information and determine if viral load suppression improves as Blacks are assisted with staying in care, reaching viral load suppression, and move towards lower level case management.

Figure 13. HIV Continuum Comparison with Race/Ethnicity and MAI Population 2017



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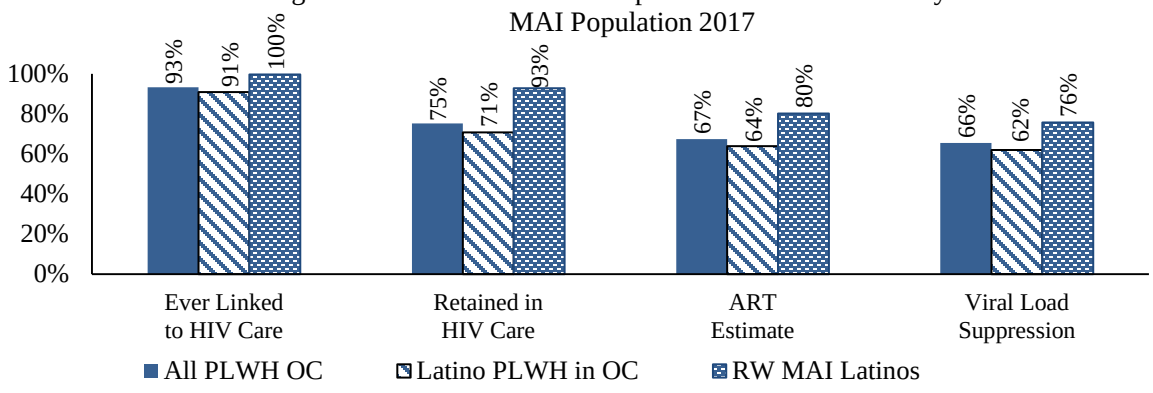
[19] MAI clients are included in Black PLWHD in OC data. Additionally, Orange County total includes all clients, regardless of funding source.
[20] MAI clients are included in Latino PLWHD in OC data. Additionally, Orange County total includes all clients, regardless of funding source.

Figure 14. HIV Continuum Comparison with Race/Ethnicity and MAI Population 2017



Addressing the unique needs of the population

Based on the most recent client needs survey conducted in 2017, Blacks and Latinos reported that the most needed services were drug assistance (ADAP), medical care, dental care (basic and advanced), food services, and medical transportation. The Case Management program ensures that clients are linked to these support services which will support their ability to improve their medical care.

Additional services to be provided include additional follow-up to African Americans who may be under-utilizing HIV-related services, regularly scheduled support groups, and health education. Providers assist clients in meeting their goals through the assignment of case managers who provide comprehensive initial assessments and individualized service plans to help clients identify their unmet needs. Latino clients funded under MAI are also offered a variety of support groups, which provide both educational and social support services. These services are of particular importance in the Latino community due to the high level of stigma associated with HIV in the community. The program realizes that success also depends on achieving a complex array of secondary goals. When appropriate, clients receive referrals and are linked to substance abuse treatment programs and mental health services. Latino clients also receive assistance with obtaining and maintaining stable and adequate income, housing, transportation, and harm reduction. The Latino MAI program will offer case management services that are linguistically and culturally appropriate to the target population. Clients enrolled in this program are assigned bilingual and bicultural case managers who conduct an initial assessment to help clients identify their unmet needs. The assigned case managers have experience working with and are knowledgeable of the needs of the Latino community. The bilingual case managers assist clients with accessing services at their respective organizations and at other community agencies by identifying the barriers to care and then creating a plan to overcome these obstacles.

c) Core medical service waiver

A core medical waiver was submitted on August 23, 2018 before the FY 2019 Emergency Relief Grant application.

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RESOLUTION OF CHALLENGES

Table of Challenges, Resolutions, Intended Outcomes, and Current Status of Implementation

Challenges/Barriers	Proposed Resolutions	Intended Outcomes	Current Status of Implementation
Ensuring Ryan White is payer of last resort.	Continued use of the centralized eligibility process that screens clients for public and private insurance, twice a year, and helps ensure individuals are aware of and assisted with accessing all services they are eligible to receive.	Individuals will have access to all programs and services they are eligible to receive.	Centralized eligibility was implemented four years ago and continues to ensure appropriate screening and referrals.
The following are challenges related to transitioning clients out of Ryan White medical care: • Infectious Disease medical providers not enrolling new patients • Navigating systems of care may increase the number out of care	To assist clients in linking to care the following items would be implemented: • Strengthen case management services to work with clients with various barriers and needs including navigating health insurance and networks. • Develop and implement a peer navigation program in 2018. • Development or coordinate trainings for case managers, community health workers, outreach workers, and eligibility workers to best assist clients.	• Case managers and peers will assist clients in becoming more self-reliant in order for them to be responsible to advocate for their care, schedule appointments, understand insurance terminology, and navigate the web of referrals needed for care. • Staffed trained to provide resources on health insurance.	• Non-medical case management was redeveloped in 2016. A pilot peer program will be implemented in FY 2018. • A calendar of trainings is developed and implemented annually.
Access to data such as health insurance coverage and Antiretroviral (ART) therapy for PLWH who do not receive medical services under the Ryan White system is limited.	Access client data on ART and income captured during case management assessments and financial eligibility screening.	Would be analyzed during annual planning process to better prioritize funding and services.	The Planning Council and Clinical Quality Management Committee will be developing strategies to develop partnerships.
Viral load suppression for PLWH outside of Ryan White medical care is poor compared to those accessing Ryan White Medical care. In Orange County, as of December 2017, 57% of all PLWH were virally suppressed compared to individuals in Ryan White-funded medical care where 87% of patients have a suppressed viral load.	The following is proposed to increase the number of virally suppressed PLWH throughout the TGA: • Utilize opportunities to educate providers regarding the importance of retention in care and viral load suppression • Educate PLWH, through trainings and newsletters, regarding importance of achieving viral load suppression • Increase funding to services that help improve retention in care for those not receiving Ryan White-funded medical care • Implement a peer navigation program	Increasing the number of PLWH that are receiving medical care, are having labs ran, and are being prescribed ART in line with recommendations from US Department of Health and Human Services and National Institutes of Health.	• Two staff members are on the AETC annual conference (AIDS on the Frontline) that provides information to medical and service providers on treatment guidelines and providing care. • Since 2012, the Planning Council has developed an Our+Care newsletter for PLWH, the Grant Recipient has developed the In+Care newsletter for providers on health care topics such as assisting patients reach viral load suppression. • The HIV/STD medical director for the local public health department contacts medical providers and networks to provide technical assistance on treatment.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

A. Clinical Quality Management (CQM)

The Orange County TGA Clinical Quality Management (CQM) program is led by the Ryan White Grant Recipient (Recipient). The QM Committee is open for membership throughout the year. A staff member from each Ryan White funded agency is required to a member of the CQM committee to represent the following preferred categories: consumers eligible for HIV Care Continuum services, prevention service providers, care provider of core medical service, providers of supportive service, other stakeholders, Planning Council members, and HIVPAC staff. This membership-based committee ensures that services are represented and information is shared between the committee and the different service providers. The CQM Committee meets on a monthly basis to carry out activities outlined in the CQM plan, such as: review performance measure data, make recommendations on service implementation, develop standards of care, and oversee Quality Improvement (QI) activities to improve health outcomes and decrease disparities.

1) Description of Performance Measure Data Evaluation for Disparities

Performance data is reviewed for each funded service category on a quarterly basis to monitor progress throughout the year. At the end of the year, results are analyzed to set goals for the upcoming year. For results that have not met the goals, further analysis is conducted to determine if there are specific populations that have been impacted. The CQM Committee also ensures data is disseminated to the Council and appropriate subcommittees in order to collaboratively identify disparities and develop strategies to better serve populations with health disparities. In September 2016, the Council approved the Orange County Integrated HIV Prevention and Care Plan with various goals aimed at reducing new infections, increasing access to care, and reducing HIV-related health disparities. Based on those goals, the CQM Committee focused on data that relate to increasing access to care and reducing HIV-related health disparities.

In 2018, Orange County TGA joined the end+disparities ECHO Collaborative to prioritize strategies that address health disparities. The Orange County TGA will be working towards addressing disparities among men who have sex with men (MSM) of color. The newly diagnosed in Orange County are young MSM of color. This population is over represented in new infections and leading to health disparities. In order to address the needs of this population, Orange County has been working with the Council, CQM, and the Case Management Workgroup which consist of providers of case management services to develop models that ensure linkage is done in a timely manner and ensure individuals are supported so that they are able to become virally suppressed. Providers and consumers provided the Recipient with their input on what Orange County can do to address each strategy of the ECHO Collaborative which will be considered in order to address meet the objectives of viral load suppression, retention in care, and addressing mental health and substance use issues among this population.

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2) Description of How CQM Data Has Been Used to Improve or Change Service Delivery

The CQM committee reviews various performance, surveillance, and quality assurance measures each year in a process to develop goals for all services funded under Ryan White. The review of data is intended to facilitate efforts to continuously improve service delivery, client engagement, and outcomes. The CQM committee reviews surveillance information, service utilization, and Ryan White Services Report, to identify opportunities for improvement. For example, during a recent review of data, it was identified that Medical Case Management had a high number of clients who were virally suppressed and may need a lower level of services. In 2017, the CQM program continued to transition case management clients to the appropriate tier of case management based on their viral load suppression, barriers to care, and need. A tiered case management system comprised of both medical and non-medical case management services was implemented March of 2016. The restructuring consisted of four levels of CM that would better meet the needs of individuals where they were at on the care continuum. The four levels are as follow: 1) Medical Retention Services (MRS); 2) Linkage to Care (LTC); 3) Client Support Services (CSS); and 4) Client Advocacy (CA). MRS is for individuals who are medically unstable, non-adherent to medication, have unmanaged co-morbidities, or are not virally suppressed. LTC is a client centered strength based utilizing the Anti-Retroviral Treatment and Access to Services (ARTAS) model adopted for individuals newly diagnosed, new to the area, re-engaging into care, or with changes to insurance or medical care. CSS is intended for individuals who are medically stable with an undetectable viral load, but need assistance on accessing support services. CA is for the medically stable, virally suppressed individual who can navigate the Ryan White system and can request assistance as needed. This change impacted the results viral load suppression outcome for MRS dramatically. At the end of FY 2017, 74% of MRS clients were virally suppressed, however, the first quarter report (March 1, 2018-May 31, 2018) showed that 55% of MRS clients were virally suppressed. Although there was a decrease in the viral load suppression, there was a 34% decrease in the number of clients accessing MRS and a 36% increase in clients accessing CSS. This shows that MRS case managers are placing clients into the appropriate tiers that best meets their needs.

Additionally, the CQM committee took the lead in formulating a peer navigation program that will be implemented in 2019 to help clients successfully link to care. The development of a peer navigation program was based on client feedback that these types of program have shown to positively impact linkage to care, especially for new clients throughout the nation. The committee reviewed various models that have been successfully implemented in other jurisdictions to identify a program that can be implemented in Orange County.

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ORGANIZATIONAL INFORMATION

A. Grant administration

1) Program Organization

a) Description of administration

See **Attachment 10** for the TGA's organization chart and **Attachment 1** for the education, experience qualifications, and rationale for key positions described in this section. The Orange County Health Care Agency (HCA) is the Grant Recipient and lead agency responsible for administering the Ryan White Act Part A and MAI program in the Orange County TGA. The disbursement of funds, including monitoring and evaluation of subrecipient performance, is a shared responsibility of three departments within HCA including: 1) HIV Planning and Coordination (HPC) under the Division of Disease Control and Epidemiology; 2) Division of Financial and Program Support Services (FPSS); and 3) Contract Services (CS).

HPC is the primary unit responsible for implementing and monitoring programmatic functions in accordance with the HIV Planning Council (Council) directives and contract requirements. Staff positions at HPC supporting administration include a Program Supervisor II (0.90 FTE) and a Staff Specialist (0.90 FTE); these positions are responsible for planning and monitoring program activities through provision of technical assistance and support, conducting site visits and annual performance reviews, negotiating and monitoring programmatic elements of contracts, and when necessary, assuring the completion of corrective action plans. The Staff Specialist is also responsible for assuring compliance with all Conditions of Awards and preparing reports for the Council. Another Staff Specialist (1.00 FTE) is responsible for Planning Council support functions. A Office Specialist (0.15 FTE) provides administrative support to the unit and is responsible for materials and food orders for Council and committee meetings. Three additional positions, a Research Analyst III (1.00 FTE), a Senior Epidemiologist (0.05 FTE), and an additional Staff Specialist (0.40 FTE) support administrative data collection and analysis needs for the program. HPC oversight is conducted Program Manager II (0.75 FTE) who is ultimately responsible for assuring compliance with all grant requirements. A Grants Manager position (0.30 FTE) is being recruited. This position will provide oversight of all grant requirements. There is also one dedicated CS staff (0.65 FTE) responsible for subrecipient contract negotiation, implementation, and administrative monitoring. Within the CS unit, additional staff (typically 2.0 FTE) oversee the procurement process every five to seven years. Procurement staff are not funded by the grant. An additional 0.77 FTE from the FPSS unit is assigned to the program, in-kind. FPSS staff oversee budget monitoring, prepare fiscal reports, and oversee the drawdown process. Currently, there is one vacant position. The grants manager position is currently being recruited.

b) Description of process to evaluate performance of contractor or fiscal agent

There are currently no contractors or fiscal agents providing services on behalf of the TGA.

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2) Grant Recipient Accountability

a) Monitoring

Monitoring of subrecipients focus on programmatic and administrative reviews. HIV Planning and Coordination (HPC) conducts annual programmatic site visits during the third quarter of the fiscal year as a formal review of all subrecipients. Programmatic site visits review various items that are detailed in the monitoring tools that are provided to subrecipients before the beginning of each fiscal year. Monitoring tools are detailed and address a wide variety of administrative and service delivery areas of inquiry. Tools are divided into four separate sections: 1) a general administrative review of policies, procedures, and documentation of staff certifications and trainings, in addition to client care procedures, required service documentation, adherence to Standards of Care, and timely submission of reports; 2) chart reviews of randomly selected program participants, reviews include examination of intake documentation, verification of eligibility, payer of last resort documentation, and program-specific assessment information; 3) a review of data entered into ARIES (database used to document Ryan White Service Report activities and service delivery); and 4) documentation of eligibility verification every six months and payer of last resort screening. Findings and results from programmatic reviews are included in the "*Three most common program and fiscal subrecipient findings".*

Administrative reviews are conducted by Orange County Health Care Agency (HCA) Contract Services (CS) staff annually in the fourth quarter of the fiscal year. The administrative site visits focus on documentation of invoices, support documentation of invoices, facility accessibility, insurance, and other administrative items. During the FY 2017 administrative reviews there wasone finding identified for one of the six contracted subrecipients. The finding identified missing Code of Conduct and confidentiality statements for some staff. The finding was addressed for staff that were still employed at the time of the findings, for staff no longer employed no corrective action could be taken.

i. Three most common program and fiscal subrecipient findings

Programmatic reviews for the current fiscal year are scheduled to begin in October 2018. Programmatic reviews include findings that are based on contractual requirements and/or Standards of Care. In addition, reviews include recommendations from HPC to the service provider that would improve internal controls, service documentation, and/or highlight best practices. All findings identified during the 2017 programmatic site visit were either corrected or addressed by subrecipients.

The three most common programmatic site visit findings identified in order of frequency include: 1) Follow-up Individual Service Plan (ISP) for Case Management services conducted every six months; 2) Screening dates for Substance Abuse and Mental Health needs entered into ARIES annually; and 3) Follow-up Psychosocial Assessment every three to six months based on acuity. The first and third most common findings are due to follow-up Individual Service Plan and Follow-up Psychosocial assessments not being completed within the required timeframe. For example, based on Case Management Standards of Care, a follow-up Individual Service Plan shall be completed every six months. The review highlighted that plans were completed after the six month timeframe, with no documentation or justification for the delay. However, if a client was documented as lost to follow-up and returned after the six months an ISP would be due. If completed as the time of return it is justifiable and would not result in a finding. The screening

date for substance abuse and mental health appears to be a data entry issue as case managers are consistently assessing substance abuse as well as mental health when completing assessment and acuity tools, but the data is not being entered into ARIES.

The process to correct findings and/or adopt recommendations begins at the site visit close out interview with the subrecipient. At the close out interview, HPC staff review the findings and recommendations identified during the site visit with subrecipient staff allowing for dialogue to ensure the subrecipient staff are clear why findings occurred and discuss best practices to move forward. A written report on the findings and recommendations, including copies of all tools completed during the site visit, are sent to the subrecipient within 10 business days. A corrective action response from subrecipients is due within 30 days of receiving the site visit summary report and tools. The response includes how findings and/or recommendations will be addressed or implemented. Subrecipients have reviewed policies and procedures with frontline staff to ensure compliance with timeliness for follow-up ISP's and Psychosocial Assessments. Additionally, the data entry process has been addressed to improve reporting of substance abuse and mental health annual screenings in ARIES and updated policies and procedures have been submitted. Follow-up visits to ascertain the implementation of corrective actions to findings are conducted as needed.

ii. Process for reviewing subrecipient compliance with single audit compliance

Subrecipients are contractually obligated to submit a copy of their annual single audit report. Contract Services (CS) staff is responsible for ensuring subrecipients are compliant in submitting their annual single audit report and reviewing the single audit report to ensure there are no material findings. In the event a finding from the subrecipient's single audit impacts their contract, CS staff work with CS management as well as HPC to determine appropriate actions to address the finding. Generally, CS will follow up with the subrecipient to ensure a corrective action plan is developed and carried out.

iii. Description of process to address any findings from single audit

CS administrators review single audit reports from subrecipients based on the subrecipients fiscal year in order to identify any findings that may impact the Ryan White program. In the case a finding is identified, follow-up will be done with the subrecipient regarding those findings during the administrative site visits conducted by CS. The fiscal years for subrecipients differ from one another, so follow-up may occur outside of the administrative site visits. CS staff will request a corrective action plan from the subrecipient to address any findings from the single audit. HPC may assist in the process by ensuring that technical assistance is available to subrecipients in order to address any findings in the audit. Assistance may include policy and procedure samples, obtaining assistance through the provider network of Capacity Building Assistance (CBA), and researching best practices. There have been no findings on any of the subrecipients single audits for fiscal year 2017. Program specific findings are identified in the site visit summary written report with a corrective action plan due from the subrecipient within 30 days of receipt. Follow-up visits may be conducted to ensure implementation of corrective action.

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b) Third Party Reimbursement

i. Process to ensure monitoring of third party reimbursement

HCA trains and monitors all subrecipients to ensure Ryan White funds are used as a last resort and when appropriate, subrecipients bill third party payers. The Request for Proposal process is the first place where the expectation for collecting third party revenue is outlined. The Description of Services General Requirements section states: "Consistent with HRSA Guidelines, Ryan White Act funds are to be used as the payer of last resort. Each program is expected to establish a plan to recover, to the extent feasible, third-party revenues to which it is entitled for services provided, garner all other available federal, state, local, and private funds; and charge beneficiaries according to their ability to pay for services without creating a barrier to those services." Standards of care, contracts, and scopes of work also include language specific to third party reimbursement; contracts state: "Contractor shall make every effort to obtain all third party reimbursement for which persons served here may be eligible." Contracts also include a provision that the contractor shall not use contract funds to make payment for any item or service to the extent that payment for that item or service has already been made, or reasonably expect to be made (1) under any State compensation program, under an insurance policy, or under Federal or State health benefits program or (2) by an entity that provides health services on a prepaid basis." HRSA Policy Clarification Notices (e.g., PCN 13-04, 13-05, 13-06, 14-01) have also been disseminated to providers to clarify the requirements for ensuring third party reimbursement.

HPC's programmatic site visits includes a review of each provider's written procedure for training staff regarding use of Ryan White as payer of last resort and eligibility screening to ensure that Ryan White is the payer of last resort. A subrecipient provider meeting is held prior to the beginning of each fiscal year. The meeting serves to review Ryan White requirements. The "Eligibility Requirements" document is disseminated at that meeting. This document provides eligibility requirements and prior resources that each client must be screened for prior to use of Ryan White services; any changes are reviewed at quarterly Provider Meetings and the most updated version is posted on HPC's website.

The implementation of centralized eligibility screening has further streamlined the process for ensuring that Ryan White is the payer of last resort. Prior resources are clearly documented on the eligibility forms and uploaded into the ARIES database. Referral forms have also been modified to communicate to providers insurance/prior resources of clients being referred.

Contracted subrecipients estimate funds from third party payers during the contracting process. Reimbursement received from third party payers is documented on the provider's monthly Expenditure and Revenue Report (ERR). Annual Cost Reports provide a final accounting of expenses and revenue. For County providers that do not submit the monthly ERR, reimbursement from all payer sources is tracked in the Practice Expert. County provider reimbursements are tracked by job code and reported on the annual Financial Status Report.

(Continued on next page)

ii. Process to conduct eligibility screening to ensure payer of last resort

Since January 2013, Orange County has utilized a centralized eligibility screening process to reduce duplicative efforts and ensure a standardized eligibility screening process. Three Ryan White providers conduct eligibility screening (17th Street Care Clinic, AIDS Services Foundation Orange County dba Radiant Health Centers, and Shanti Orange County). Clients are assessed for all Ryan White programs (including ADAP, State Office of AIDS Health Insurance Premium Program, and Part D services that have specific eligibility criteria). Clients are also screened for private insurance, Medicaid (Medi-Cal in California), and Covered California (California's Healthcare Exchange), when needed. Furthermore, they are screened for other public benefits (e.g., SNAP, WIC, etc.), in addition to screenings of financial, health, and psychosocial support questions to further identify resources available to meet the needs of the client.

Staff document a client's eligibility on the "Eligibility Verification Form (EVF)" or the biannual "Self-Attestation Form (SAF)." The form and appropriate documentation to support eligibility is maintained in the client's chart. The completed EVF or SAF is also uploaded into ARIES, based on a signed release of information, to confirm eligibility screening. Service providers are able to view and download the completed eligibility documents before providing services.

Clients receiving medical services must have documentation showing that they are ineligible for Medicaid and Medicare. Clients must also sign a statement stating that they do not currently have and are not eligible for private medical insurance. The eligibility forms (EVF and SAF) have been modified due to the implementation of the Affordable Care Act (ACA) to document any of the following: 1) client is not eligible for ACA benefits; 2) client provided a certified exemption from IRS; 3) based on client's modified adjusted gross income (MAGI), the client was referred to apply for Medicaid or purchase insurance; 4) the client was shown how to access the Covered California (CC) website or assistance is provided for enrollment assistance, if applicable; 5) client was advised on qualifying event if enrollment for CC was closed at time of eligibility screening; 6) client was informed of tax penalties for not enrolling in insurance; and 7) the client's signed statement that he/she is opting-out of enrolling in insurance. In 2015, HCA implemented the revised ADAP criteria for eligibility screening for all Ryan White programs. The revision included standards for utilizing tax returns for assessment of non-taxable social security benefits, tax-exempt interests, and excluded foreign earned income and housing expenses in determining one's MAGI.

Compliance with conducting biannual eligibility screening is monitored during annual programmatic site visits.

(Continued on next page)

iii. Process to track and monitor income earned

For contracted subrecipients, program income is documented on the monthly Expenditure Revenue Report (ERR) and reported on the annual cost report. For County subrecipients, tracking of income is reported on the monthly Units of Service (UOS) report and the monthly Public Health Services Monthly Charges Revenue Report. Services in ARIES are also set up to track funding sources. In addition, services for medical and dental services are tracked by Current Procedural Terminology (CPT) and Code on Dental Procedures and Nomenclature (CDT) codes to ensure proper comparison of services among funding sources.

The monthly report (ERR or UOS) submitted includes the overview of services provided that are billed to other funding (primarily Medicaid). Subrecipients report income on the designated ERR received from Medicaid, 340B, etc. in compliance with grant requirements. HCA's Medical Billing Unit (MBU) submits all claims to Medicaid for county providers. Claims are submitted and tracked by MBU into a system called Practice Expert. Once income is received, HCA's accounting unit tracks the income in a system called ERMI and CAPS+. Income received is tracked by job code to ensure revenue is appropriately applied back to the program. Income is reported annually to HRSA and the Council.

c) Fiscal Oversight

i. Process to ensure reporting, reconciliation, and tracking of program expenditures

Weekly meetings are scheduled between HPC (Program) and FPSS (Fiscal) staff to coordinate fiscal activities including the review of reported expenses, reconciliation of expenses to service delivery, and ensuring appropriate expenses are tracked. Meeting agendas include the following standard topics: claims submission, billing reconciliation, allocations and reallocations to reduce the possibility of unobligated balances, staffing changes affecting grants, and need for job code corrections for identified billing errors. These meetings are not limited to just Part A/MAI grant related issues; therefore, the meetings also serve to ensure that all funding streams are effectively being monitored. At minimum, quarterly meetings focus on review of expenditures for grant billing. In addition, meetings are held to review grant conditions of award prior to submission (e.g., planned allocations, budget narrative, maintenance of effort, consolidated list of contracts, contract review certification, and final expenditures).

In addition to meetings held with FPSS, HPC staff review all contractor invoices for payment approval. HPC review includes 1) verification of units reported by provider compared to units in the ARIES system; 2) review of expenses by funding source; 3) review of revenue reported to ensure subrecipients are appropriately documenting revenue from other funding sources; and 4) monitoring of expenses to ensure that approved budgets are maintained or to identify the need for budget revisions. In 2017, meetings were held with each contracted subrecipient to review PCN 15-03 and 15-04 to provide technical assistance regarding income reporting requirements and processes. The monthly ERR is also being modified to better track program expenditures and revenue.

(Continued on next page)

ii. Process used to separately track formula, supplemental, MAI, and carryover funds

The process utilized to track formula, supplemental, MAI, and carryover funds in Orange County includes the use of the ARIES database, unique job codes, and Council approved allocations. The ARIES database tracks services by funding stream distinguishing all funding sources including Part A and MAI funds. Separate job codes have been established to separately monitor expenditures for administrative services, clinical quality management, and direct services by service category and funding stream. Formula funds are expended and invoiced first to ensure that no more than five percent of formula funding is unexpended at the end of the fiscal year. Supplemental funds are tracked and expended next. If carryover is awarded, those funds are specifically allocated within one service category or service categories that benefit from one-time funding for proper tracking of expenditures. Additional data systems utilized to track funds is included in the "*Process for Reimbursing Subrecipients"* below.

iii. Process for reimbursing subrecipients

Subrecipients are reimbursed based on actual costs or fee-for-service. The majority of services are actual cost reimbursement. However, Legal Services, Mental Health Services, and Home Delivered Meals are on a fee-for-service reimbursement. Contractors submit monthly ERR. The report is submitted using an Excel spreadsheet that tracks expenditures including those of subcontractors, staffing time expended on the grant, and units of service provided as reported in the ARIES database. HPC and Contract Services (CS) review these reports to ensure that units of service provided and costs of programs are comparable and reasonable monthly prior to payment. HPC staff also review data entered into ARIES for comparison to units reported. Based on feedback from HPC, CS staff finalize approval of invoices by indicated the approved amounts, by funding source and job code, on the invoice. The invoice is forwarded to accounting for payment. The approved invoice is entered into the County-wide Accounting and Personnel System (CAPS) for payment. Payment is processed and released no more than 21 days from receipt of correctly completed billing documents. An electronic payment process was implemented in 2011. The majority of contracted subrecipients have been set up to receive electronic payments which has expedited the payment process. The Electronic Report Management and Imaging (ERMI) system is also used to generate reports regarding expenditures and payments which are reviewed monthly to ensure appropriate and timely reimbursement.

Expenditures for County providers are reviewed and reimbursed in a different manner. Expenditures are monitored monthly using data retrieved from CAPS. In addition, payroll data from the Virtual Timecard Initialization (VTI) system is used to track employee's time spent on the various grants. Each grant has separate job codes to ensure that staff time is appropriately documented by funding source. Staff have established percentages to charge to grants based on budget but also modify their time reported based on actual work for each time period. HPC works directly with County programs to ensure that units of service provided and actual costs of programs are equitable. Expenditures are compiled and verified with FPSS staff prior to the grant draw down process. Once the draw down is completed, funds are distributed to appropriate funding sources based on distinct job codes to the County programs.

(Continued on next page)

B. Maintenance of Effort (MOE)

Orange County's maintenance of effort calculations are included as **Attachment 11.**

BUDGET

iii. SF-424A

See uploaded **SF-424A** for the budget.

iv. Budget Narrative

See **Attachment 13** for the budget narrative.

HIV services are administered by an interdisciplinary team, staffed by 6.10 Full Time Equivalent (FTEs). The staffing chart below provides a biographical summary of key employees.

Name	Position	Education	Percent FTE			Responsibilities/Biographical Sketches
			Admin	CQM	MAI	
Tamarra Jones	Administrative Manager II	DrPH	0.40	0.20	0.15	Oversees implementation and evaluation of HIV services. Oversees development of the Integrated HIV Plan. Dr. Jones has 13 years of HIV program management experience and an additional eight years in public health.
Sam Monroy	Program Supervisor II	MPA	0.30	0.45	0.15	Supervises care and prevention program monitoring of contractors' service delivery. Supervises Clinical Quality Management (CQM) activities. Mr. Monroy has 15 years of experience in community health and over nine years of experience in HIV programs. He is also fluent in Spanish and reviews all translated documents.
Janlus Chou	Contract Analyst	--	0.65	0.00	0.00	Develops, negotiates, and monitors contracts. Oversees reimbursement and conducts fiscal site visits. Mrs. Chou joined HIV contracting services in 2017.
Mindy He	Staff Specialist	MPH	0.40	0.40	0.10	Assists in grant writing and administration, prepares reports for the Planning Council, and grant Conditions of Award. Assists in CQM committee and activities. Ms. He has worked in the field for nine years.
Diane Pinto	Staff Specialist	--	0.10	0.25	0.05	Assists with data collection and analysis, conducts CQM monitoring, and oversees site visits. Mrs. Pinto has worked at HCA for over 25 years. Mrs. Pinto is fluent in Spanish and assists with translation.
Martha Garcia	Staff Specialist	--	1.00	0.00	0.00	Oversees all Planning Council activities; Mrs. Garcia joined the unit in 2017. Mrs. Garcia is fluent in Spanish and assists with all translation needs for planning activities and documents.
James Williams	Research Analyst III	--	0.55	0.45	0.00	Oversees the data collection and analysis of Ryan White services. Provides technical assistance (TA) to providers on the data system. Prepares data for QM assessments and provides TA for the collection of CQM data. Mr. Williams has been with the program 27 years.
Rebecca Mares	Senior Epidemiologist	MS	0.00	0.05	0.00	Assists in data analysis for planning and CQM activities. Mrs. Mares has been with the program for 10 years.
Grecia Estrada	Office Specialist	--	0.15	0.00	0.00	Assists in ordering materials and food for Council/committee meetings.
Vacant	Grants Manager	--	0.30	0.00	0.00	Position will provide oversight to ensure compliance with all grant requirements.

FY 2019 AGREEMENTS AND COMPLIANCE ASSURANCES
Ryan White HIV/AIDS Program
Part A HIV Emergency Relief Grant Program

I, the Chief Elected Official of the Eligible Metropolitan Area or Transitional Grant Area Orange County, California, (hereinafter referred to as the EMA/TGA) assure that:

Pursuant to Section 2602(a)(2)[3, 4]
The EMA/TGA will establish a mechanism to allocate funds and a Planning Council that comports with section 2602(b).

Pursuant to Section 2602(a)(2)(B)
The EMA/TGA has entered into intergovernmental agreements with the Chief Elected Officials of the political subdivisions in the EMA/TGA that provide HIV-related health services and for which the number of AIDS cases in the last 5 years constitutes not less than 10 percent of the cases reported for the EMA/TGA.

Pursuant to Section 2602(b)(4)
The EMA/TGA Planning Council will determine the size and demographics of the population of individuals with HIV/AIDS, as well as the size and demographics of the estimated population of individuals with HIV/AIDS who are unaware of their HIV status; determine the needs of such population, and develop a comprehensive plan for the organization and delivery of health and support services. The plan must include a strategy with discrete goals, a timetable, and appropriate funding, for identifying individuals with HIV/AIDS who do not know their HIV status, making such individuals aware of their HIV status, and enabling such individuals to use the health and support services. The strategy should particularly address disparities in access and services among affected subpopulations and historically underserved communities.

Pursuant to Section 2603(c)
The EMA/TGA will comply with statutory requirements regarding the timeframe for obligation and expenditure of funds, and will comply with any cancellation of unobligated funds.

Pursuant to Section 2603(d)
The EMA/TGA will make expenditures in compliance with priorities established by the Planning Council/Planning Body.

Pursuant to Section 2604(a)
The EMA/TGA will expend funds according to priorities established by the Planning Council/Planning Body, and for core medical services, support services, and administrative

[3] All statutory references are to the Public Health Service Act, unless otherwise specified.

[4] TGAs are exempted from the requirement related to Planning Councils, but must provide a process for obtaining community input as described in **section 2609(d)(1)(A)** of the PHS Act. TGAs that have currently operating Planning Councils are strongly encouraged to maintain that structure.

expenses only.

Pursuant to Section 2604(c)
The EMA/TGA will expend not less than 75 percent of service dollars for core medical services, unless waived by the Secretary.

Pursuant to Section 2604(f)
The EMA/TGA will, for each of such populations in the eligible area expend, from the grants made for the area under Section 2601(a) for a FY, not less than the percentage constituted by the ratio of the population involved (infants, children, youth, or women in such area) with HIV/AIDS to the general population in such area of individuals with HIV/AIDS, unless a waiver from this provision is obtained.

Pursuant to Section 2604(g)
The EMA/TGA has complied with requirements regarding the Medicaid status of providers, unless waived by the Secretary.

Pursuant to Section 2604(h)(2), Section 2604(h)(3), Section 2604(h)(4)
The EMA/TGA will expend no more than 10 percent of the grant on administrative costs (including Planning Council or planning body expenses), and in accordance with the legislative definition of administrative activities, and the allocation of funds to subrecipients will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

Pursuant to Section 2604(h)(5)
The EMA/TGA will establish a CQM Program that meets HRSA requirements, and that funding for this program shall not exceed the lesser of five percent of program funds or $3 million.

Pursuant to Section 2604(i)
The EMA/TGA will not use grant funds for construction or to make cash payments to recipients.

Pursuant to Section 2605(a)
With regard to the use of funds,

a. funds received under Part A of Title XXVI of the Act will be used to supplement, not supplant, state funds made available in the year for which the grant is awarded to provide HIV related services to individuals with HIV disease;
b. during the period of performance, political subdivisions within the EMA/TGA will maintain at least their prior FY's level of expenditures for HIV related services for individuals with HIV disease;
c. political subdivisions within the EMA/TGA will not use funds received under Part A in maintaining the level of expenditures for HIV related services as required in the above paragraph; and
d. documentation of this MOE will be retained.

Pursuant to Section 2605(a)(3)
The EMA/TGA will maintain appropriate referral relationships with entities considered key points of access to the health care system for the purpose of facilitating EIS for individuals diagnosed with HIV infection.

Pursuant to Section 2605(a)(5)
The EMA/TGA will participate in an established HIV community based continuum of care, if such continuum exists within the EMA/TGA.

Pursuant to Section 2605(a)(6)
Part A funds will not be used to pay for any item or service that can reasonably be expected to be paid under any state compensation program, insurance policy, or any Federal or state health benefits program (except for programs related to the Indian Health Service) or by an entity that provides health services on a prepaid basis.

Pursuant to Section 2605(a)(7)(A)
Part A funded HIV primary medical care and support services will be provided, to the maximum extent possible, without regard to a) the ability of the individual to pay for such services or b) the current or past health conditions of the individuals to be served.

Pursuant to Section 2605(a)(7)(B)
Part A funded HIV primary medical care and support will be provided in settings that are accessible to low-income individuals with HIV disease.

Pursuant to Section 2605(a)(7)(C)
A program of outreach services will be provided to low-income individuals with HIV disease to inform them of the HIV primary medical care and support services.

Pursuant to Section 2605(a)(8)
The EMA/TGA has participated in the Statewide Coordinated Statement of Need (SCSN) process initiated by the state, and the services provided under the EMA/TGA's comprehensive plan are consistent with the SCSN.

Pursuant to Section 2605(a)(9)
The EMA/TGA has procedures in place to ensure that services are provided by appropriate entities.

Pursuant to Section 2605(a)(10)
The EMA/TGA will submit audits every 2 years to the lead state agency under Part B of Title XXVI of the PHS Act.

Pursuant to Section 2605(e)
The EMA/TGA will comply with the statutory requirements regarding imposition of charges for services.

Pursuant to Section 2681(d)
Services funded will be integrated with other such services, programs will be coordinated with other available programs (including Medicaid), and that the continuity of care and prevention services of individuals with HIV is enhanced.

Pursuant to Section 2684
No funds shall be used to fund AIDS programs, or to develop materials, designed to directly promote or encourage intravenous drug use or sexual activity, whether homosexual or heterosexual.

Signature _____ Date 7/12/18
David Souleles, Designee

RICHARD SANCHEZ
DIRECTOR
(714) 834-2830
Richard.Sanchez@ochca.com

405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701
FAX: (714) 834-5506

OFFICE OF THE DIRECTOR

April 19, 2017

TO: Public Health Services and HCA Contract Services Files

SUBJECT: Delegated Signing Authority to the Deputy Agency Director, Public Health Services

I hereby delegate signing authority to Mr. David M. Souleles, MPH, Deputy Agency Director, Public Health Services, for the following items:

- Supporting documents required for authorized Public Health grants and revenue agreements.

Richard Sanchez, Director

HIV (non-AIDS) and AIDS Prevalence Data by Demographic Group and Exposure Category

Demographic Group/ Exposure Category	2013- PREVALENCE AS OF 12/31/13				2014- PREVALENCE AS OF 12/31/14				2015- PREVALENCE AS OF 12/31/15			
Race/Ethnicity	**HIV**		**AIDS**		**HIV**		**AIDS**		**HIV**		**AIDS**	
White, not Hispanic	1091	1,323	40.1%	40.3%	1,164	42.3%	1,350	39.9%	1,250	41.8%	1,371	39.7%
Black, not Hispanic	149	169	5.1%	5.2%	162	5.9%	170	5.0%	173	5.8%	174	5.0%
Hispanic	1080	1,577	47.7%	47.8%	1,177	42.7%	1,616	47.8%	1,293	43.2%	1,653	47.9%
Other[1] / Unknown	218	234	7.1%	6.8%	251	9.1%	248	7.3%	276	9.2%	256	7.4%
Total	**2,538**	**3,303**	**100.0%**	**100.0%**	**2,754**	**100.0%**	**3,384**	**100.0%**	**2,992**	**100.0%**	**3,454**	**100.0%**
Gender	**HIV**		**AIDS**		**HIV**		**AIDS**		**HIV**		**AIDS**	
Male	2,177	85.8%	2,867	86.8%	2,373	86.2%	2,939	86.8%	2,596	86.8%	3,001	86.9%
Female	333	13.1%	400	12.1%	351	12.7%	408	12.1%	364	12.2%	415	12.0%
Transgender	28	1.1%	36	1.1%	30	1.1%	37	1.1%	32	1.0%	38	1.1%
Total	**2,538**	**100.0%**	**3,303**	**100.0%**	**2,754**	**100.0%**	**3,384**	**100.0%**	**2,992**	**100.0%**	**3,454**	**100.0%**
Current Age as of 12/31/2015	**HIV**		**AIDS**		**HIV**		**AIDS**		**HIV**		**AIDS**	
<13 years	5	0.2%	1	0.0%	6	0.2%	2	0.1%	6	0.2%	2	0.1%
13 - 24 years	51	2.0%	26	0.8%	86	3.1%	29	0.9%	130	4.3%	35	1.0%
25 - 44 years	1,171	46.1%	820	24.8%	1,304	47.3%	866	25.6%	1,446	48.3%	905	26.2%
45 - 64 years	1,162	45.8%	2,138	64.7%	1,205	43.8%	2,169	64.1%	1,255	41.9%	2,193	63.5%
65+ years	149	5.9%	318	9.6%	153	5.6%	318	9.4%	155	5.2%	319	9.2%
Total	**2,538**	**100.0%**	**3,303**	**100.0%**	**2,754**	**100.0%**	**3,384**	**100.0%**	**2,992**	**100.0%**	**3,454**	**100.0%**
Exposure Category	**HIV**		**AIDS**		**HIV**		**AIDS**		**HIV**		**AIDS**	
Men who have sex with men (MSM)	1,885	74.3%	2,339	70.8%	2,057	74.7%	2,400	70.9%	2,248	75.1%	2,459	71.2%
Persons Who Inject Drugs (PWID)	150	5.9%	293	8.9%	163	5.9%	300	8.9%	174	5.8%	301	8.7%
MSM and PWID	134	5.3%	181	5.5%	141	5.1%	185	5.5%	149	5.0%	186	5.4%
Heterosexuals	297	11.7%	398	12.0%	313	11.4%	404	11.9%	328	11.0%	412	11.9%
Other[2]/Unknown	72	2.8%	92	2.8%	80	2.9%	95	2.8%	93	3.1%	96	2.8%
Total	**2,538**	**100.0%**	**3,303**	**100.0%**	**2,754**	**100.0%**	**3,384**	**100.0%**	**2,992**	**100.0%**	**3,454**	**100.0%**

Source: HIV/AIDS Case Registry, Data as of January 31, 2018

[1] Includes the following races Asian, Pacific Islanders, Native Americans, Native Alaskan, and Mixed Race

[2] Includes Blood Transfusion, Pediatric Transmission, and Perinatal

HIV (non-AIDS) and AIDS Prevalence Data by Demographic Group and Exposure Category (continued)

Demographic Group/ Exposure Category	2016- PREVALENCE AS OF 12/31/16				2017- PREVALENCE AS OF 12/31/17			
Race/Ethnicity	**HIV**		**AIDS**		**HIV**		**AIDS**	
White, not Hispanic	1,340	41.3%	1,385	39.4%	1,336	39.8%	1,302	38.8%
Black, not Hispanic	191	5.9%	176	5.0%	205	6.1%	163	4.9%
Hispanic	1,412	43.5%	1,691	48.1%	1,478	44.0%	1,623	48.4%
Other[1] / Unknown	304	9.4%	263	7.5%	339	10.1%	265	7.9%
Total	**3,247**	**100.0%**	**3,515**	**100.0%**	**3,358**	**100.0%**	**3,353**	**100.0%**
Gender	**HIV**		**AIDS**		**HIV**		**AIDS**	
Male	2,830	87.2%	3,056	86.9%	2,904	86.5%	2,929	87.4%
Female	381	11.7%	420	11.9%	409	12.2%	390	11.6%
Transgender	36	1.1%	39	1.2%	45	1.3%	34	1.0%
Total	**3,247**	**100.0%**	**3,515**	**100.0%**	**3,358**	**100.0%**	**3,353**	**100.0%**
Current Age as of 12/31/2015	**HIV**		**AIDS**		**HIV**		**AIDS**	
<13 years	6	0.2%	2	0.1%	7	0.2%	2	0.1%
13 - 24 years	198	6.1%	44	1.3%	214	6.4%	33	1.0%
25 - 44 years	1,586	48.8%	935	26.6%	1,633	48.6%	861	25.7%
45 - 64 years	1,298	40.0%	2,213	63.0%	1,328	39.5%	2,111	63.0%
65+ years	159	4.9%	321	9.1%	176	5.2%	346	10.3%
Total	**3,247**	**100.0%**	**3,515**	**100.0%**	**3,358**	**100.0%**	**3,353**	**100.0%**
Exposure Category	**HIV**		**AIDS**		**HIV**		**AIDS**	
Men who have sex with men (MSM)	2,453	75.5%	2,506	71.3%	2,521	75.1%	2,409	71.8%
Persons Who Inject Drugs (PWID)	184	5.7%	305	8.7%	179	5.3%	270	8.1%
MSM and PWID	161	5.0%	186	5.3%	148	4.4%	165	4.9%
Heterosexuals	343	10.6%	417	11.9%	373	11.1%	404	12.0%
Other/Unknown	106	3.3%	101	2.9%	137	4.1%	105	3.1%
Total	**3,247**	**100.0%**	**3,515**	**100.0%**	**3,358**	**100.0%**	**3,353**	**100.0%**

Source: HIV/AIDS Case Registry, Data as of January 31, 2018

[1] Includes the following races Asian, Pacific Islanders, Native Americans, Native Alaskan, and Mixed Race

[2] Includes Blood Transfusion, Pediatric Transmission, and Perinatal

Overview of Co-occurring Conditions Table

	Sexually Transmitted Infections	Incidence within General Population of TGA		Incidence among PLWH		2018 Estimates for PLWH Based on Incidence Data from 2013-2017	
		Cases	Case Rate Per 100,000	Cases	Case Rate Per 100,000	Cases	Case Rate Per 100,000
a)	Acute[1] Hepatitis C Virus (HCV)	10[3]	0.3	0[6]	0.0	1	16.4
b)	Sexually Transmitted Infections						
	Syphilis (All cases)	1,650[2,3]	51.6	467[6]	6,958.7	404	6,019.9
	Gonorrhea	3,511[3]	109.7	314[6]	4,678.9	195	2,905.7
	Chlamydia	13,997[3]	437.3	299[6]	4,455.4	211	3,144.1
c)	Mental Illness	138,721[8]	4,583.1	153[6]	2,279.8	211	3,144.1
d)	Substance Use Disorder	224,783[9]	6,840.6	104[6]	1,549.7	206	3,069.6
e)	Homelessness/Unstably Housed	4,792[4]	150.0	122[6]	1,817.9	99	1,579.2
f)	Former Incarcerated	6,211[5]	194.0	215[7]	3,203.7	166	2,292.2

Sources for General Population:

[1]Acute Hepatitis C are newly diagnosed cases in which the individual is symptomatic and ill.

[2] County of Orange, Health Care Agency, Disease Control, CalREDIE Database and Syphilis Access Database, April 2018. Includes both diagnosed cases of Syphilis and positive Syphilis results that were not investigated due to patient's history or priority level for incidences that were created during 2017.

[3] County of Orange, Epidemiology and Assessment Morbidity Data, April 23, 2018 Unpublished Data, 2017

[4] Focus Strategies, *2017 Orange County Homeless Count and Survey Report*

[5] Orange County Sheriff's Department, Average Daily Inmate Population, Board of Corrections Jail Profile Survey, June 2018

[8] California Mental Health Prevalence Estimates: State and County Levels, California Department of Health Care Services, 2004

[9] California Substance Use Prevalence Estimates: State and County Levels, California Department of Health Care Services, 2004

Sources for PLWH Population:

[6] HIV/AIDS Case Registry, PLWH as of January 31, 2018, Cases diagnosed with Syphilis, Chlamydia, Gonorrhea, or Hepatitis C in 2017

[7] Cases reported in 2017 from the County or City Jail or lab reports in 2017 from the County or City Jail

[10] ARIES Ryan White Services Report 2017, Orange County

Funding Source	FY 2018 Funding Amount		Number of Agencies Providing Services	Prevention Services					Core Medical-related Services														Supportive Services																
	Dollar Amount	Percent		HIV Testing	Partner Services	PrEP Services	Condom Distribution		Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium and Cost-Sharing	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Mgmt, incl. Tx Adherence	Substance Abuse Outpatient Care		Case Management: Non-Medical	Child Care Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Health Education/Risk Reduction	Housing Services	Linguistic Services	Medical Transportation	Other Professional Services: Legal Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services Residential
Part A/MAI	$6,213,093	41.6%	7						x			x	x	x	x	x	x	x	x	x			x		x	x		x		x	x	x					
Part B	$2,481,661	16.6%	4						x	x		x	x	x					x	x			x					x									
Part C	$790,970	5.3%	1						x			x	x							x			x						x								
Part D	$139,246	0.9%	1						x											x																	
Part F[1]	$224,963	1.5%	1																																			
CDC[2]	$1,136,144	7.6%	5	x	x	x	x																															
HOPWA	$894,323	6.0%	2																	x						x	x	x									
STATE / LOCAL	$3,046,815	20.4%	Unk[3]						x	x					x	x	x	x	x	x	x												x	x	x	x
Total	$14,927,215	100%	21+																																			

[1] Part F funding is limited to AIDS Education Training Center Activities.
[2] Providers may receive direct funding not reported in this table.
[3] The total number of agencies is unknown.

August 8, 2018

RE: Letter of Assurance from HIV Planning Council Chair

It gives me great pleasure to submit this Letter of Assurance addressing the work done by the Orange County HIV Planning Council (Council). I proudly confirm that:

a) FY 2018 Formula, Supplemental, and Minority AIDS Initiative funds awarded are being expended according to the priorities established by the Council and are reviewed quarterly to ensure compliance with Council directives;

b) All FY 2018 Conditions of Award relative to the Council are reviewed by Council prior to submission;

c) The Council determined the FY 2019 priorities using an approved process for establishing those priorities that included the discussion of the following:

- How services contribute to desired outcomes
- How services address overall service needs
- What criteria has changed that would impact decision making (e.g., Reinstatement of Adult Denti-Cal (Medicaid) Services)
- Changes in service utilization trends or epidemiological data
- How data from the consumer perspective (e.g., surveys, focus groups, etc.) can improve services

d) The Council's Membership and Training (Membership) Committee provided new members with training guides, which included a history of HIV in Orange County, Council Bylaws, Council and Recipient responsibilities, and other documents pertaining to Council responsibilities during the "Refresher and New Member Training" held on April 30, 2018. On August 24, 2018, a "Leadership" training facilitated by the Community Leadership Training Institute will be held for individuals interested in taking a leadership role on the Council or its committees. Additional trainings have been incorporated into Council meetings as follows:

- Overview of the Community HIV/AIDS Technical Assistance and Training (CHATT): April 11, 2018
- Overview of Orange County HIV Epidemiology for 2017: June 13, 2018
- Overview of the Continuum of HIV Care in Orange County: July 11, 2018

Tutorials have also been offered prior to Council meetings to help members better understand the epidemiological, expenditure, and utilization data presented so that they could more fully and actively participate in the annual planning process. Additionally,

PSAP members completed three pre and post-tests related to the Health Resources and Services Administration's (HRSA) expectations for priority setting and resource allocation prior to taking any actions on priorities and allocations for FY 2019.

The Council is fully committed to maintaining our responsibilities to assure that persons living with HIV in our TGA have full access to needed services. Thank you for the opportunity to participate in this process.

Sincerely,

Wesley Fought, Chair
HIV Planning Council

Attachment 7 – FY 2019 HIV Care Continuum

Recipient Name: Orange County TGA			**Fiscal Year: 2019**	
Stages of the HIV Care Continuum	**Goal**	**Outcome (Note 1)**		**Service Category (One or more may apply)**
I. Diagnosed (Note 2)	Increase the percentage of individuals living with HIV who know their status.	HIV Positivity (HHS Measure)		
		Baseline: %, Numerator/Denominator	**Target:** %, Numerator/Denominator	
		Numerator: Number of HIV positive tests in 12-month measurement period. Denominator: Number of HIV tests conducted in 12-month measurement period. Baseline: =109/13,913=.78%	Numerator: Number of HIV positive tests in 12-month measurement period. Denominator: Number of HIV tests conducted in 12-month measurement period. Target: .83%	Outpatient Ambulatory Health Service Early Intervention Services Outreach
II. Ever Linked to Care (Note 3)	Increase the proportion of newly diagnosed patients linked to clinical care.	Linkage to HIV Medical Care (HHS Measure)		
		Baseline: %, Numerator/Denominator	**Target:** %, Numerator/Denominator	
		Numerator: Number of persons who attend a routine HIV medical care visit after the month and year of HIV diagnosis. Denominator: Number of persons with an HIV diagnosis in 12-month measurement period. Baseline: 6,252/7,652= 82%	Numerator: Number of persons who attend a routine HIV medical care visit after the month and year of HIV diagnosis. Denominator: Number of persons with an HIV diagnosis in 12-month measurement period. Target: 87%	Outpatient Ambulatory Health Service Medical Case Management Non-Medical Case Management Health Insurance Premium Payment and Cost Sharing Assistance Emergency Financial Assistance for Medications Medical Transportation Mental Health Services Housing Services Early Intervention Services Substance Abuse Services Legal Services Outreach

Note 1: Outcome are based on data for the Orange County TGA. Outcomes for Ryan White clients are higher for linked to care, retained in care, on ART and virally suppressed.

Note 2: HIV diagnosis is limited to the number of HIV tests conducted in the 12-month period for County-funded testing sites and does not include all tests conducted in Orange County.

Note 3: Orange County's decision to utilize "Ever Linked" data rather than "Linked to Care" data is twofold: 1) Ever linked more accurately depicts the "cascade" of Orange County's epidemic and 2) Utilizing ever linked data for comparison to HIV diagnosed and retained in care clearly shows effectiveness (or disparities) of interventions along both sides of the Continuum.

Attachment 7 – FY 2019 HIV Care Continuum

Recipient Name: Orange County TGA			**Fiscal Year: 2018**	
Stages of the HIV Care Continuum	**Goal**	**Outcome**		**Service Category (One or more may apply)**
III. Retained in Care (Note 4)	Increase the percentage of clients who have a HIV medical visit in each 6-month period of 24-month measurement period.	Retention in HIV Medical Care (HHS Measure)		
		Baseline: %, Numerator/Denominator	**Target:** %, Numerator/Denominator	
		Numerator: Number of patients with at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period compared to the last medical visit in the subsequent 6-month period. Denominator: Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the first 6 months of the 24-month measurement period. Baseline: 5,046/7,652=66%	Numerator: Number of patients with at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period compared to the last medical visit in the subsequent 6-month period. Denominator: Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the first 6 months of the 24-month measurement period. Target: 71%	Outpatient Ambulatory Health Service Treatment Adherence Medical Case Management Non-Medical Case Management Health Insurance Premium Payment and Cost Sharing Assistance Emergency Financial Assistance for Medications Medical Transportation Oral Health Mental Health Services Legal Services Home Health Care/Home and Community Based Health Services Food Bank Home Delivered Meals Nutritional Supplements Outreach

Note 4: The timeframe for "Retained in Care" has been expanded to include those individuals that are in care but are not scheduled to see their HIV specialist every six months. Persons diagnosed with HIV and whose most current address was in Orange County as of December 31, 2017 who had at least two CD4 or viral load results with at least three months in-between the first and last result. For persons diagnosed prior to 2017, the two results ocurred in 2016 and/or 2017. For persons diangosed in 2017, the results occurred between January 2017 and April 2018.

Attachment 7 – FY 2019 HIV Care Continuum

Recipient Name: Orange County TGA			**Fiscal Year: 2019**	
Stages of the HIV Care Continuum	**Goal**	**Outcome**		**Service Category (One or more may apply)**
IV. ART Estimate (Note 5)	Increase the percentage of Ryan White clients who are on ART.	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care (HHS Measure)		Outpatient Ambulatory Health Service Medical Case Management Health Insurance Premium and Cost Sharing Assistance
		Baseline: %, Numerator/Denominator	**Target:** %, Numerator/Denominator	
		Numerator: Number of persons with an HIV diagnosis with an undetectable viral load at their last test in 2017 and persons whose viral load has declined between the last test in 2017 and the previous test. Denominator: Number of persons with an HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period and had an undetectable viral load. Baseline: 4,526/6,711=67%	Numerator: Number of persons with an HIV diagnosis with an undetectable viral load at their last test in 2018 and persons whose viral load has declined between the last test in 2018 and the previous test. Denominator: Number of persons with an HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period and had an undetectable viral load. Target: 72%	

Note 5: This is the estimated percent of HIV-positive individuals who are taking antiretroviral medications. The number of individuals on ART is not readily available for Orange County; therefore, a proxy measure has been used (persons with an undetectable viral load at their last test in 2017 and persons whose viral load has declined between the last test in 2017 and the previous test).

Attachment 7 – FY 2019 HIV Care Continuum

Recipient Name: Orange County TGA			**Fiscal Year: 2018**	
Stages of the HIV Care Continuum	**Goal**	**Outcome**		**Service Category (One or more may apply)**
		Viral Load Suppression Among		
		Baseline: %, Numerator/Denominator	**Target:** %, Numerator/Denominator	
V. Virally Suppressed	Increase the proportion of PLWH/A with supressed viral load (<200 copies per m/L).	Numerator: Number of patients with a viral load test less than 200 copies/mL at last viral load test during the measurement year. Denominator: Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year. Baseline: 4,399/7,652=58%	Numerator: Number of patients with a viral load test less than 200 copies/mL at last viral load test during the measurement year. Denominator: Number of patients, over the age of 24 months, with a diagnosis of HIV/AIDS with at least one medical visit with a provider with prescribing privileges in the measurement year. Target: 63%	Outpatient Ambulatory Health Service Treatment Adherence Medical Case Management Non-Medical Case Management Health Insurance Premium and Cost Sharing Assistance Emergency Financial Assistance for Medications Oral Health Mental Health Services Legal Services Home Health Care Medical Nutrition Services Food Bank Home Delivered Meals Nutritional Supplements

FY 2018 Service Category Table						
FY18 Priority #	**Service Category**	**FY 2018 Part A and MAI Allocations**	**Projected Unduplicated Clients**	**Unit of Service Definition**	**Projected Units of Service**	**Target Populations (MAI only)**
1	**Outpatient / Ambulatory Health Services**	**$1,328,173**				
1.1	Ambulatory Care	1,133,173	500	Primary Care Visit	1,400	N/A
				Lab Visit	910	N/A
1.2	Specialty Care	195,000	160	Service / Procedure	280	N/A
2	**Case Management: Medical**	**$998,814**				
2.1	Linkage to Care	297,807	321	15 Minute Face-to-Face Visit	1,685	N/A
				15 Minute Service Coordination	1,160	N/A
2.2	Medical Retention Services	471,804	316	15 Minute Face-to-Face Visit	2,121	N/A
				15 Minute Service Coordination	3,906	N/A
2.1	Linkage to Care (MAI)	168,310	79	15 Minute Face-to-Face Visit	310	Blacks and Latinos
				15 Minute Service Coordination	670	
2.2	Medical Retention Services (MAI)	60,893	144	15 Minute Face-to-Face Visit	1,850	Blacks and Latinos
				15 Minute Service Coordination	4,210	
3	**Substance Abuse Services: Outpatient / Residential Services / Detox**	**$0**				
3.1	Narcotic Replacement Program (Note 1)	0	0	N/A	0	N/A
3.2	Substance Abuse Outpatient Counseling (Note 1)	0	0	N/A	0	N/A
4	**EFA - Medications / Health Insurance Premium and Cost Sharing Assistance / ADAP**	**$85,000**				
4.1	Health Insurance Premium Program (HIPP)	85,000	130	Insurance Payment or Co-Payments for Mental Health or Medical Visits	200	N/A
5	**Oral Health Care**	**$706,506**				
	Dental Service	656,506	670	Service / Procedure	5,700	N/A
	Dental Coordination	50,000	450	Referral Coordination	1,000	N/A
7	**Mental Health Services**	**$55,000**				
	Individual/Family/Couples Counseling	55,000	315	15 Minute Individual/Family/Couples Counseling	2,200	N/A
	Group Counseling			15 Minute Group Counseling	1,860	N/A
8	**Nutrition Services**	**$214,000**				
8.1	Medical Nutrition Therapy	115,000	300	15 Minute Face-to-Face Visit	1,500	N/A
8.2	Food Bank	30,000	76	Food Order	600	N/A
8.3	Home Delivered Meals	4,000	4	Meal	500	N/A
8.4	Nutritional Supplements	65,000	125	Supplement Order	875	N/A
11	**Early Intervention Services**	**$112,800**				
		112,800	400	HIV Counseling and Testing	510	N/A
				15 Minute Service Coordination	3,200	N/A
13	**Home Health Care / Home and Community-Based Health Services / Hospice / Rehabilitation**	**$101,011**				
13.1	Home Health / Specialized Care / Professional	1,011	4	One Day Specialized Care	20	N/A
			3	Professional Nursing Visit	10	N/A
13.2	Home Health / Para-Professional Care	100,000	10	One Hour CNA Visit	1,100	N/A
			24	DME Item	150	N/A
			10	One Hour Home Health Aide Visit	1,900	N/A
	Core Medical Services Total	**$3,601,304**				
	Percent of Core Medical Services (Note 2)	**67%**				

FY 2018 Service Category Table (Continued)

FY18 Priority #	Service Category	FY 2018 Part A and MAI Allocations	Projected Unduplicated Clients	Unit of Service Definition	Projected Units of Service	Target Populations (MAI only)
2	**Case Management: Non-Medical**	**$967,072**				
2.3	Client Support Services	271,872	301	15 Minute Face-to-face Visit	1,940	N/A
				15 Minute Service Coordination	2,004	N/A
2.4	Client Advocacy	182,500	719	15 Minute Face-to-face Visit	620	N/A
				15 Minute Service Coordination	1,080	N/A
2.3	Client Support Services (MAI)	130,000	231	15 Minute Face-to-face Visit	1,990	Blacks and Latinos
				15 Minute Service Coordination	3,222	
2.4	Client Advocacy (MAI)	2,700	45	15 Minute Face-to-face Visit	160	Blacks and Latinos
				15 Minute Service Coordination	50	
2.5	Benefits Counseling and Eligibility Screening	380,000	275	15 Minute Benefits Counseling	1,800	N/A
				15 Minute Service Coordination	1,600	N/A
			1,160	15 Minute Eligibility Screening	3,870	N/A
				15 Minute Service Coordination	1,300	N/A
4	**EFA - Medications / Health Insurance Premium and Cost Sharing Assistance / ADAP**	**$5,500**				
4.2	EFA - Medications	5,500	15	Medication Payment	80	N/A
4	**Substance Abuse Services: Outpatient / Residential Services / Detox**	**$0**				
4.3	Residential (Note 1)	0	0	N/A	0	N/A
4.4	Detox Services (Note 1)	0	0	N/A	0	N/A
6	**Housing**	**$159,920**				
6.1	Emergency Financial Assistance - Housing	0	0	N/A	0	N/A
6.2	Housing Coordination (Note 1)	0	0	N/A	0	N/A
6.3	Short-Term Supportive Housing	159,920	71	Bed Night	8,035	N/A
8	**Nutrition Services**	**$126,699**				
8.2	Food Bank	126,699	267	Food Order	2,241	N/A
9	**Medical Transportation Services**	**$335,429**				
		335,429	416	One-Way Van Ride	1,000	N/A
				One-Way Taxi Ride	577	N/A
				Daily Bus Pass	1,685	N/A
				Monthly Bus Pass	650	N/A
				ACCESS Coupon	3,143	N/A
10	**Outreach Services**	**$50,000**				
		50,000	210	15 Minute Face-to-face contact	110	N/A
				15 Minute Service Coordination	1,500	N/A
12	**Prevention with Positives (Note 3)**	**$0**	0	N/A	0	N/A
14	**Psychosocial Support Services (Note 1)**	**$0**	0	N/A	0	N/A
15	**Independent Skills - Health Education / Risk Reduction (Note 1)**	**$0**	0	N/A	0	N/A
16	**Other Professional Services including Legal Services**	**$98,445**	100	15 Minute Legal Service Unit	4,519	N/A
	Support Services Total	**$1,743,065**				
	Percent of Support Services	**33%**				
	Total Service Dollars	**$5,344,369**				
	Admin - Up to 10% of Part A and MAI	580,436				
	Quality Management - Up to 5% of Part A and MAI	291,288				
	GRAND TOTAL	**$6,216,093**				

Note 1: This service was prioritized during the planning process but is anticipated to be fully funded by other resources in Orange County.

Note 2: A Core Medical Services Waiver was approved for FY 2018.

Note 3: State prevention funding for behavioral interventions for Prevention with Positives was eliminated as of July 1, 2018. Funding priorities to prevent HIV transmission have shifted to HIV testing, PrEP services, and Care services for HIV-positive individuals.

FY 2019 Service Category Table						
FY19 Priority #	**Service Category**	**Anticipated FY 2019 Part A and MAI Allocations**	**Projected Unduplicated Clients**	**Unit of Service Definition**	**Projected Units of Service**	**Target Populations (MAI only)**
1	**Outpatient / Ambulatory Health Services**	**$1,355,000**				
1.1	Ambulatory Care	1,160,000	500	Primary Care Visit	1,950	N/A
				Lab Visit	930	N/A
1.2	Specialty Care	195,000	160	Service / Procedure	280	N/A
2	**Case Management: Medical**	**$1,063,814**				
2.1	Medical Retention Services	496,804	275	15 Minute Face-to-Face Visit	2,950	N/A
				15 Minute Service Coordination	5,570	N/A
2.2	Linkage to Care	337,807	570	15 Minute Face-to-Face Visit	5,550	N/A
				15 Minute Service Coordination	2,700	N/A
2.1	Medical Retention Services (MAI)	60,893	144	15 Minute Face-to-Face Visit	1,850	Blacks and Latinos
				15 Minute Service Coordination	4,210	
2.2	Linkage to Care (MAI)	168,310	79	15 Minute Face-to-Face Visit	310	Blacks and Latinos
				15 Minute Service Coordination	670	
3	**EFA - Medications / Health Insurance Premium and Cost Sharing Assistance / ADAP**	**$85,000**				
3.1	Health Insurance Premium Program (HIPP)	85,000	130	Insurance Payment or Co-Payments for Mental Health or Medical Visits	200	N/A
4	**Mental Health Services**	**$55,000**				
	Individual/Family/Couples Counseling	55,000	315	15 Minute Individual/Family/Couples Counseling	2,200	N/A
	Group Counseling			15 Minute Group Counseling	1,860	N/A
5	**Oral Health Care**	**$738,903**				
	Dental Service	688,903	730	Service / Procedure	8,000	N/A
	Dental Coordination	50,000	450	Referral Coordination	1,000	N/A
7	**Early Intervention Services**	**$150,000**				
		150,000	450	HIV Counseling and Testing	675	N/A
				15 Minute Service Coordination	4,500	N/A
9	**Substance Abuse Services: Outpatient / Residential Services / Detox**	**$0**				
9.1	Narcotic Replacement Program (Note 1)	0	0	N/A	0	N/A
9.2	Substance Abuse Outpatient Counseling (Note 1)	0	0	N/A	0	N/A
10	**Nutrition Services**	**$250,000**				
10.1	Medical Nutrition Therapy	115,000	300	15 Minute Face-to-Face Visit	1,500	N/A
10.2	Food Bank	50,000	76	Food Order	600	N/A
10.3	Home Delivered Meals	10,000	4	Meal	500	N/A
10.4	Nutritional Supplements	75,000	125	Supplement Order	875	N/A
14	**Home Health Care / Home and Community-Based Health Services / Hospice / Rehabilitation**	**$101,011**				
14.1	Home Health / Specialized Care / Professional	1,011	4	One Day Specialized Care	20	N/A
			3	Professional Nursing Visit	10	N/A
14.2	Home Health / Para-Professional Care	100,000	10	One Hour CNA Visit	1,100	N/A
			24	DME Item	150	N/A
			10	One Hour Home Health Aide Visit	1,900	N/A
	Core Medical Services Total	**$3,798,728**				
	Percent of Core Medical Services (Note 2)	**67%**				

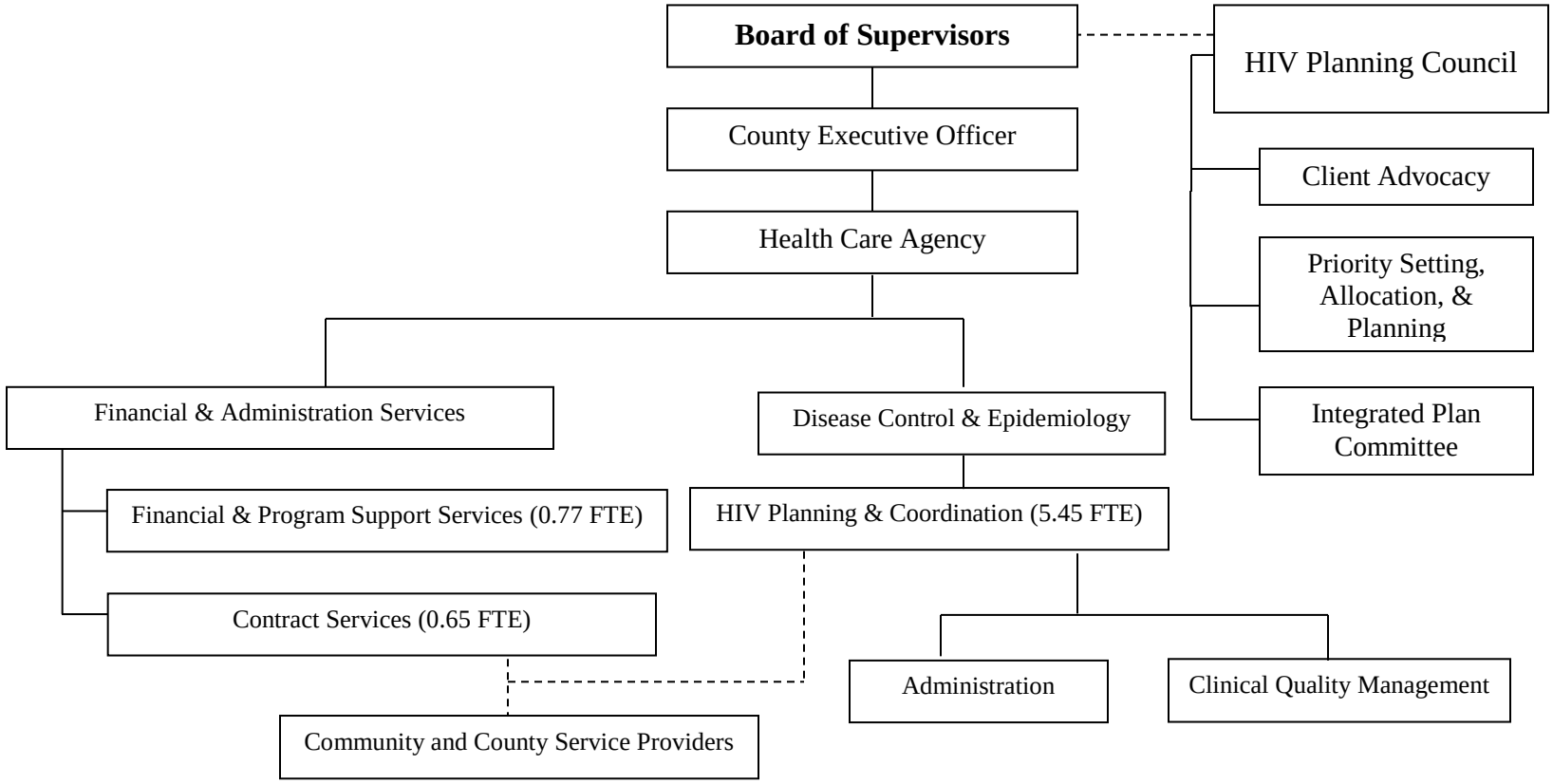
FY 2019 Service Category Table (Continued)

FY19 Priority #	Service Category	Anticipated FY 2019 Part A and MAI Allocations	Projected Unduplicated Clients	Unit of Service Definition	Projected Units of Service	Target Populations (MAI only)
2	**Case Management: Non-Medical**	**$967,072**				
2.3	Client Support Services	271,872	301	15 Minute Face-to-face Visit	1,940	N/A
				15 Minute Service Coordination	2,004	N/A
2.4	Client Advocacy	182,500	719	15 Minute Face-to-face Visit	620	N/A
				15 Minute Service Coordination	1,080	N/A
2.3	Client Support Services (MAI)	130,000	231	15 Minute Face-to-face Visit	1,990	Blacks and Latinos
				15 Minute Service Coordination	3,222	
2.4	Client Advocacy (MAI)	2,700	45	15 Minute Face-to-face Visit	160	Blacks and Latinos
				15 Minute Service Coordination	50	
2.5	Benefits Counseling and Eligibility Screening	380,000	275	15 Minute Benefits Counseling	1,800	N/A
				15 Minute Service Coordination	1,600	N/A
			1,160	15 Minute Eligibility Screening	3,870	N/A
				15 Minute Service Coordination	1,300	N/A
3	**EFA - Medications / Health Insurance Premium and Cost Sharing Assistance / ADAP**	**$5,500**				
3.2	EFA - Medications	5,500	15	Medication Payment	80	N/A
6	**Housing**	**$200,000**				
6.1	Emergency Financial Assistance -	0	0	N/A	0	N/A
6.2	Housing Coordination (Note 1)	0	0	N/A	0	N/A
6.3	Short-Term Supportive Housing	200,000	80	Bed Night	2,500	N/A
8	**Outreach Services**	**$80,000**				
		80,000	335	15 Minute Face-to-face contact	160	N/A
				15 Minute Service Coordination	3,050	N/A
9	**Substance Abuse Services: Outpatient / Residential Services / Detox**	**$0**				
9.3	Residential (Note 1)	0	0	N/A	0	N/A
9.4	Detox Services (Note 1)	0	0	N/A	0	N/A
10	**Nutrition Services**	**$170,000**				
10.2	Food Bank	170,000	575	Food Order	4,000	N/A
11	**Medical Transportation Services**	**$335,429**				
		335,429	416	One-Way Van Ride	1,000	N/A
				One-Way Taxi Ride	577	N/A
				Daily Bus Pass	1,685	N/A
				Monthly Bus Pass	650	N/A
				ACCESS Coupon	3,143	N/A
12	**Other Professional Services including Legal Services**	**$98,445**	100	15 Minute Legal Service Unit	4,519	N/A
13	**Prevention with Positives (Note 3)**	**$0**	0	N/A	0	N/A
14	**Independent Skills - Health Education / Risk Reduction (Note 1)**	**$0**	0	N/A	0	N/A
15	**Psychosocial Support Services (Note 1)**	**$0**	0	N/A	0	N/A
	Support Services Total	**$1,856,446**				
	Percent of Support Services	**33%**				
	Total Service Dollars	**$5,655,174**				
	Admin - Up to 10% of Part A and MAI	580,436				
	Quality Management - Up to 5% of Part A and MAI	291,288				
	GRAND TOTAL	**$6,526,898**				

Note 1: This service was prioritized during the planning process but is anticipated to be fully funded by other resources in Orange County.
Note 2: A Core Medical Services Waiver was submitted on August 23, 2018 for FY 2019 and is pending approval.
Note 3: State prevention funding for behavioral interventions for Prevention with Positives was eliminated as of July 1, 2018. Funding priorities to prevent HIV transmission have shifted to HIV testing, PrEP services, and Care services for HIV-positive individuals.

County of Orange Organizational Chart

The organizational chart below illustrates the lines of responsibility for the administrative structure responsible for the Ryan White-Part A/MAI grant. The Board of Supervisors (BOS) appoints the County Executive Officer (CEO) and members of the Orange County planning body (HIV Planning Council). The Council is responsible for planning activities that include needs assessments, priority setting, and resource allocation. The three committees below are responsible for the planning activities. The Health Care Agency (HCA) of the County has designated two sections, Financial and Administrative Services and Disease Control and Epidemiology the responsibilities for the Ryan White program. HIV Planning and Coordination (HPC) staff are responsible for grant administration and clinical quality management. Contract Services, in collaboration with HPC, is responsible for procuring services and monitoring service delivery. Financial and Program Support funding is included in the indirect allocation. Seven service providers (five community and two county) have programs that meet the prioritized and funded service needs of the county.



The Orange County Health Care Agency (HCA) has maintained expenditures at the same level as the previous period. The table below shows the FY 2017-18 Maintenance of Effort (MOE) for HCA's HIV programs, excluding Part C services, and the current year (FY 2018-19) estimated MOE.

Non-Federal Expenditures

FY 2017-18 **Prior Year to Application (Actual)**	**FY 2018-19** **Current Year of Application (Estimated)**
Actual prior FY non-federal TGA political subdivision expenditures related for HIV-related core and medical support services MOE Amount: $408,012	Estimated current FY non-federal TGA political subdivision expenditures related for HIV-related core and medical support services MOE Estimate Amount: $410,000

HCA has not changed the methodology for its MOE calculation. The following core services are included in the calculation of the MOE: Outpatient/Ambulatory Health Services, Medical Nutrition Therapy, Oral Health Care, Medical Case Management, and Early Intervention Services. Support services include Case Management: Non-Medical, Medical Transportation, and Outreach Services. For simplicity, the MOE is reported for the county fiscal year (July-June) because the core and medical services expenditures vary based on grant fiscal years. The MOE is calculated based on unallowable expenses (e.g., salary rate limitations) and unclaimed indirect expenses (actual indirect exceeds budgeted indirect). The detailed documentation of the contribution is maintained and on file at the HCA.

State of California—Health and Human Services Agency
California Department of Public Health

KAREN SMITH, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

January 31, 2018

Anna Peters
Director, Administrative Services
Orange County
405 W 5th Street, 7th Floor
Santa Ana, CA 92702

Dear Anna Peters:

Thank you for submitting your Indirect Cost Rate (ICR) documentation to the California Department of Public Health (CDPH). CDPH is excited to have a standardized process that allows each Local Health Department (LHD) to use the negotiated ICR for all contracts, unless the ICR is otherwise designated by state or federal statutes, regulations, or specific grant guidelines, with CDPH.

For Fiscal Year (FY) 2018-19, CDPH has accepted the documentation you have provided and, on a one-year basis, will approve your ICR proposal as follows:

20.308% calculated based on Salaries, Wages and Fringe Benefits

Please note, the rate you provided was approved up to the maximum allowed by CDPH policy (up to 25% for ICR calculated based on Salaries, Wages and Fringe Benefits and up to 15% for ICR calculated based on Total Allowable Direct Costs).

We look forward to working with you to document your approved ICR in CDPH contracts with a start date of July 1, 2018, or later.

If you have any questions, contact CDPH at CDPH-ICR-Mailbox@cdph.ca.gov.

Thank you,

Duane Cousin
For

Jaana H. Brown, Accounting Section Chief
California Department of Public Health

1615 Capitol Avenue, Suite 73.230, MS 1601 P.O. Box 997376 Sacramento, CA 95899-7376
(916) 552-8404 (916) 552-8403 FAX
Internet Address: www.cdph.ca.gov

RWHAP PART A BUDGET SUMMARY APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20							
	Part A			Minority AIDS Initiative (MAI)			Total
Object Class Categories	Administration	CQM	HIV Services	Administration	CQM	HIV Services	
a. Personnel	$ 308,373	$ 147,315	$ 0	$ 27,541	$ 13,771	$ 0	$ 497,000
b. Fringe Benefits	$ 152,676	$ 72,936	$ 0	$ 13,636	$ 6,818	$ 0	$ 246,065
c. Travel	$ 8,700	$ 2,500	$ 0	$ 0	$ 0	$ 0	$ 11,200
d. Equipment	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
e. Supplies	$ 14,561	$ 15,675	$ 0	$ 0	$ 0	$ 0	$ 30,236
f. Contractual	$ 0	$ 0	$ 5,293,271	$ 0	$ 0	$ 361,903	$ 5,655,174
g. Other	$ 16,550	$ 9,000	$ 0	$ 0	$ 0	$ 0	$ 25,550
Direct Charges	$ 500,860	$ 247,426	$ 5,293,271	$ 41,177	$ 20,588	$ 361,903	$ 6,465,225
Indirect Charges	$ 37,000	$ 22,574		$ 1,399	$ 700		$ 61,673
TOTALS	$ 537,860	$ 270,000	$ 5,293,271	$ 42,576	$ 21,288	$ 361,903	$ 6,526,898
Program Income			$ 1,108,156			$ 6,509	$ 1,114,665

PART A ADMINISTRATIVE BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20				
Personnel				
Salary	**FTE**	**Name, Position**	**Budget Impact Justification**	**Amount**
$ 122,200	0.30	Tamarra Jones, Program Manager II	Overall leadership of Ryan White services, oversees the integration of various funding sources, and serve as point of contact for HRSA. This position ensures the implementation of services based on the Integrated Plan and assures compliance with grant requirements. Oversees the development of reports and grant application. FTE percentages: 30% Part A Admin, 10% Part A PC, 20% Part A QM, 10% MAI Admin, 5% MAI QM, 15% Prevention, 10% Part B.	$ 36,660
$ 84,947	0.20	Sam Monroy, Program Supervisor II	Overall supervision of service delivery and monitoring. Ensures that service providers are implementing and providing services as outlines in contracts and Standards of Care. Helps with the development of reports and grant application. FTE percentages: 20% Part A Admin, 10% Part A PC, 45% Part A QM. 10% MAI Admin, 5% MAI QM, 5% Prevention, 5% Part B.	$ 16,989
$ 68,266	0.30	Mindy He, Staff Specialist	Leads efforts for preparation and submission of Conditions of Award and annual grant application. FTE percentages: 30% Part A Admin, 10% Part A PC, 40% Part A QM. 5% MAI Admin, 5% MAI QM, 10% HOPWA.	$ 20,480
$ 68,266	0.10	Diane Pinto, Staff Specialist	Leads site visit activities and follow up. Provides assistance in generating reports. FTE percentages: 10% Part A Admin, 25% Part A QM. 5% MAI Admin, 60% Prevention.	$ 6,827
$ 79,789	0.55	James Williams, Research Analyst III	Oversees ARIES data entry and technical support. Provides training for all service providers and submits annual RSR. FTE percentages: 55% Part A Admin and 45% Part A QM.	$ 43,884
$ 85,966	0.30	Vacant, Administrative Manager I (Grant)	Position will be the lead for all grant requirements including the grant application and submission of grant reports. FTE percentages: 30% Part A Admin, 20% Part B Admin, 20% Part C Admin, 10% HOPWA, 10% Prevention, 10% STD, 10% HIV Surveillance.	$ 25,790
$ 40,394	0.05	Grecia Estrada, Office Specialist	Position provides clerical support and oversees purchasing. FTE percentages: 5% Part A Admin, 10% Part A PC, 23% Part A Case Management Non-Medical, 15% Part A Dental, 5% Part A Outpatient Ambulatory Care, 5% Part C Outpatient Ambulatory Care, 13% Part B Case Management Non-Medical, 10% ADAP, 14% County.	$ 2,020
$ 85,966	0.65	Janlus Chou, Administrative Manager I	Oversees contract development and monitoring. Also, responsible for reviewing and approving provider invoices. FTE percentages: 65% Part A Admin and 35% County.	$ 55,878
			Personnel Total	**$ 208,527**

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PART A ADMINISTRATIVE BUDGET APPLICANT (Continued)				
Fringe Benefits				
Percentage	**Components**			**Amount**
49.51%	Fringe benefits include: retirement, health insurance, dental insurance, other insurance and worker's compensation insurance			$ 103,242
			Fringe Benefit Total	**$ 103,242**
Travel				
Local				
Mileage Rate	**Number of Miles**	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification**	**Amount**
0.54	370	Tamarra Jones, Program Manager II	Mileage and parking for meetings, site visits, and local conferences. Impact to program is ability to ensure compliance with grant, help implement and identify best practices, and to provide technical assistance as needed for implementation of service delivery goals.	$ 200
0.54	370	Sam Monroy, Program Supervisor II	Mileage and parking for meetings, site visits, and local conferences. Impact to program is ability to ensure compliance with grant, help implement and identify best practices, and to provide technical assistance as needed for implementation of service delivery goals.	$ 200
0.54	370	Mindy He, Staff Specialist	Mileage and parking for meetings, site visits, and local conferences. Impact to program is ability to ensure compliance with grant, help implement and identify best practices, and to provide technical assistance as needed for implementation of service delivery goals.	$ 200
0.54	370	Diane Pinto, Staff Specialist	Mileage and parking for meetings, site visits, and local conferences. Impact to program is ability to ensure compliance with grant, help implement and identify best practices, and to provide technical assistance as needed for implementation of service delivery goals.	$ 200
0.54	370	Vacant, Administrative Manager I (Grant)	Mileage and parking for meetings, site visits, and local conferences. Impact to program is ability to ensure compliance with grant, help implement and identify best practices, and to provide technical assistance as needed for implementation of service delivery goals.	$ 200
			Local Travel Sub-Total	**$ 1,000**

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PART A ADMINISTRATIVE BUDGET APPLICANT (Continued)

Long Distance

Type of Travel	Name, Position of Traveler(s)	Travel Expenses/Budget Impact Justification	Amount
National Conference	Tamarra Jones, Program Manager II	Lodging at $250/night, Airfare: $725, Per diem $75, Registration: $250, Parking/Transportation: $150: Conferences allow the opportunity to share and gather best practices to implement improvements in service delivery.	$ 2,500
National Conference	Sam Monroy, Program Supervisor II	Lodging at $250/night, Airfare: $725, Per diem $75, Registration: $250, Parking/Transportation: $150: Conferences allow the opportunity to share and gather best practices to implement improvements in service delivery.	$ 2,500
		Long Distance Travel Sub-Total	**$ 5,000**
		Travel Total	**$ 6,000**

Supplies

List of Supplies	Budget Impact Justification	Amount
Office Supplies and materials (paper, pens, pencils, toner, paper clips, post its, staples, chart paper)	Required materials for meetings and document production.	$ 10,561
	Supplies Total	**$ 10,561**

Other

List of Other	Budget Impact Justification	Amount
Cost for Training (s)	Cost to hire training to provide trainings on identified needs (e.g., cultural competency, HIV 101, etc.)	$ 1,500
Rent/Facilities	Requires space for staff to carryout program requirements.	$ 2,500
	Other Costs Total	**$ 4,000**
	Total Direct Cost	**$ 332,330**

Indirect Cost

Type of Indirect Cost	Rate	Insert Base	Total
Final	**20.308%**	The Indirect Cost Rates (ICR) for California Department of Public Health (CDPH) agreements with Local Health Departments (LHD) are expressed as a percentage, which is applied to the total of Personnel Services (Salary and Benefits). LHDs may elect to reduce their published ICR percentage with CDPH programs.	**$ 25,000**
		Part A Administrative Total	**$ 357,330**

PART A PLANNING COUNCIL BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20				
Personnel				
Salary	**FTE**	**Name, Position**	**Budget Impact Justification**	**Amount**
$ 122,200	0.10	Tamarra Jones, Program Manager II	Providers direct oversight of Planning Council support position. Prepares and presents data to the Council. Helps ensure that the Council conducts mandating planning activities. FTE percentages: 30% Part A Admin, 10% Part A PC, 20% Part A QM, 10% MAI Admin, 5% MAI QM, 15% Prevention, 10% Part B.	$ 12,220
$ 84,947	0.10	Sam Monroy, Program Supervisor II	Prepares and presents data to the Council. Leads Council trainings as needed. Helps ensure that the Council conducts mandating planning activities. FTE percentages: 20% Part A Admin, 10% Part A PC, 45% Part A QM. 10% MAI Admin, 5% MAI QM, 5% Prevention, 5% Part B.	$ 8,495
$ 68,266	0.10	Mindy He, Staff Specialist	Prepares and presents data to the Council. Leads Council trainings as needed. Helps ensure that the Council conducts mandating planning activities. FTE percentages: 30% Part A Admin, 10% Part A PC, 40% Part A QM. 5% MAI Admin, 5% MAI QM, 10% HOPWA.	$ 6,827
$ 68,266	1.00	Martha Garcia, Staff Specialist	Provider all administrative support to the Council and its committees. Helps ensure that the Council conducts mandating planning activities. FTE 100% Part A PC.	$ 68,266
$ 40,394	0.10	Grecia Estrada, Office Specialist	Responsible for coordinating meals for all meetings. Helps ensure that the Council conducts mandating planning activities. FTE percentages: 5% Part A Admin, 10% Part A PC, 23% Part A Case Management Non-Medical, 15% Part A Dental, 5% Part A Outpatient Ambulatory Care, 5% Part C Outpatient Ambulatory Care, 13% Part B Case Management Non-Medical, 10% ADAP, 14% County.	$ 4,039
			Personnel Total	**$ 99,846**

Fringe Benefits		
Percentage	**Components**	**Amount**
49.51%	Fringe benefits include: retirement, health insurance, dental insurance, other insurance and worker's compensation insurance	$ 49,434
	Fringe Benefit Total	**$ 49,434**

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PART A PLANNING COUNCIL BUDGET APPLICANT (Continued)				
Travel				
Local				
Mileage Rate	**Number of Miles**	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification**	**Amount**
0.54	370	Martha Garcia, Staff Specialist	Mileage and parking for meetings and local conferences. Impact to program is ability to ensure compliance with grant, help implement and identify best practices, and to provide technical assistance as needed for implementation of mandated planning activities	$ 200
			Local Travel Sub-Total	**$ 200**
Long Distance				
Type of Travel		**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification**	**Amount**
National Conference		Martha Garcia, Staff Specialist	Lodging at $250/night, Airfare: $725, Per diem $75, Registration: $250, Parking/Transportation: $150: Conferences allow the opportunity to share and gather best practices to implement improvements in the annual planning process.	$ 2,500
			Long Distance Travel Sub-Total	**$ 2,500**
			Travel Total	**$ 2,700**
Supplies				
List of Supplies			**Budget Impact Justification**	**Amount**
Office Supplies and materials (paper, pens, pencils, toner, paper clips, post its, staples, chart paper)			Required materials for meetings and document production.	$ 4,000
			Supplies Total	**$ 4,000**
Contractual				
List of Contracts	**Deliverables**		**Budget Impact Justification**	**Amount**
				$ 0
			Contracts Total	**$ 0**

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PART A PLANNING COUNCIL BUDGET APPLICANT (Continued)		
Other		
List of Other	**Budget Impact Justification**	**Amount**
Training Consultant	Consultant to provide training for planning process.	$ 500
Gas Card/Bus Pass for consumer members	Travel reimbursement for consumers to participate in the planning process.	$ 2,000
Planning Council Meals	Meals for meetings to ensure engagement and participation in developing the Integrated Plan and conducting planning activities.	$ 7,550
Rent/Facilities	Requires space for staff to carryout program requirements.	$ 2,500
	Other Costs Total	**$ 12,550**
Total Direct Cost		**$ 168,530**

Indirect Cost			
Type of Indirect Cost	**Rate**	**Insert Base**	**Total**
Final	**20.308%**	The Indirect Cost Rates (ICR) for California Department of Public Health (CDPH) agreements with Local Health Departments (LHD) are expressed as a percentage, which is applied to the total of Personnel Services (Salary and Benefits). LHDs may elect to reduce their published ICR percentage with CDPH programs.	**12,000**

Part A Planning Council Total	**$ 180,530**

PART A CLINICAL QUALITY MANAGEMENT BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20				
Personnel				
Salary	**FTE**	**Name, Position**	**Budget Impact Justification**	**Amount**
$ 122,200	0.20	Tamarra Jones, Program Manager II	Oversight of continuous quality management to improve progress along HIV care continuum for all persons living with HIV in Orange County. Participant in the Ending Disparities Collaborative. FTE percentages: 30% Part A Admin, 10% Part A PC, 20% Part A QM, 10% MAI Admin, 5% MAI QM, 15% Prevention, 10% Part B.	$ 24,440
$ 84,947	0.45	Sam Monroy, Program Supervisor II	Oversight of the QM committee to monitor outcomes and develop quality improvement activities. Participant in the Ending Disparities Collaborative. FTE percentages: 20% Part A Admin, 10% Part A PC, 45% Part A QM. 10% MAI Admin, 5% MAI QM, 5% Prevention, 5% Part B.	$ 38,226
$ 68,266	0.40	Mindy He, Staff Specialist	Development of the in+care and our+care newsletters to increase community awareness and involvement and improve health outcomes. FTE percentages: 30% Part A Admin, 10% Part A PC, 40% Part A QM. 5% MAI Admin, 5% MAI QM, 10% HOPWA.	$ 27,306
$ 68,266	0.25	Diane Pinto, Staff Specialist	Assistance with reports and materials for QM/QI activities. FTE percentages: 10% Part A Admin, 25% Part A QM. 5% MAI Admin, 60% Prevention.	$ 17,066
$ 79,789	0.45	James Williams, Research Analyst III	ARIES data analysis and report generation to develop appropriate goals and objective for QI activities. FTE percentages: 55% Part A Admin and 45% Part A QM.	$ 35,905
$ 87,422	0.05	Rebecca Mares, Sr. Epidemiologist	Surveillance data analysis and report generation to develop appropriate goals and objective for QI activities. FTE percentages: 5% Part A QM, 80% HIV Surveillance, 15% Part A EIS.	$ 4,371
			Personnel Total	**$ 147,315**
Fringe Benefits				
Percentage	**Components**			**Amount**
49.51%	Fringe benefits include: retirement, health insurance, dental insurance, other insurance and worker's compensation insurance			$ 72,936
			Fringe Benefit Total	**$ 72,936**

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PART A CLINICAL QUALITY MANAGEMENT BUDGET APPLICANT (Continued)			
Travel			
Long Distance			
Type of Travel	**Name, Position of Traveler(s)**	**Travel Expenses/Budget Impact Justification**	**Amount**
National Conference	Mindy He, Staff Specialist	Lodging at $250/night, Airfare: $725, Per diem $75, Registration: $250, Parking/Transportation: $150: Conferences allow the opportunity to share and gather best practices to implement Quality Improvement initiatives.	$ 2,500
		Long Distance Travel Sub-Total	**$ 2,500**
		Travel Total	**$ 2,500**
Supplies			
List of Supplies		**Budget Impact Justification**	**Amount**
Office Supplies and materials (paper, pens, pencils, toner, paper clips, post its, staples, chart paper)		Required materials for meetings, document production, trainings, and Quality Improvement trainings or activities.	$ 15,675
		Supplies Total	**$ 15,675**
Other			
List of Other		**Budget Impact Justification**	**Amount**
Training Consultant		Consultant to provide training on QM/QI principles.	$ 500
Quality Management Evaluation		Survey Monkey subscription for surveys and evaluation.	$ 1,000
Gas Card/Bus Pass for consumer members		Travel reimbursement for consumers to participate in the QM/QI activities.	$ 500
Food for meetings		Meals for meetings to ensure engagement and participation in QM/QI activities.	$ 4,500
Rent/Facilities		Requires space for staff to carryout program requirements.	$ 2,500
		Other Costs Total	**$ 9,000**
Total Direct Cost			**$ 247,426**
Indirect Cost			
Type of Indirect Cost	**Rate**	**Insert Base**	**Total**
Final	**20.308%**	The Indirect Cost Rates (ICR) for California Department of Public Health (CDPH) agreements with Local Health Departments (LHD) are expressed as a percentage, which is applied to the total of Personnel Services (Salary and Benefits). LHDs may elect to reduce their published ICR percentage with CDPH programs.	**$ 22,574**
Part A Clinical Quality Management Total			**$ 270,000**

PART A HIV SERVICES BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20			
Contractual			
List of Contracts	**Deliverables**	**Budget Impact Justification**	**Amount**
Note: The contracted providers (List of Contracts) and the services provided (Deliverables) were submitted as part of the grant application. However, for the purposes of printing and distributing, the List of Contracts and Deliverables were omitted to maintain anonymity.		Services help to ensure linkage, retention in HIV Care, and viral load suppression. Costs estimated based on prior year expenditures, cost per client, cost per unit, actual cost for services (e.g., bus passes, cost of food), actual staffing costs, and Medicare/Medicaid rates.	$ 190,200
		Services help to ensure linkage, retention in HIV Care, and viral load suppression. Services also help re-engage individuals who have never linked or fallen out of care. Costs estimated based on prior year expenditures, cost per client, cost per unit, actual cost for services (e.g., bus passes), actual staffing costs, and Medicaid rates.	$ 2,713,903
		Service helps to ensure access to core and support services to increase engagement in care. Cost estimate is based on actual cost for bus passes.	$ 3,958
		Service helps improve access to benefits and increase engagement in care. Costs estimated based on prior year expenditures, cost per client, cost per unit, traditional legal service fees, and actual staffing costs.	$ 98,445
		Services help to ensure linkage, retention in HIV Care, and viral load suppression. Costs estimated based on prior year expenditures, cost per client, cost per unit, actual cost for services (e.g., bus passes, cost of food), actual staffing costs, and Medicare/Medicaid rates.	$ 2,118,158
		Services help to ensure linkage, retention in HIV Care, and viral load suppression. Costs estimated based on prior year expenditures, cost per client, cost per unit, and actual staffing costs.	$ 168,607
		Contracts Total	**$ 5,293,271**

Total Direct Cost	**$5,293,271**
Part A HIV Services Total	**$ 5,293,271**

MAI ADMINISTRATIVE BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20				
Personnel				
Salary	**FTE**	**Name, Position**	**Budget Impact Justification**	**Amount**
$ 122,200	0.10	Tamarra Jones, Program Manager II	Overall leadership of Ryan White services, oversees the integration of various funding sources, and serve as point of contact for HRSA. This position ensures the implementation of services based on the Integrated Plan and assures compliance with grant requirements. Oversees the development of reports and grant application. FTE percentages: 30% Part A Admin, 10% Part A PC, 20% Part A QM, 10% MAI Admin, 5% MAI QM, 15% Prevention, 10% Part B.	$ 12,220
$ 84,947	0.10	Sam Monroy, Program Supervisor II	Overall supervision of service delivery and monitoring. Ensures that service providers are implementing and providing services as outlines in contracts and Standards of Care. Helps with the development of reports and grant application. FTE percentages: 20% Part A Admin, 10% Part A PC, 45% Part A QM. 10% MAI Admin, 5% MAI QM, 5% Prevention, 5% Part B.	$ 8,495
$ 68,266	0.05	Mindy He, Staff Specialist	Leads efforts for preparation and submission of Conditions of Award and annual grant application. FTE percentages: 30% Part A Admin, 10% Part A PC, 40% Part A QM. 5% MAI Admin, 5% MAI QM, 10% HOPWA.	$ 3,413
$ 68,266	0.05	Diane Pinto, Staff Specialist	Leads site visit activities and follow up. Provides assistance in generating reports. FTE percentages: 10% Part A Admin, 25% Part A QM. 5% MAI Admin, 60% Prevention.	$ 3,413
			Personnel Total	**$ 27,541**
Fringe Benefits				
Percentage	**Components**			**Amount**
49.51%	Fringe benefits include: retirement, health insurance, dental insurance, other insurance and worker's compensation insurance			$ 13,636
			Fringe Benefit Total	**$ 13,636**
Total Direct Cost				**$ 41,177**
Indirect Cost				
Type of Indirect Cost	**Rate**	**Insert Base**		**Total**
Final	**20.308%**	The Indirect Cost Rates (ICR) for California Department of Public Health (CDPH) agreements with Local Health Departments (LHD) are expressed as a percentage, which is applied to the total of Personnel Services (Salary and Benefits). LHDs may elect to reduce their published ICR percentage with CDPH programs.		**$ 1,399**
MAI Administrative Total				**$ 42,576**

MAI CLINICAL QUALITY MANAGEMENT BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20				
Personnel				
Salary	**FTE**	**Name, Position**	**Budget Impact Justification**	**Amount**
$ 122,200	0.05	Tamarra Jones, Program Manager II	Oversight of continuous quality management to improve progress along HIV care continuum for all persons living with HIV in Orange County. Participant in the Ending Disparities Collaborative. FTE percentages: 30% Part A Admin, 10% Part A PC, 20% Part A QM, 10% MAI Admin, 5% MAI QM, 15% Prevention, 10% Part B.	$ 6,110
$ 84,947	0.05	Sam Monroy, Program Supervisor II	Oversight of the QM committee to monitor outcomes and develop quality improvement activities. Participant in the Ending Disparities Collaborative. FTE percentages: 20% Part A Admin, 10% Part A PC, 45% Part A QM. 10% MAI Admin, 5% MAI QM, 5% Prevention, 5% Part B.	$ 4,247
$ 68,266	0.05	Mindy He, Staff Specialist	Development of the in+care and our+care newsletters to increase community awareness and involvement and improve health outcomes. FTE percentages: 30% Part A Admin, 10% Part A PC, 40% Part A QM. 5% MAI Admin, 5% MAI QM, 10% HOPWA.	$ 3,413
			Personnel Total	**$ 13,771**
Fringe Benefits				
Percentage	**Components**			**Amount**
49.51%	Fringe benefits include: retirement, health insurance, dental insurance, other insurance and worker's compensation insurance			$ 6,818
			Fringe Benefit Total	**$ 6,818**
Total Direct Cost				**$ 20,588**
Indirect Cost				
Type of Indirect Cost	**Rate**	**Insert Base**		**Total**
Final	**20.308%**	The Indirect Cost Rates (ICR) for California Department of Public Health (CDPH) agreements with Local Health Departments (LHD) are expressed as a percentage, which is applied to the total of Personnel Services (Salary and Benefits). LHDs may elect to reduce their published ICR percentage with CDPH programs.		**$ 700**
MAI Clinical Quality Management Total				**$ 21,288**

MAI HIV SERVICES BUDGET APPLICANT: Orange County, CA TGA FISCAL YEAR: 2019-20			
Contractual			
List of Contracts	**Deliverables**	**Budget Impact Justification**	**Amount**
Note: The contracted providers (List of Contracts) and the services provided (Deliverables) were submitted as part of the grant application. However, for the purposes of printing and distributing, the List of Contracts and Deliverables were omitted to maintain anonymity.		Services help to ensure linkage, retention in HIV Care, and viral load suppression. Services also help to reduce HIV-related health disparities. Costs estimated based on prior year expenditures, cost per client, cost per unit, and actual staffing costs.	$ 150,467
		Services help to ensure linkage, retention in HIV Care, and viral load suppression. Services also help to reduce HIV-related health disparities. Costs estimated based on prior year expenditures, cost per client, cost per unit, and actual staffing costs.	$ 211,436
		Contracts Total	**$ 361,903**
Total Direct Cost			**$ 361,903**
Indirect Cost			**$ 0**
MAI HIV Services Total			**$ 361,903**

Attachment re: Program/Project Congressional Districts

Program/Project Congressional Districts include:

CA-38, CA-39, CA-45, CA-46, CA-047, CA-048, CA-049