2017-2021

County of Orange Integrated HIV Prevention and Care Plan

health CARE AGENCY

Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

Orange County is comprised of 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 3.1 million people. Orange County ranks 5th [1] in the total number of HIV cases among the state's 58 counties. As of December 2015, there were 6,287 persons living with HIV disease (PLWHD) in Orange County that were aware of their disease. In addition, it is estimated that an additional 622 individuals are living with HIV but are unaware of their status[2]. 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 PLWHD were residing in Santa Ana, an urban area with a disproportionately high population of Hispanic and low-income residents.

Orange County's Integrated HIV Prevention and Care Plan for 2017-2021 (Integrated Plan) provides an overview of the current landscape of HIV services in the county and identifies goals and strategies in moving forward to address the epidemic. The Integrated Plan addresses the HIV Care Continuum including those that are at high-risk for HIV and mirrors the goals outlined in the National HIV/AIDS Strategy for 2020. The goals of the plan are to: 1) reduce new HIV infections; 2) increase access to care and improve health outcomes for people living with HIV; and 3) reduce HIV-related disparities and health inequities.

The Integrate Plan is the result of an open community planning process that took place over a series of meetings in 2015 and 2016. The Integrated Plan represents the efforts of many individuals and communities including the HIV Planning Council (Council), the Prevention and Care Strategies Committee (PCSC), Orange County Health Care Agency (HCA), the HIV Client Advocacy Committee (HCAC), the Priority Setting, Allocations, and Planning (PSAP) Committee, the Ryan White Quality Management Committee, persons living with HIV, and service providers.

Lastly, Orange County's Integrated Plan considers recent developments such as the implementation of the Affordable Care Act, expansion of Medi-Cal (Medicaid), changes in client needs, and the uncertainties of the future.

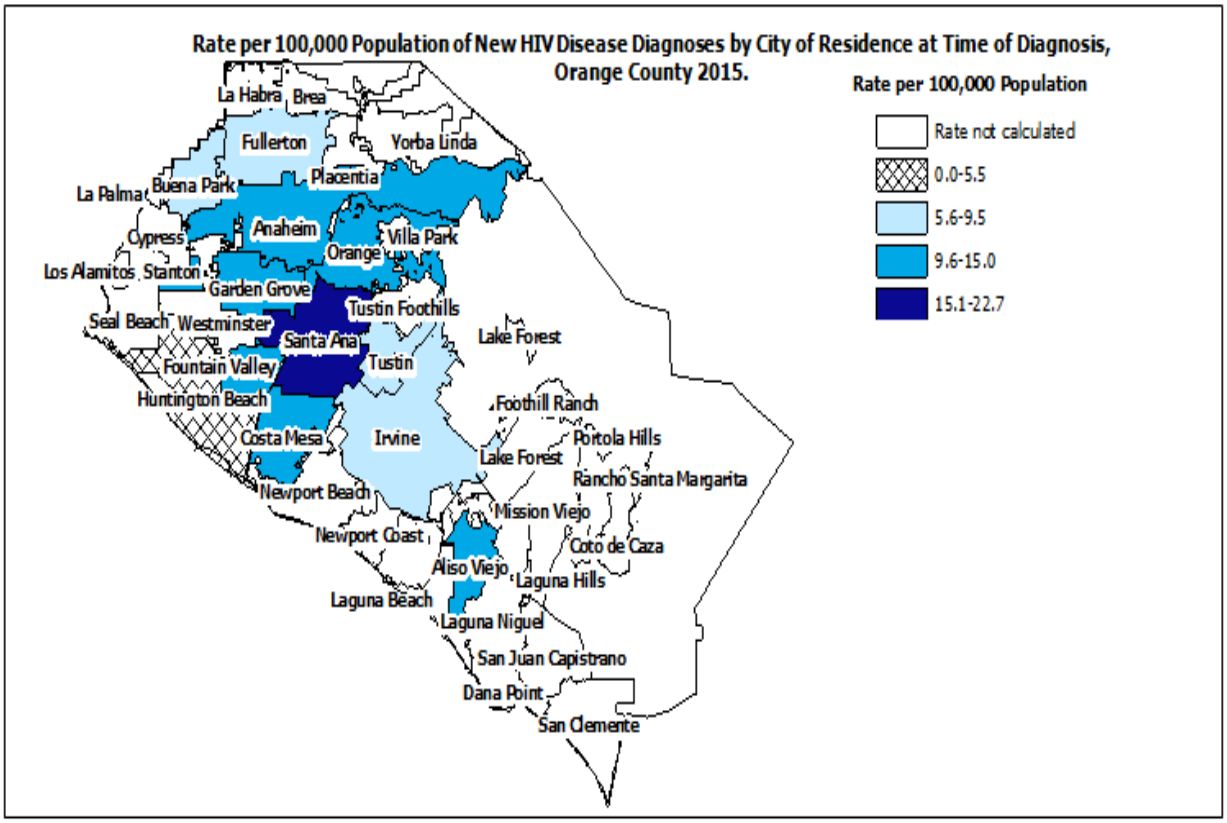
[1] California Department of Public Health, Office of AIDS, HIV/AIDS Surveillance Section, data as of December 23, 2014.

[2] The total number of persons estimated to be living with HIV disease is based on the Centers for Disease Control and Prevention calculation methodology as of July 28, 2016. The calculation is the number of persons known to be living with HIV disease (6,287) divided by 0.91. The difference between this calculation (6,909) and 6,287 is the additional number of persons estimated to be living with HIV disease but are unaware of their diagnosis (622).

A. Epidemiological Overview

a. **Map of Jurisdiction with Communities Affected by HIV**

The map below displays the rate per 100,000 populations of persons newly diagnosed with HIV in 2015 by city of residence at the time of that diagnosis. Santa Ana has the highest rate at 22.7 and Huntington Beach the lowest at 5.5. Rates are not calculated for cities with fewer than five diagnosed cases or where population estimates are unavailable.



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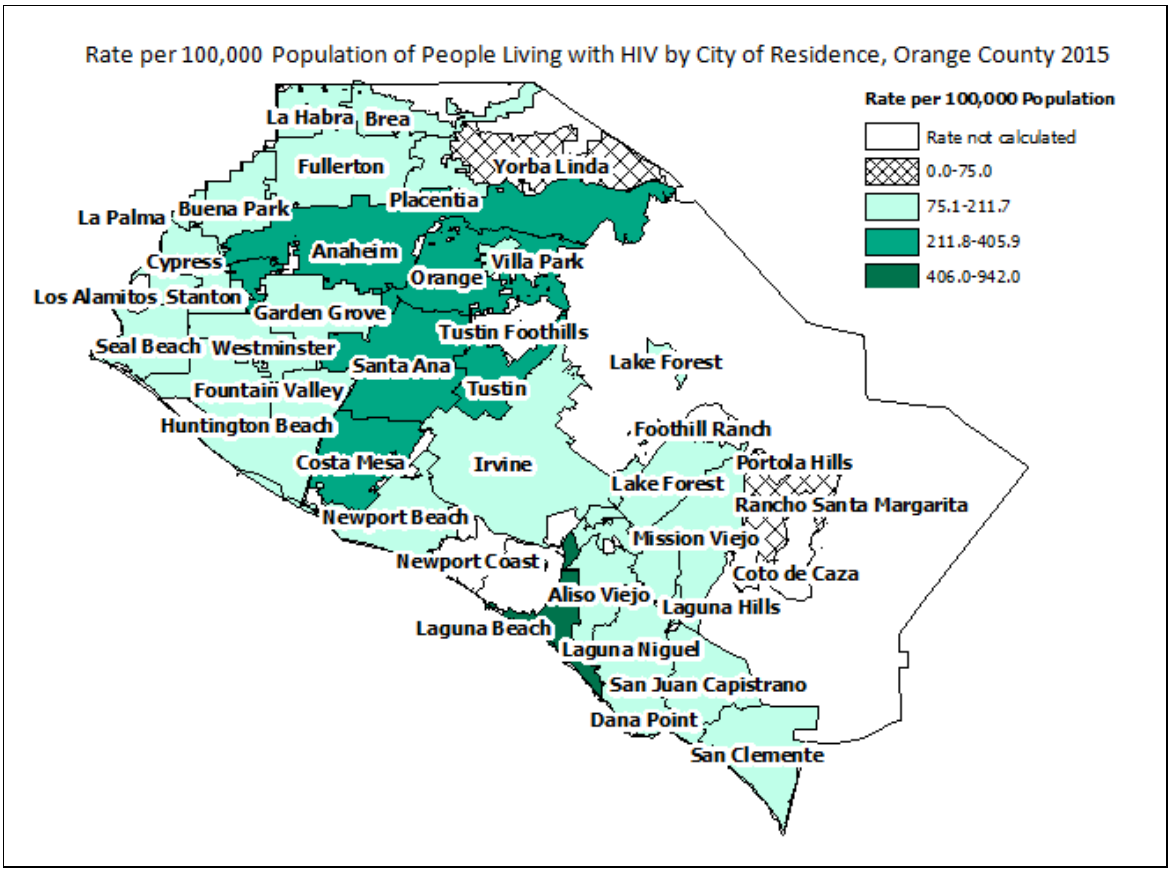
Additionally, the map below shows the rate per 100,000 populations of PLWHD by city of residence at the time of diagnosis. Laguna Beach has the highest rate at 942.0, followed by the central county cities of Santa Ana (405.9) and Anaheim (275.7).



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b. **Socio Demographic Characteristics of Newly Diagnosed, PLWHD, and Persons at Higher Risk for HIV Infection**

i. The table below shows the 2015 demographic detail for all newly diagnosed individuals, PLWHD, and high-risk populations that received a State Office of AIDS funded HIV test. 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:

- Males
- Asian/Pacific Islander (API)
- MSM
- Hispanics
- Younger Populations

Data for high-risk populations are similar to data for newly diagnosed and PLWHD except among the following populations:

Percent of high-risk testers is lower than the percent for newly HIV diagnosed in 2015 and PLWHD

- Whites
- Older Adults
- Heterosexual Contact

Percent of high-risk testers is higher than the percent for newly HIV diagnosed in and PLWHD

- Asian/Pacific Islander (API)
- Individuals between 19-25

Table 1: Demographic Detail for 2015 Newly Diagnosed Individuals, PLWHD, and High-Risk Populations

	2015		PLWHD		High-Risk Populations	
	Number	Percent	Number	Percent	Number	Percent
Total Number of Cases	**300**	**100.0%**	**6,287**	**100.0%**	**4,375**[3]	**100.0%**
Gender/Sex						
Male	278	92.7%	5,458	86.8%	4,023	92.0%
Female	19	6.3%	771	12.3%	159	3.6%
Transgender	*	*	58	0.9%	192	4.4%
Race/Ethnicity						
Black[4]	12	4.0%	324	5.2%	163	3.7%
Hispanic	153	51.0%	2,928	46.6%	2,180	49.8%
White	108	36.0%	2,543	40.4%	1,164	26.6%
Asian/Pacific Islander (API)	25	8.3%	433	6.9%	761	17.4%
Other/More than One Race/ Unknown	*	*	59	0.9%	107	2.4%
Age at Diagnosis						
0-18 Years	5	1.7%	33	0.5%	110	2.5%
19-25 Years	67	22.3%	240	3.8%	1517	34.7%
26-35 Years	100	33.3%	1,021	16.2%	1494	34.1%
36-45 Years	61	20.3%	1,478	23.5%	695	15.9%
46-55 Years	47	15.7%	2,071	32.9%	371	8.5%
56 Years and Older	20	6.7%	1,444	23.0%	188	4.3%

[3] The total number of high risk populations may include duplicate individuals that are repeat testers.
[4] Black and African-American are used interchangeably.

Table 2: Demographic Detail for
2015 Newly Diagnosed Individuals, PLWHD, and High-Risk Populations

	2015		PLWHD		High-Risk Populations	
	Number	Percent	Number	Percent	Number	Percent
Total Number of Cases	**300**	**100.0%**	**6,287**	**100.0%**	**4,375**	**100.0%**
Risk Factor/Transmission Category						
Men Having Sex With Men (MSM)	241	80.3%	4,567	72.6%	3,800	86.9%
Heterosexual Contact	19	6.3%	678	10.8%	79	1.8%
Injection Drug Use (IDU)	12	4.0%	481	7.7%	201	4.6%
MSM/IDU	10	3.3%	327	5.2%	67	1.5%
Other/Unknown	18	6.0%	234	3.7%	228	5.2%

*Fewer than five cases diagnosed. Other Race/Ethnicity includes Native American/Alaskan Native. Other Mode of Exposure includes recipients of transfusions or transplants, persons who received treatment for hemophilia, and all pediatric modes of transmission.

ii. The table below shows available socioeconomic data for individuals that were newly diagnosed in 2015, PLWHD in the Ryan White system, and high-risk populations that received a State Office of AIDS funded HIV test in 2015. The narrative in the Integrated Plan will include information about the limitations in socioeconomic data.

Table 3: Socioeconomic Detail for
2015 Newly Diagnosed Individuals, Ryan White, and High-Risk Populations

	2015		Ryan White		High-Risk Populations	
	Number	Percent	Number	Percent	Number	Percent
Total Number of Cases	**300**[5]	**100.0%**	**2,280**	**100.0%**	**4,375**	**100.0%**
Federal Poverty Level (FPL)						
Under 100% FPL	84	61.8%	1,318	57.8%	Data is not available	
101-138% FPL	14	10.3%	316	13.9%		
139-200% FPL	13	9.6%	307	13.5%		
201-250% FPL	8	5.9%	138	6.1%		
251-400% FPL	12	8.8%	174	7.6%		
401-500% FPL	3	2.2%	15	0.7%		
501% FPL and above	0	0.0%	4	0.2%		
Not Reported	2	1.5%	8	0.4%		
Health Insurance Status[6]						
Private Insurance	105	35.0%	315	13.8%	1,316	30.0%
Medi-Cal/Medicare	49	16.3%	925	40.6%	709	16.2%
No Insurance	128	42.7%	1,163	51.0%	1,965	44.9%
Unknown	18	6.0%	0	0.00%	42	0.9%
Other Public[7]	0	0.00%	0	0.00%	343	7.8%

[5] The number of newly diagnosed individuals in the FPL category does not add up to 300 because data is based on individuals that entered the Ryan White system.

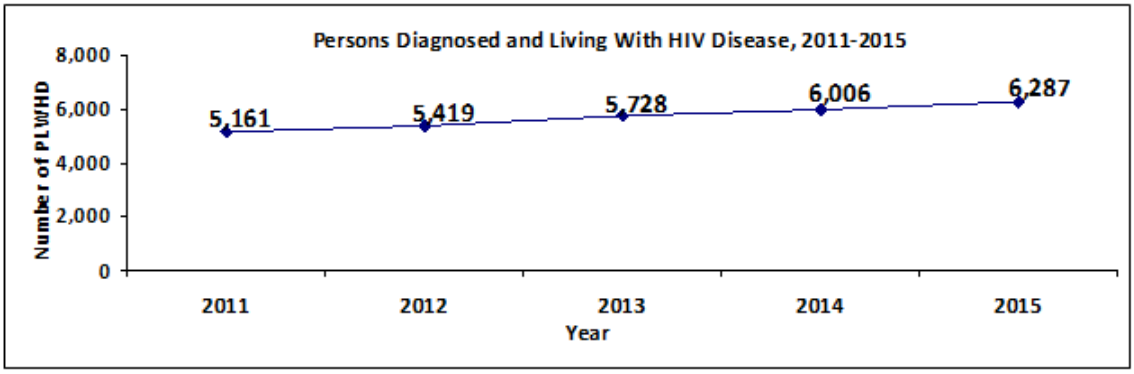
[6] Individuals may have more than one insurance listed in ARIES (Ryan White database) because an individual may move through different payer sources in the same year.

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

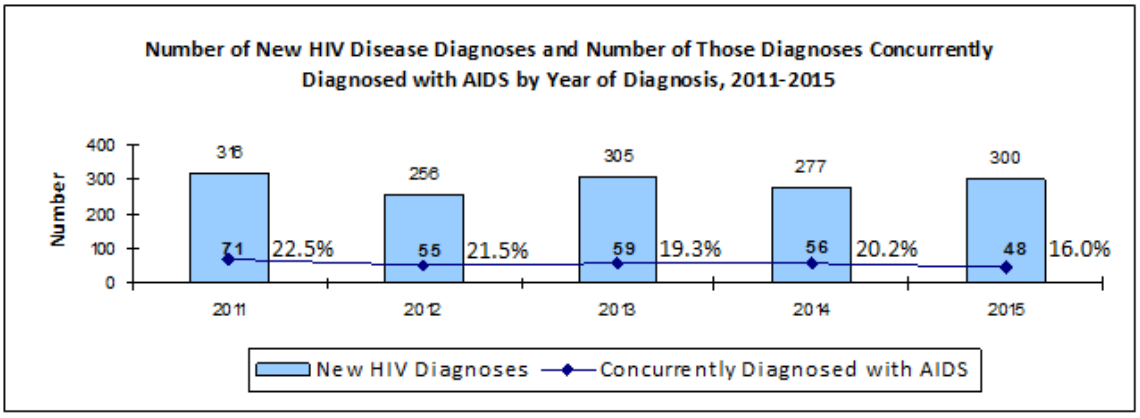
c. **Description of the Burden of HIV in the Service Area**

The tables and graphs below show the burden of HIV in Orange County based on the characteristics of the population. The information includes total number of PLWHD, concurrent diagnoses[8], rates by gender, rates by race/ethnicity, rates by age at diagnosis, and rates based on mode of exposure. Data in some of the graphs is grouped into three year groupings. This is done in order to understand trends and not let a spike from one year skew the data.

Over the five year period of 2011 through 2015 there has been an increase of 1,126 people living with HIV in Orange County. The average is an increase of 225 individuals a year. This number does not include individuals that have passed away or have been confirmed to have moved outside of Orange County.



The bar graph below shows the number of individuals that are newly diagnosed by year of diagnosis. In addition, the line graph shows the number of newly diagnosed individuals that were diagnosed with HIV and AIDS within the same month, indicates the number of individuals that are tested late (concurrently diagnosed with HIV and AIDS). Over the past five years, the number of concurrently diagnosed individuals has decreased by 6.5% percentage points.



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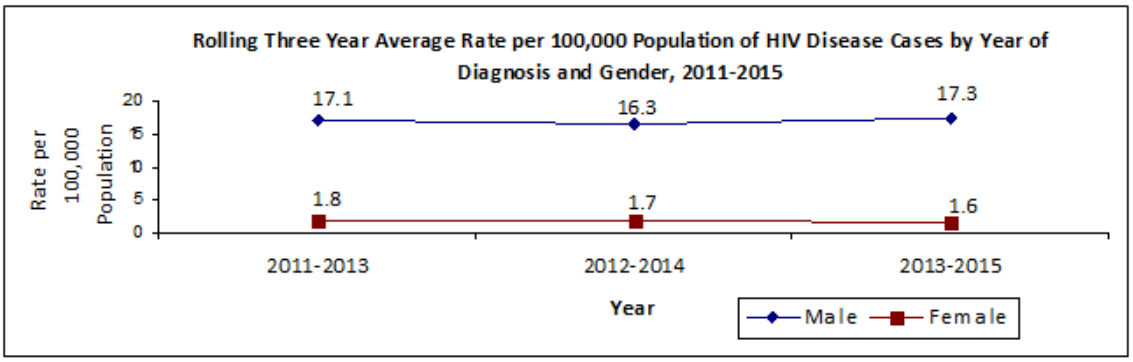
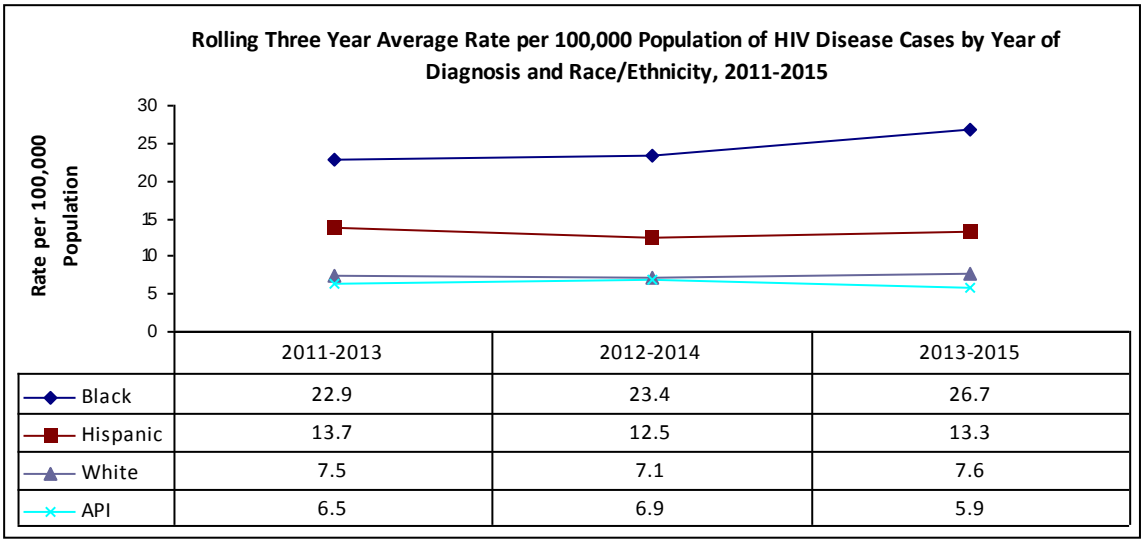
[8] Concurrent diagnosis is newly diagnosed individuals that were diagnosed with HIV and AIDS within the same month.

The graph below shows the rate of infection based on gender. Over the last five years the rate has been stable for both males and females. The rate has decreased slightly for females.



The graph below shows the rate of infection based on Race/Ethnicity. Over the last five years, the rates for Black/African American's have increased, while rates for Hispanics and Whites have remained stable. The rates for Asian/Pacific Islander (API) have decreased slightly.



	2011-2013	2012-2014	2013-2015
Black	22.9	23.4	26.7
Hispanic	13.7	12.5	13.3
White	7.5	7.1	7.6
API	6.5	6.9	5.9

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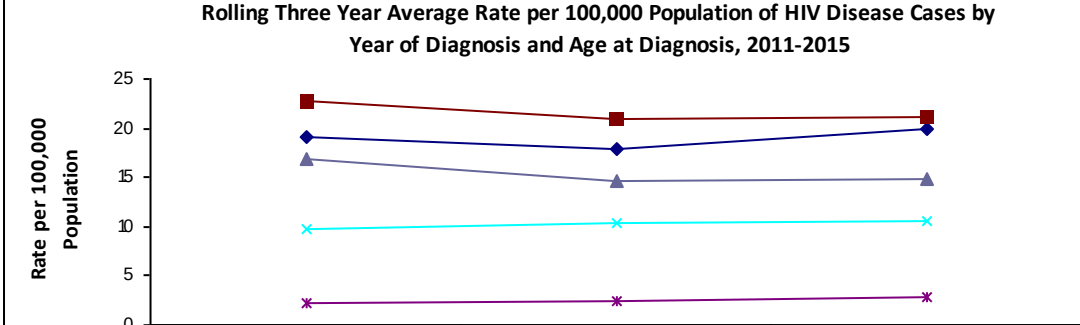
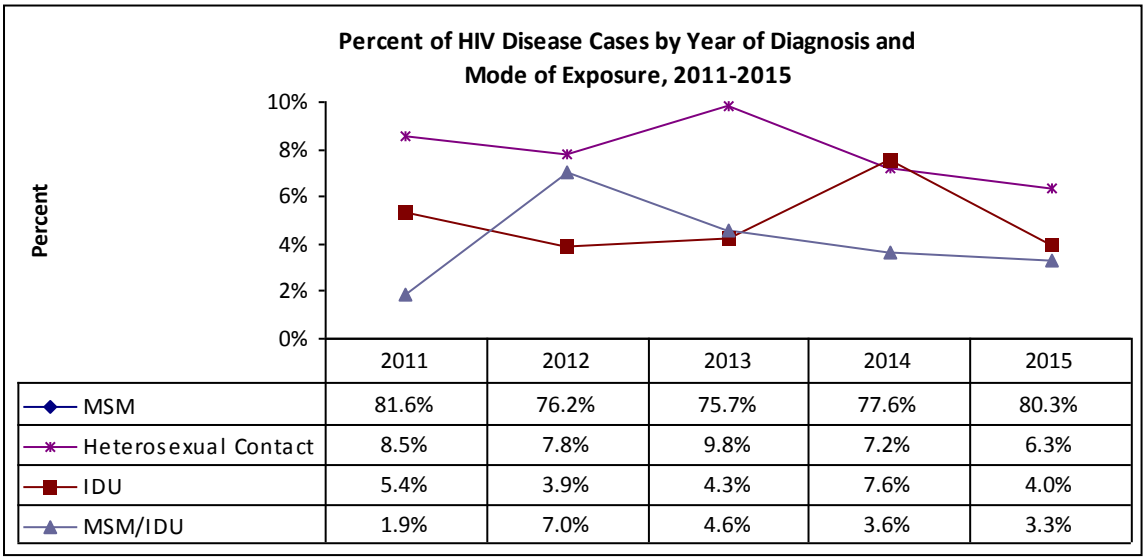
The graph below shows the rate of infection based on the Age at Diagnosis. Over the last five years, the rates for 19-25, 46-55, and 56+ year olds have seen slight increases, while the rates for 26-35 and 36-45 year olds have seen slight decreases.



	2011-2013	2012-2014	2013-2015
19-25	19.2	17.8	20.0
26-35	22.8	21.0	21.1
36-45	16.8	14.7	14.9
46-55	9.8	10.3	10.6
56+	2.3	2.5	2.8

The graph below shows the rate of infection based on the Mode of Exposure or Risk Factor. Over the last five years, the rates for men who have sex with men/injection drug user (MSM/IDU) have been unstable with a large spike in 2012 and an overall increase in 2015 over 2011. For all other risk factors there have been slight decreases in 2015 over 2011. MSM percentages are not shown in the line graph below in order to demonstrate changes among IDU, Heterosexual Contact, and MSM/IDU. The MSM case percentage is provided for each year.



	2011	2012	2013	2014	2015
MSM	81.6%	76.2%	75.7%	77.6%	80.3%
Heterosexual Contact	8.5%	7.8%	9.8%	7.2%	6.3%
IDU	5.4%	3.9%	4.3%	7.6%	4.0%
MSM/IDU	1.9%	7.0%	4.6%	3.6%	3.3%

d. **Description of the Indicators of Risk for HIV infection**

i. Behavioral surveillance data

These systems do not offer Orange County specific data and is not currently used as part of the planning process.

ii. HIV Surveillance Data including HIV Testing Program Data

The table below shows information about the 9,570 tests that were conducted in Orange County in 2015 through the State Office of AIDS funded targeted testing program. The tests resulted in 75 newly identified positives and 37 previously identified positive test. Of the 75 newly identified positive tests, 65 were linked to medical care and received a viral load test. Of the 37 previously identified positives, 31 were linked to medical care and received a viral load test.

Newly diagnosed positive HIV test events:	**Total**
Number of test events	**9,570**
Number of newly diagnosed and positive test events	**75** (0.8%)[1]
Number of newly diagnosed positive test events with clients linked to HIV medical care (Based on testing provider reports)	**55** (73%)[2]
Newly diagnosed confirmed positive test events:	**Total**
Number of newly diagnosed confirmed positive test events	**75**
Number of newly diagnosed confirmed positive test event with client referred to partner services	**75** (100%)
Number of newly diagnosed confirmed positive test events with client interviewed for partner services	**75** (100%)[2]
Number of newly diagnosed confirmed positive test events with client referred to prevention services	**57** (75%)[2]
Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing (Based on surveillance reports)	**65** (86%)[2]
Previously diagnosed positive HIV test events:	**Total**
Number of test events	**9,570**
Number of previously diagnosed and positive test events	**37** (0.4%)[1]
Number of previously diagnosed positive test events with clients re-engaged in HIV medical care (Based on testing provider reports)	**21** (57%)[2]
Previously diagnosed confirmed positive test events:	**Total**
Number of previously diagnosed confirmed positive test events	**37**
Number of previously diagnosed confirmed positive test events with client interviewed for partner services	**36** (97%)[2]
Number of previously diagnosed confirmed positive test events with client referred to prevention services	**19** (51%)[2]
Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing (Based on surveillance reports)	**31** (84%)[2]

[1] Percentage based on the number of positive test events divided by the number of total test events.
[2] Percentages shown are calculated using the category number divided by the total number of positive test events.
Includes State-funded tests from 17th Street T&T, ASF, APAIT, Jail Testing, REACH, and The Center.
Data sources: Local Evaluation Online (LEO) data as of February 2016.
HIV Case Registry, Data as of March 2016.

iii. Ryan White Program Data

Currently, Ryan White Services Report data is used to analyze service utilization by individuals in the Ryan White System and is not used to analyze higher risk populations. There is also no unified data provided regarding the AIDS Drug Assistance Program that can be applied to higher risk individuals.

iv. Other Relevant Demographic Data Including STD/STI and Comorbidities

The tables below show the cases and case rate of STD/STIs among the general population in Orange County in comparison to the number of cases and case rate among PLWHD in Orange County for 2014. Additionally, the comparison among Orange County residents and PLWHD in Orange County is also done for comorbidities such as homelessness, incarcerated, mental illness, and substance abuse. In every category except mental illness there is a higher case rate among PLWHD than there is for the general population.

Sexually Transmitted Infections	Estimated Prevalence within General Population of TGA		Prevalence among PLWHD		Risk Ratio
	Cases	Case Rate	Cases	Case Rate	
Syphilis (All cases)	1,804[1]	57.6/100,000	325[6]	5,642.4/100,000	98.0
Chlamydia	9,272[2]	296.0/100,000	139[6]	2,413.2/100,000	8.2
Gonorrhea	1,781[2]	56.9/100,000	101[6]	1,753.5/100,000	30.8
Hepatitis C Virus (HCV)	3,912[3]	124.9/100,000	96[6]	1,666.7/100,000	13.3

	Estimated Prevalence within General Population of TGA		Prevalence within Ryan White System		Risk Ratio
	Cases	Case Rate	Cases	Case Rate	
Homelessness	15,271[4]	507.3 / 100,000	101[10]	1,753.5/100,000	3.5
Incarcerated	6,805[5]	217.2/100,000	142[6,7]	2,465.3/100,000	11.4
Mental Illness	138,721[8]	4,583.1 / 100,000	255[10]	4,427.1/100,000	0.9
Substance Abuse	224,783[9]	6,840.6 / 100,000	845[10]	14,670.1/100,000	2.1

Sources for General Population:

[1] County of Orange, Health Care Agency, Disease Control, CalREDIE Database and Syphilis Access Database, April 2015. 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 2014.

[2] County of Orange, Epidemiology and Assessment Morbidity Data, April 28, 2015 Unpublished Data, 2015

[3] CalREDIE, Data Distribution Portal, Chronic and Acute cases of Hepatitis C

[4] Focus Strategies, *2015 Orange County Homeless Count and Survey Report*

[5] Orange County Sheriff's Department, Average Daily Inmate Population, Board of Corrections Jail Profile Survey, July 2015

[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 HIV-Infected Population:

[6] HIV/AIDS Case Registry, PLWHD as of January 31, 2015, Cases diagnosed with Syphilis, Chlamydia, Gonorrhea, or Hepatitis C in 2014

[7] Weekly Inmate List, Orange County Sheriff's Department

[10] ARIES Ryan White Services Report 2014, Orange County

v. Qualitative Data

In 2013, the Health Care Agency conducted surveys with individuals who tested positive for HIV at the 17th Street Testing, Treatment and Care Clinic (17th Street) to determine their barriers to HIV testing. The goal of this project was twofold: 1) identify potential barriers to HIV testing among clients recently diagnosed with HIV, especially those concurrently diagnosed with AIDS (late testers) and 2) detect missed testing opportunities at local health care provider locations. Results showed that of the 40 participants in the survey 35 (88%) had a healthcare related visit in the 12 months before testing HIV-positive. Of the 40 participants only 16 (40%) had an HIV test previously. Below is more detail regarding the results from the survey.

Gender	Number	Percent	OC Epidemic
Male	34	85%	84.7%
Female	5	13%	13.6%
Transgender	1	3%	1.7%

Ethnicity	Number	Percent	OC Epidemic
White	3	8%	22.9%
Hispanic	23	58%	65.5%
Black	1	3%	4.3%
Asian	11	28%	6.7%
Other	2	5%	0.6%

Tested for HIV in year prior to first positive HIV Test?	Number	Percent
No	24	60%
Yes	16	40%

Health Care Visits	Number	Percent	Offered HIV Test	Not Offered HIV Test	Percent Offered
Emergency Room/ED	12	30%	2	10	17%
Private Doctor	20	50%	1	19	5%
Overnight Hospital	6	15%	2	4	33%
Community Health Center	8	20%	5	3	63%
STD Clinic	11	28%	11	0	100%
Dentist	12	30%	0	12	0%
Mobile Clinic	4	10%	2	2	50%
Clinica[9]	10	25%	0	10	0%

Had Any Healthcare Visit?	35	88%

[9] Clinica is the Spanish term for community clinic.

vi. Vital statistics data
Vital Statistics databases such as death records are reviewed to determine if any confirmed PLWHD has passed away or if any individual has HIV listed as an underlying condition but was not previously reported HIV-positive and has died. These individuals are removed from the data for individuals living with HIV in Orange County. This data is not currently used to analyze individuals that are at high risk for HIV.

vii. Other Relevant Program Data:
Data regarding STD information, Partner Services[10], and high-risk individuals who receive Pre-Exposure Prophylaxis (PrEP) through 17th Street will be reviewed and included in the Plan as appropriate.

B. HIV Care Continuum

a. **Prevalence-based HIV Care Continuum**
Orange County has opted to use a prevalence-based HIV Care Continuum. In addition, to better identify gaps or improvements along the continuum, Orange County has modified some of the stages as defined below:

i. Infected with HIV: 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;

ii. Diagnosed with HIV: 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;

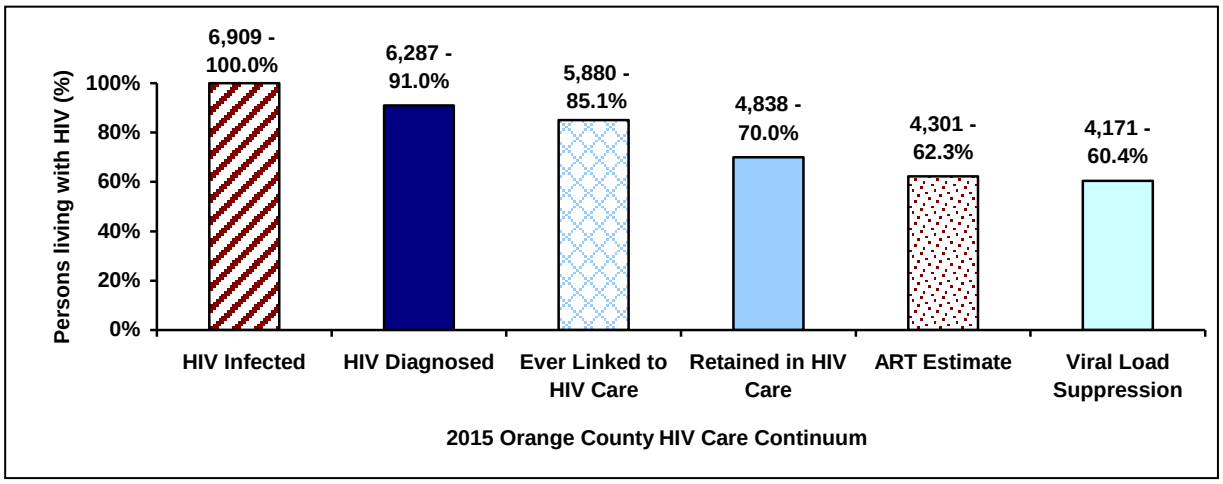
iii. Ever Linked to Care: This is the percent of HIV-positive individuals who have been linked to HIV medical care (as indicated by having at least one viral load and/or CD4 count blood test after the month and year of diagnosis);

iv. Retained in Care: This is persons diagnosed with HIV and whose most current address was in Orange County as of December 31, 2015 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 2015, the two results occurred in 2014 and/or 2015. For persons diagnosed in 2015, the results occurred between January 2015 and July 2016;

v. 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 an undetectable viral load at their last test in 2015 and persons whose viral load has declined between the last test in 2015 and the previous test); and

[10] Partner Services provides assistance to HIV positive persons in notifying their sexual and/or needle sharing partners of possible exposure to HIV.

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



b. **Disparities among Key Populations**

Each jurisdiction is able to select populations that, based on available data, have health disparities (e.g., Men who have Sex with Men [MSM], Injection Drug Users [IDU], racial disparities, etc.). Health disparities may include higher rates of HIV infection, lower rates of linkage to HIV care, lower rates of retention in care, or lower viral load suppression rates in a given group compared to the general population or comparable counterpart. Previous analyses have identified that the key populations for Orange County where the largest health disparities exist include:

- Hispanics and Black/African-Americans
- Transgender
- Injection Drug Users (IDU)
- Heterosexuals

The following provides an overview of the health disparity data among these populations.

1) Hispanics and Black/African American

The chart below shows that the percentage of Hispanic PLWHD is lower at each step of the continuum in comparison to White and all PLWHD. Black PLWHD have a percentage of ever linked to care similar to White, but then fall out of care at higher rates than Whites. These minority populations are falling out of care at higher percentages and are not reaching viral load suppression at the same rates as Whites. Based on total numbers Hispanics and Whites have the most PLWHD out of care.

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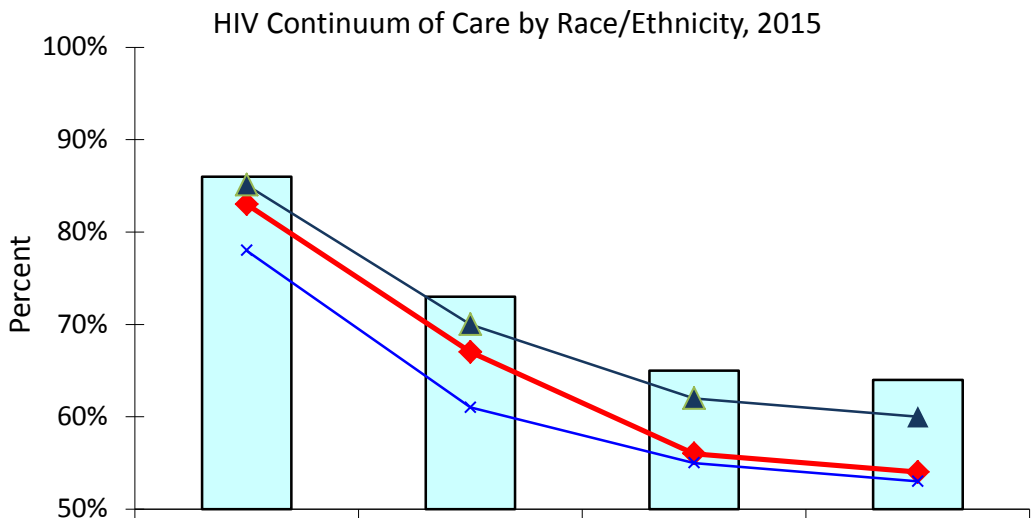

	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
White (N=2,832)	86%	73%	65%	64%
Black (N=375)	83%	67%	56%	54%
Hispanic (N=3,433)	78%	61%	55%	53%
All PLWHD (N=6,909)	85%	70%	62%	60%

The graph above shows the differences in each point of the continuum for Blacks and Hispanics compared to Whites. As shown above, Hispanics have the largest gap (disparity) compared to Whites for all stages of the Continuum. Blacks also start lower that Whites at linked to care and continue to fall out of care at higher rates than Whites at every step among the continuum. Ultimately, 10% fewer Blacks and 11% fewer Hispanics are reaching viral load suppression in comparison to Whites.

In Orange County, the number of Blacks compared to other race/ethnicities is low (as shown below). However, the percentages along the continuum show the disparities in care for this population. Furthermore, the number of Hispanic PLWHD is the highest among all racial groups. Comparing the number and percentages along the continuum indicate the most significant disparities among this population.

	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
White (N=2,832)	2,428	2,066	1,851	1,798
Black (N=375)	312	251	210	201
Hispanic (N=3,433)	2,671	2,109	1,871	1,807
All PLWHD (N=6,909)	5,880	4,838	4,301	4,171

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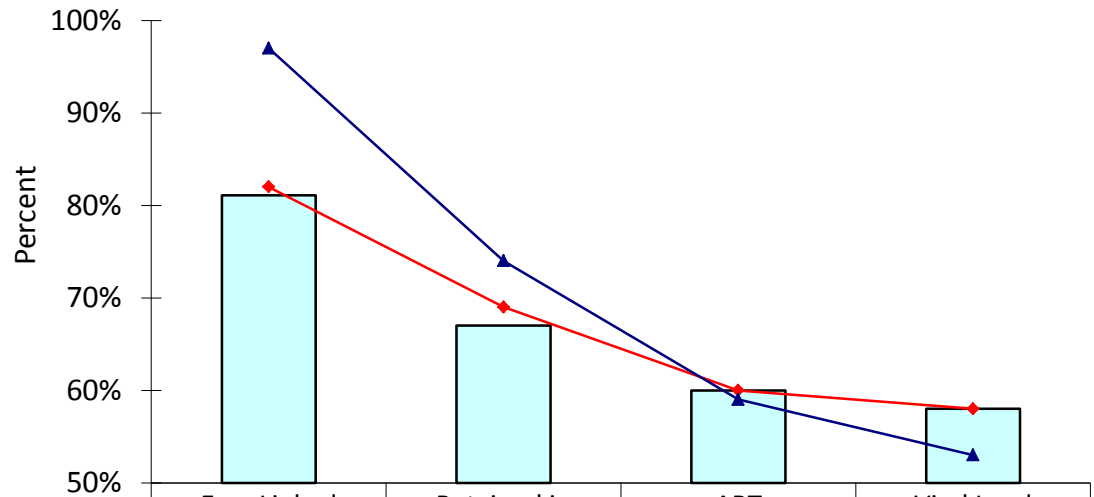
2) Transgender

Overall transgender numbers are significantly smaller than male and female PLWHD. Transgender PLWHD are retained in care in higher percentages but reach viral load suppression at lower percentages. Transgender PLWHD are 5% less likely to be virally suppressed than males and females. Additionally, of the 58 transgender individuals identified to be HIV positive, only 31 have reached viral load suppression.

HIV Continuum of Care by Gender, 2015



	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
Male (N=6,275)	81%	67%	60%	58%
Female (N=870)	82%	69%	60%	58%
Transgender (N=58)	97%	74%	59%	53%

	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
Male (N=6,275)	5,108	4,199	3,749	3,636
Female (N=870)	870	596	518	504
Transgender (N=58)[11]	56	43	34	31

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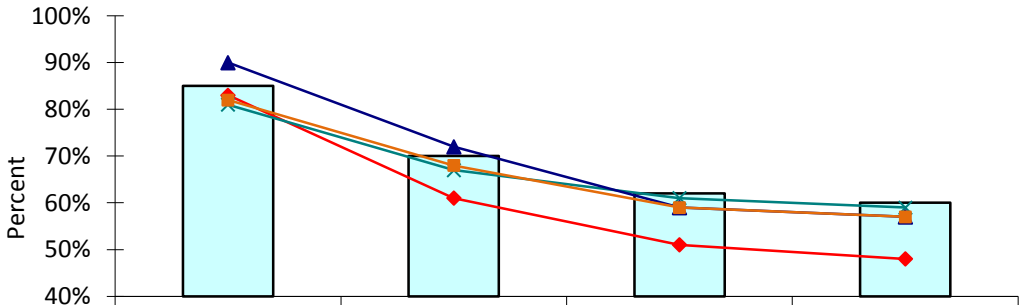
[11] For transgender N represents the actual number of transgender individuals living with HIV. An estimate is not created because we do not have an estimated number of transgender individuals in the general population.

3) Injection Drug Users (IDU)

Reported mode of transmission for HIV shows a disparity among IDU. Individuals reporting exposure via IDU are less likely to be linked to care and have noteworthy disparities along all stages of the continuum. Individuals reporting heterosexual exposure also show disparities in retention in care to viral load suppression.

HIV Continuum of Care by Mode of Transmission, 2015



	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
All PLWHD (N=6,909)[6]	85%	70%	62%	60%
IDU (N=507)[7]	83%	61%	51%	48%
MSM (N=5,358)	81%	67%	61%	59%
MSM/IDU (N=349)	90%	72%	59%	57%
Heterosexual (N=790)[7]	82%	68%	59%	57%

	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
All PLWHD (N=6,909)	5,880	4,838	4,301	4,171
IDU (N=507)	419	309	261	245
MSM (N=5,358)	4,316	3,600	3,240	3,155
MSM/IDU (N=349)	315	250	207	199
Heterosexual Contact (N=790)	649	536	465	450

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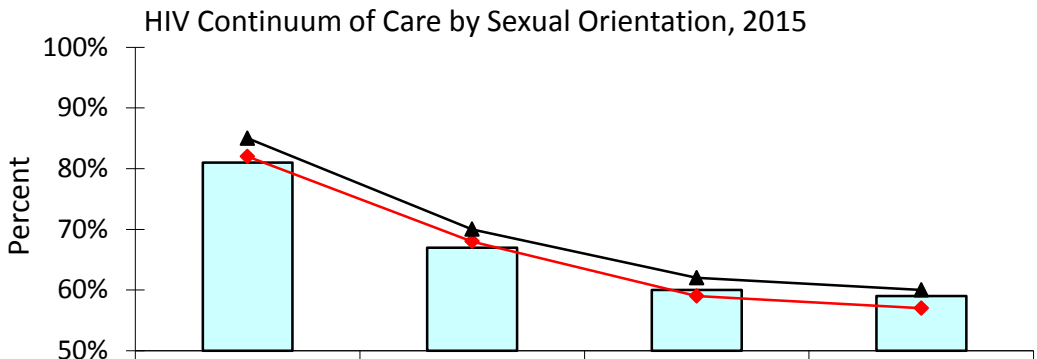
[12] Individuals with unknown or unreported mode of transmission are all included under "All PLWHD."
[13] Mode of transmission hierarchy is determined by the Centers for Disease Control and Prevention. Individuals reporting a mode of transmission of both IDU and Heterosexual contact are reported and shown as IDU.

4) Heterosexuals

Men who have Sex with Men (MSM) make up the largest portion of those living with HIV in Orange County (approximately 78%). Health disparities in heterosexuals are shown by comparing heterosexuals to the MSM and MSM/IDU populations. Heterosexuals have better outcomes in being linked to care and retained in care but reach viral load suppression at lower percentages than MSM (as shown below).



	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
MSM & MSM/IDU (N=5,707)	81%	67%	60%	59%
Heterosexual (N=790)	82%	68%	59%	57%
All PLWHD (N=6,909)	85%	70%	62%	60%

	Ever Linked to HIV Care	Retained in HIV Care	ART Estimate	Viral Load Suppression
MSM & MSM/IDU (N=5,707)[14]	4,631	3,850	3,447	3,354
Heterosexual Contact (N=790)[8]	649	536	465	450
All PLWHD (N=6,909)	5,880	4,838	4,301	4,171

c. **Overview of Current Use of the Continuum Data**

The following provides details on how the continuum data is used in Orange County.

- Priority Setting: The Priority Setting, Allocations, and Planning (PSAP) committee considered how each Ryan White service contributes to increasing identification of those unaware of their HIV status; increasing the number of clients linked to care, increasing the number of clients retained in care, and increasing the number of individuals who are virally suppressed.

- Quality Improvement: Service providers have been provided data on the HIV Care Continuum for Orange County and data for their specific agency to identify ways of prioritizing and targeting activities to improve outcomes along each stage of the continuum.

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[14] Pediatric cases are not included in either category because sexual orientation is not known.

- Health Disparities: The Prevention and Care Strategies Committee (PCSC) and PSAP have reviewed data regarding disparities among populations along the continuum as a means to identify areas for which interventions could be implemented that result in improvements along the continuum.

- Linkage to Care/Outreach/Data to Care: A process has been developed to increase linkage to care for individuals newly diagnosed, new to Orange County, and individuals who have fallen out-of-care or never initiated care. Surveillance data (Data to care) has been utilized to identify individuals that may require assistance linking to and becoming engaged in care.

- PLWHD Engagement: HIV Care Continuum data can be a tool to reduce stigma and engage people living with HIV disease (PLWHD). The HIV Care Continuum shows that people are living longer, healthier, productive lives. The continuum can include the voice of PLWHD with examples of tools individuals used to move from one bar to the next and why reaching virally load suppression is important. The numbers of individuals at each level of the continuum and able to reach viral load suppression is an educational tool that helps people be aware of the reality of the HIV epidemic in Orange County.

C. Financial and Human Resources Inventory

a. **Jurisdictional Funding Table**
The funding table provides an estimated overview of funding, by funding sources, available in Orange County to address the HIV Care Continuum. Information presented may not fully represent all funding available for PLWHD and those at risk for HIV in Orange County. **(See Attachment A labeled Jurisdictional Funding Sources Resource Table)**

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b. **HIV Workforce Capacity**

The workforce inventory is based on staff and interns that work on a variety of services among the prevention and care service continuum. A workforce inventory survey was distributed to 20 organizations or programs that have been previously identified as providing services among the continuum. Of the 20 surveys distributed, nine (9) organizations or programs responded (representing a 45% response rate) with information on the following items:

Total Full Time Equivalent (FTE) Staffing	207.40 FTE	
Staffing Dedicated to HIV Related Services	129.92 FTE	
Total Interns	20.00 FTE	
Interns Dedicated to HIV Related Services	7.70 FTE	
Anticipated Staff Vacancies in the Next 12 Months	13.00 FTE	
Staff and Interns by Service Category	Service Category[15]	Number of Staff/Interns
	Administration	26
	Primary Medical Care	49
	Mental Health Service	8
	PrEP Services	8
	Medical Case Management	15
	Non-Medical Case Management	23
	Outreach Services	2
	Early Intervention Services	8
	Dental Care	5
	Prevention Services	5
	Transportation Services	3
	Housing Services	2
	Nutrition Services	1
	Treatment Adherence	1
	Substance Abuse Counseling	15

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[15] Service Category information is based on survey responses and does not include all grant funded service categories. In addition, some categories listed are not grant funded but provided in Orange County via other funding sources.

Staff and Interns Average Year Experience working with PLWHD by Service Category

Service Category[16]	Avg. Year Experience
Administration	11 years
Primary Medical Care	8 years
Mental Health Service	3 years
PrEP Services	0.5 years
Medical Case Management	4 years
Non-Medical Case Management	6 years
Outreach Services	10 years
Early Intervention Services[17]	15 years
Dental Care	11 years
Prevention Services	3 years
Transportation Services	6 years
Housing Services	10 years
Nutrition Services	2 years
Treatment Adherence	3 years
Substance Abuse Counseling	5 years

Education/Licensure

Degree/Licensure	Number of Staff/Interns
Doctor of Medicine (MD)	19
Doctor of Dental Surgery	3
Bachelor/Bachelor of Science (BA/BS)	18
Register Nurse (RN)	6
Registered Dental Assistant (RDA)	2
Certified Addiction Specialist (CADC/CAADE/RADT)	10
Master of Business Administration	1
Marriage and Family Therapist (MFT)	9
Bachelor of Science in Nursing (BSN)	13
Nurse Practitioner (NP)	3
Doctor of Psychology (Psy.D.)	2
Master of Social Work (MSW)	2
Masters/Masters of Science (MA/MS)	2
Licensed Clinical Social Work (LCSW)	2
Licensed Vocational Nurse (LVN)	2
Doctor of Philosophy (PhD)	1
Master of Science in Nursing (MSN)	1

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[16] Service Category information is based on survey responses and does not include all grant funded service categories. In addition, some categories listed are not grant funded but provided in Orange County via other funding sources.

[17] Early Intervention Services (EIS) definitions across Ryan White Parts differ. Under Part C, EIS includes Primary Medical Care. Under Part A, EIS is limited to HIV counseling and testing and referrals to services based on diagnosis. The reported average years of experience is likely to include staff who have provided Primary Medical Care under EIS, Part C funding.

The responses above show a workforce that is concentrated in Ryan White core medical services (104 of the 171 (or 61%) reported FTE provide a core medical service). In accordance with Health Resources Services Administration (HRSA) expectations, the Orange County HIV Planning Council has prioritized and funded core medical services to improve health outcomes for individuals who have no other source for HIV care. However, the reported degrees and licensure reported indicate that over half (90 of the 171 FTE) of the workforce is made up of individuals who do not possess a degree or licensure.

Survey respondents reported a spectrum of average years in HIV-related work ranging from two years (Nutrition Services) to 15 years (Early Intervention Services). Services with a lower average number of years have been reported by non-profits. Services such as nutrition services and prevention services may be attributed to turnover rates at non-profits which the 2015 Nonprofit Employment Practices Survey says was 19% in 2014[18]. The survey states that turnover is much higher in entry level positions and low-level management. This turnover can impact the services that clients receive because generally the first point of contact for a client is staff in entry level positions. This factor places the burden of training and knowledge transfers on the system as a whole. A 2013 HIV Workforce Survey conducted by the Black AIDS Institute, the Centers for Disease Control, National Alliance of State and Territorial AIDS Directors, and others stated that 76% of the HIV related workforce was in either AIDS Service Organizations or Community Based Organizations. Of the staff that was non-medical:

- 62% were competent in HIV/AIDS science
- 55% were competent in HIV treatment
- 45% competent in clinical/biomedical interventions[19]

The report states that trainings, technical assistance, and capacity building is needed at all levels in order to successfully implement services and improving outcomes along the continuum

The survey results indicated the following:

- The total average number of HIV year work experience is six
- 67 FTE (39%) provide non-core medical service
- 90 FTE (53%) do not have a degree or licensure
- Of those with a degree, 64 FTE (67%) have an advanced degree (Masters or higher)

To best address the needs of those at risk for contracting HIV and those living with HIV, a strong, well-qualified, workforce is needed. Based on the survey, the following may help improve the Orange County workforce:

- Increase opportunities and funding to hire more staff
- Provide opportunities for staff training and continuing education
- Provide funding to support continued education
- Identify resources for free or low-cost technical assistance (including HRSA, National Quality Center, Target Center, etc.)

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[18] Nonprofit HR (2015). 2015 Nonprofit Employment Practices Survey Results. Retrieved from http://www.nonprofithr.com/wp-content/uploads/2015/02/2015-Nonprofit-Employment-Practices-Survey-Results-1.pdf

[19] The Black AIDS Institute (2013). Knowledge, Attitudes, and Beliefs Survey of the HIV/AIDS Workforce. Retrieved from https://www.blackaids.org/programs/us-hiv-workforce-survey

- Prioritize funding to service categories where staffing is low or inadequate to appropriate address improvements along the continuum (i.e., staffing for Outreach, Housing, and Prevention Services)

c. **Services Provided by Funding Source**

The Council and its subcommittees work together to ensure there is a comprehensive continuum of care from prevention to HIV care services as indicative of the Comprehensive HIV Prevention and Care Plan developed for Orange County in 2012. This goal continues with the Integrated Plan. Previously the Prevention Planning Committee (PPC) and now PCSC has been charged with activities to prevent HIV transmission and the lead on EIIHA activities. HOPWA, Ryan White Part B, and Ryan White Part C are also considered during the annual allocation process to ensure interaction between the funding sources and continuity between services.

(**See Attachment B labeled Overview of Funding for HIV Care Continuum in Orange County**)

d. **Needed Resources**

The Integrated plan must identify needed resources and/or services and the steps taken to secure them. The following information was provided in response to the workforce survey:

Respondent Identified Need	Identified Impact on the System	Steps Taken to Secure Resources
• Additional staff for Linkage to Care (LTC), HIV screening in jails, and overall support • Additional funding to recruit and retain existing staff • Increase reimbursement rates • Additional training in service delivery and education opportunities to update knowledge with current information	• Turned eligible clients away/Referred clients to other programs • Implemented a waiting list • Increased estimated length of time before individuals received service • Tightened eligibility criteria for services • Unable to expand services in needed areas such as HIV screenings in jails and education services • Reduction in referrals for services • Unreasonable delays in service delivery	• Restructuring of staff assignments • Implemented new Evidence Based Interventions (EBIs) such as ARTAS • Utilized other funding sources • Develop a larger intern pool by creating capacity and recruiting more interns • Applied for additional grants

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D. Assessing Needs, Gaps, and Barriers

a. **Process to Identify Service Needs for People at High-Risk for HIV and for PLWHD**

The following has been done to identify the needs of persons at high-risk for HIV:

- **2010 HIV Testing Practices**: The goal of the survey was to determine HIV testing practices among medical care providers in Orange County and identify ways to increase HIV testing. A total of 252 surveys were submitted. Key findings included:
  - The most cited reason for not regularly offering HIV testing was that "patients seen are not at risk of HIV" (32.1% of respondents), followed by "HIV is not area of specialty" (13.9% of respondents) and "confidentiality concerns" (7.5% of respondents).
  - 5.7% of respondents indicated "never" discussing the risk of HIV with their non-pregnant patients.
  - 4.9% of respondents indicated being "not very" and 25.5% of respondents indicated being "somewhat" comfortable discussing HIV with patients.
  - "Training on how to talk to patients about HIV" was most cited as the best method to help improve HIV testing in Orange County.
- **2012 Prevention Assessment**: The goal of the assessment was to identify and emphasize the utilization of evidenced-based interventions for HIV prevention activities. Recommendations for HIV prevention services included:
  - Ensuring appropriate training of prevention providers on the evidenced-based interventions.
  - Maintaining the fidelity of the interventions.
  - Evaluating the effectiveness of the intervention to meet targeted outcomes.
  - Emphasis on targeted HIV testing for high-risk populations rather than high-volume testing.
  - Reframing Partner Services from a "service" to an "intervention" with evidenced-based outcomes for reaching high-risk populations.
- **2013 Testing Barriers Survey**: The goal of the survey was twofold 1) identify potential barriers to HIV testing among clients recently diagnosed with HIV, and 2) detect missed testing opportunities in healthcare settings. 40 surveys were completed of which 24 respondents were late testers (concurrently diagnosed). Key findings for the 24 respondents included:
  - 88% of respondents did not believe they were at risk for HIV infection.
  - 83% of respondents indicated that they thought their behaviors kept them safe from contracting HIV.
  - 63% of respondents said that no one offered them an HIV test.
- **2015 Pre-Exposure Prophylaxis (PrEP) Survey**: The goal of the PrEP surveys were to evaluate knowledge, access, and barriers to services related to PrEP to develop recommendations for access to PrEP. Key findings included:
  - Survey identified the need to increase information about PrEP because 62% of clients (124 of 194) responded that they did not know or were not sure they knew about PrEP. In addition, over three quarters (76%) of providers reported that they had never heard of PREP.
  - Only 37% of client respondents (58 of 156) stated that they would get PrEP from a private doctor.

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- By risk factor, 54% (52 of 96) of MSM, a high-risk population, responded that they might begin PrEP someday.

The following has been done to identify the needs of PLWHD:

- **Client Needs Surveys**: The goal of the needs surveys are to identify PLWHD experiences in accessing services, identify service needs, and barriers to care. Client Needs Surveys are conducted every odd year (e.g., 2015, 2013, 2011, etc.). The surveys identify the following:
  - Five most important services overall, by gender, by race/ethnicity, by primary language spoken, by AIDS diagnosis, and by disability.
  - An overview of the services identified as needed compared to the services received (gap in service access).
  - Description of the most significant problems (barriers) to accessing services.
- **Review of Focus Group Data**: The goal of the focus groups is to choose a specific topic for which qualitative data can be gathered to uncover trends in thoughts or opinions about needs. Focus groups are conducted every even year (e.g., 2016, 2014, 2012, etc.). Focus group topics have included: Impact of the Affordable Care Act, Identifying Case Management needs, Assessing Barriers to Care, and Assessing Legal Services Needs for PLWHD. Focus group results have included:
  - Development of recommendations to increase access to services.
  - Creation of materials to promote knowledge about services available.
  - Increase training and education for service providers.
- **Evaluation of Health Disparities Data**: The goal of assessing health disparity data is to identify needs of populations who are disproportionately impacted by HIV. Health disparity data has identified the following populations in Orange County where the largest disparities exist:
  - Hispanics and Blacks/African-Americans
  - Transgender individuals
  - Injection Drug Users
  - Heterosexuals
- **Review of Service Utilization Data**: The goal of reviewing service utilization data is to identify trends in HIV care service utilization. Utilization trends are reported by gender, race/ethnicity, reported mode of transmission, age, and income level for all Ryan White-funded service categories. Utilization trends provide the following information:
  - Trends in service utilization (increases and decreases).
  - Identification of service categories that may require increased or decreased funding based on utilization.
  - Identification of specific populations that would be impacted by changes in funding.

b. **Description of Service Needs of Persons at Risk for HIV and PLWHD**

The following has been identified as the service need of persons at high-risk for HIV:
Pre-Exposure Prophylaxis (PrEP): A survey was conducted in 2016 to determine knowledge about PrEP among high-risk populations, access to PrEP services, and barriers to services. Survey respondents indicated the following regard PrEP:

- Respondents indicated that they had heard of PrEP as follows:
  - Individuals have heard of PrEP and know what it is: 74 of 194 (38%)

  - Individuals who have heard of PrEP but not sure what it is: 37 of 194 (19%)
  - Individuals who have not heard about PrEP: 83 of 194 (43%)
- Respondents who indicated they were currently on PrEP: Two of 194 (1%)
- Respondents who indicated that they might begin PrEP some day: 74 of 194 (38%)

Based on survey responses, information about PrEP and how to access PrEP services is needed to increase the proportion of high-risk individuals who access PrEP to reduce the risk of acquiring HIV.

Needle Exchange: Injection Drug Users (IDU) are considered to be at high-risk for HIV and hepatitis C infections. One of the tools the National Institute of Health suggests is a needle exchange program that provides new sterile needles can decrease new infections by 33% among IDU populations[20]. The World Health Organization (WHO) recommends providing 200 sterile needles and syringes to IDUs per year to effectively tackle HIV transmission[21]. In Orange County, a needle exchange was approved and began distribution of sterile needles in 2016. The implementation of the program has increased access to HIV prevention services which will hopefully lead to a reduction in new infections.

The following has been identified as consistent service needs of PLWHD:
Oral Health Services: Based on the Client Needs Survey conducted in 2013 (500 survey responses) and 2015 (240 survey Reponses) dental care and more specifically advance dental care services such as root canals and crowns have consistently ranked in the top five in responses by PLWHD. These services are generally not fully covered by public and private insurance and can be cost prohibitive for clients to pay out of pocket. Advance dental services needs are at times addressed through the use of dentistry schools. However, Orange County does not currently have a dental school and accessing dental schools in neighboring Los Angeles County can difficult and time consuming.

Housing Services: Based on responses from Clients Needs Surveys housing services have ranked in the top five most needed services. These services specifically include transitional housing and emergency financial assistance (EFA) for housing. Transitional housing provides short term housing on behalf of PLWHD with various needs including those completing residential substance abuse treatment, homeless coming off the streets, and individuals released from hospitals or jails. EFA for housing provides PLWHD in difficult financial situations such as a loss of a job, a cut in work hours, and unexpected costs with cash assistance to help PLWHD stay in their housing. These services align with the National HIV AIDS Strategy (NHAS) to reduce the number of PLWHD who are in medical care and homeless. Consumer on the HIV Client Advocacy

[20] Vlahov, D., & Junge, B. (1998). The role of needle exchange programs in HIV prevention. Public Health Reports, 113(Suppl 1), 75–80.
[21] World Health Organization. (2004). Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users. Retrieved August 30, 2016, from http://www.who.int/hiv/pub/prev_care/effectivenesssterileneedle.pdf

Committee (HCAC) have stated that it is difficult to engage in medical care if a person is sleeping on the streets or struggling to figure out where they will be safely living.

c. **Description of Service Gaps Identified by and for Persons at Higher Risk for HIV and PLWHD**
Needs assessment strategies for high-risk populations currently do not identify service gaps. Needs assessments focus on service needs and barriers to services. A process for assessing service gaps will be developed and implemented in future years.

The following has been identified as service gaps of PLWHD:
Oral Health Services: Based on the Client Needs Survey conducted in 2015 (240 survey Reponses) dental care and more specifically advance dental services such as root canals and crowns had one of the largest gaps between survey respondents who stated they needed the service and were able to receive it. Of the 112 individuals that stated they needed advance dental only 38 (34%) people stated they received the services. This percentage was a decrease from 2013 when on the survey of the 196 individuals that stated they needed advance dental care 92 (47%) stated they received it. Based on the survey results, the gap between individuals needing oral health advance services increased. Recently, the waiting list for advance services was eliminated. The impact of the removal of the waiting list will be measured on the next Client Needs Survey.

Housing Services: Based on the Client Needs Survey conducted in 2015 (240 survey reponses) housing services including temporary or transitional housing, emergency financial assistance (EFA) for housing, and housing coordination had some of the largest gaps between survey respondents who stated they needed the service and were able to receive it. Of the 137 individuals that stated they needed the various housing services only 46 (34%) people stated they received the services. This percentage was a decrease from 2013 when on the survey of the 269 individuals stated they needed housing services and 116 (43%) stated they received it. Based on the survey results the gap of individuals needing housing services increased. Recently, new funding for short-term rental assistance was awarded to Orange County. The impact of new funding will be measured on the next Client Needs Survey.

Legal Services: Based on the Client Needs Survey conducted in 2015 (240 survey Reponses) legal services including discrimination cases, end of life planning, and access to benefits had a large gap between survey respondents who stated they needed the service and were able to receive it. Of the 57 individuals that stated they needed legal services only 21 (37%) people stated they received the services. This percentage was a decrease from 2013 when on the survey of the 93 individuals stated they needed legal services and 42 (45%) stated they received it. Based on the survey results the gap of individuals needing legal services has increased . Due to the variety of legal issues PLWHD may have including bankruptcy and criminal cases that are not covered by Ryan White in Orange County, it is difficult to know if the legal service that a person stated they needed was not provided because of Ryan White funding limitations. However, 14 of the 21

respondents reported that they were either not aware of the service or did not know where to receive legal services.

d. **Description of Barriers to HIV Prevention and Care Services**

i. Social and Structural Barriers

Language and Culture: The epidemic in Orange County has moved in the last 30 years from affecting White MSM to one that is now affecting a larger number of Latino MSM. The barriers to prevention and care service for the Latino MSM may be different than the White MSM. First, there is a higher need to have information and outreach in Spanish, because the Latino MSM may be monolingual Spanish speakers or simply feel more comfortable speaking in Spanish. Some of the barriers can be attributed to the language spoken by Latinos and others can be cultural. Cultural barriers for Latinos can include things like the foods they eat. In order to reduce some of these barriers, in Orange County food offerings under food bank have expanded to include items like tortillas instead of bread for Latino PLWHD that seek foods that are more culturally appropriate.

Cost of Living in Orange County: The Bureau of Economic Analysis and the Bureau of Labor Statistics state that on average the cost of living in Orange County is at least 18 percent higher than national benchmark cities. According to the Massachusetts Institute of Technology's living wage calculator in 2016 a single individual would need to earn at least $13.89 an hour or $28,893 annually to make a living wage. However, the minimum wage is $9.00 an hour and those living on disability or social security make on average less than minimum wage. These create housing instability, food shortages, and other barriers to care that can lead to PLWHD falling out of care.

ii. Federal, State, or Local Policy Barriers

Integration of Various Payer Sources: The full implementation of the Affordable Care Act in California and the creation of the healthcare exchange through Covered California has led to more PLWHD being transitioned through various payer sources. These providers have varying experience treating PLWHD. In addition, PLWHD may have to navigate a health care system that is based on referrals, a complex preauthorization process, and that relies on the self-advocacy of the patient to get his/her needed care. This process is very different from the Ryan White system. These changes have caused a barrier to some PLWHD.

iii. Health Department Barriers

Recruitment for Vacant Positions: Orange County has shifted from a Human Resource (HR) model that had HR representatives for each department to assist with recruitment to fill vacant positions to a centralized HR that assists any department in recruitment. This new process has caused delays in filling vacancies. These delays can now cause up to eight months to go through the recruitment process. This makes it difficult to be reactive or flexible to changes in the community.

iv. Program Barriers

Coordination with Medical Providers: As more Ryan White clients and PLWHD obtain medical care outside of the Ryan White System, service providers have found it difficult to obtain medical information about clients from the medical provider. When clients received medical care under Ryan White, there was a coordination of care and services between the medical staff, case managers, and supportive service providers. This has become

increasingly difficult to manage with the increase in number of medical providers and their lack of knowledge of the Ryan White system.

v. Service Provider Barriers
Health Care Systems: Some of the largest managed care systems in Orange County include Kaiser Permanente as a private insurance and medical provider, and CalOptima who manages Medi-Cal (Medicaid in California). These systems are rarely at the planning table or work with service providers to assist PLWHD who are having difficulties staying engage in care. These systems see a large number of PLWHD who are not a part of the Ryan White system and whose patient outcomes among the HIV Continuum of Care do not meet that of the Ryan White System.

vi. Client Barriers
Lack of Information: According to the needs survey in 2015, 47% (346 of 732) of reasons individuals said why they did not receive a service they felt they needed was because they "Didn't know about service" or "Didn't know where to go". Other responses were spread among 12 other reasons including needing transportation, process to obtain service was complicated, or they did not qualify, with no other response having more than five percent. The biggest barrier according to the needs survey was the lack of information the survey completers believed they had about services. Ryan White as a system will have to determine how information is being disseminated and how it would be best to reach all PLWHD including those not currently receiving Ryan White funded services.

E. Data: Access, Sources, and Systems

a. **Sources of Data**

- Ryan White Program Services Report (RSR) – The RSR is comprised of three sections; 1) Grantee Report, 2) Service Provider Report, 3) Client Report and is required by the Health Resources and Services Administration (HRSA) for Ryan White funded services every calendar year. The report provides basic information about the Grantee, funded service providers, description of services, and client information that includes demographic status, HIV clinical information, medical core and support services received.

  RSR data is used to determine the number of individuals that receive services, trends in service need based on utilization over a period of time, and assists in determining changes in services utilization. More specifically RSR data can provide a deeper understanding of Ryan White clients at various steps of the HIV Care Continuum by understanding their ability to reach viral load suppression. The RSR data can provide community planners with information to understand how individuals engaged in a specific service such as case management which is meant to assist clients in linking and retaining in medical care reach viral load suppression in comparison to other supportive services or non-Ryan White clients. RSR data provides data on specific demographic, city of residence, and/or other client characteristics that help to identify different needs based on various demographic measures.

- Surveillance Data – Public health surveillance data is the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. HIV surveillance data provides information on the

impact of an intervention or may track progress towards specified goals. HIV surveillance data reported to the public health department includes name, contact information, demographics, residence, medical facility information, risk categories, positive HIV test results, CD4 and/or viral load results, opportunistic infections, payer source, pregnancy information, and other sexually transmitted diseases (STDs) data.

Each year surveillance data is used to determine the number of persons living with HIV disease (PLWHD) who are aware and unaware of their status who are not in care. This information assists planners in determining the number of individuals that need to be outreached to for testing and linkage to care. Additionally, surveillance data is critical in developing the HIV Care Continuum. Using the lab information and applying definitions from the National HIV/AIDS Strategy estimates are developed for each component of the HIV Care Continuum including the number of PLWHD that know their status, have been linked to care, retained in care, and have reached viral load suppression. The continuum provides a benchmark for comparing Orange County efforts to the state and nation.

- Focus Groups – Focus groups provide qualitative data on a range of topics. Past focus group topics include oral health, barriers to care, case management, and the impact of the Affordable Care Act. Focus group participants are asked about their perceptions, opinions, beliefs, and attitudes towards a service or idea. Questions are asked in a group setting where participants are free to talk while the moderator or assistant take notes. Focus group data can be used to get information of shared understandings or common views.

  The focus groups conducted between 2010 and 2015 were based on responses from the client needs survey or from qualitative comments provided during the planning process by various consumers or providers and are intended to provide information that expand on the knowledge of the system. These expanded responses bring a deeper understanding of the service delivery system from the consumer perspective. In addition, focus groups provide feedback as to barriers that may be encountered by participants that make it difficult to access the system of care and/or be retained in care. This information assists in building a narrative around the HIV Care Continuum. Specifically, why PLWHD may fall out of care between being linked to care and retained in care. It may also provide information why individuals may have trouble reaching viral load suppression.

- Surveys – Orange County conducts various surveys to obtain information from PLWHD and those at high-risk of contracting HIV including the needs survey, client satisfaction surveys, HIV testing barriers survey, and Pre-Exposure Prophylaxis (PrEP) survey. A survey is a list of predetermined questions aimed at obtaining specific data from a representative sample. The hope is that the representative sample can be used to describe ideas, attitudes, knowledge, and needs of the larger population. The use of surveys over a period of time can show changes in needs. Surveys are administered anonymously, but contain demographic detail that allows reviewers to extrapolate data to the larger group.

  Orange County has conducted Client Needs Survey on odd years since 2003 targeting PLWHD that may or may not receive Ryan White Services. The Client Needs Survey asks participants about services they felt they needed, whether they received the service, and reason service was not received. This information provides a large portion of the needs assessment that is conducted by the Planning Council and subcommittees for the planning

process. Needs assessment information provides data that can inform planners on service priority, gaps in service, and possible allocation needs.

Orange County has also conducted surveys that target high-risk HIV negative individuals. Surveys such as those on HIV testing barriers and PrEP provide information that provides insight on risk knowledge and behaviors. The HIV testing barriers survey provided information about perceived HIV risk and reasons why individuals were not being tested for HIV regularly or based on risk. A separate survey on testing practices among medical providers highlights the steps needed to implement routine HIV testing because medical providers are not always properly identifying a patient's risk. Combining the surveys showed a gap between people asking for an HIV test and providers identifying a need for an HIV test. The PrEP survey identified the need to increase information about PrEP and access to PrEP services to prevention HIV. As part of the planning process homeless count numbers from the Point in Time Orange County Homeless Count &Survey Report are used to determine an estimate of PLWHD that report being unsheltered. Lack of housing and/or inconsistent housing is a significant barrier to compliance in care; therefore, evaluating trends from this survey provide useful information regarding this often unrepresented population.

- AIDS Regional Information and Evaluation System (ARIES) - ARIES is a centralized HIV client management system that allows for coordination of client services among medical care, treatment, and support providers and offers comprehensive data for program reporting and monitoring. ARIES is used by Ryan White-funded service providers to plan, manage, standardize, and report on client data. In Orange County all funded providers are required to use ARIES for the data entry of funded services. ARIES facilitates the development and submission of the RSR report to HRSA every calendar year.

  ARIES, similar to RSR data, is used as part of the needs assessment to determine the number of individuals that receive services, trends over a period of time, and assists in determining changes in services utilization.

- Local Evaluation Online (LEO) - LEO is an online system that assists in tracking information about California State Office of AIDS (OA)-funded HIV education and prevention programs, including HIV counseling and testing services.

  LEO provides planners information about those who are being tested for HIV. This information includes where individuals are getting tested, their level of risk, and demographic detail. This information can be used to develop interventions that can reduce the number of individuals that do not know their HIV status and further improving the HIV Care Continuum. Additionally, data from the prevention programs that are Effective Behavioral Interventions (EBIs) that target both high-risk negatives and PLWHD assist planners in understanding the demographics of high-risk populations and service utilization.

- California Reportable Disease Information Exchange (CalREDIE) – CalREDIE is the electronic database required by the California Department of Public Health (CDPH) for disease reporting and surveillance. Diseases and conditions including sexually transmitted diseases (STDs), Tuberculosis, microbial diseases, and communicable diseases are captured in CalREDIE.

CalREDIE can provide planners information about high-risk negatives and PLWHD. This data includes the demographic detail; clinical information; treatment information ;reported risks for substance use, social history, and risk factors STD history; HIV status; partner information; and interview information of individuals that have tested positive for STDs such as syphilis that may categorize the individual as high risk for HIV. This information can be used to develop interventions that further improving the HIV Care Continuum.

b. **Data Policies and their Effect on the Needs Assessment and/or HIV Care Continuum**

- Policies that facilitated needs assessments including the development of HIV Care Continuum
  - Use of Surveillance Data – In late 2012, California legal interpretations of policies regarding use of surveillance data created the opportunity to utilize surveillance data for data to care efforts. Data to care means utilizing surveillance data to identify individuals who have not been linked to care or appear to be out of care and initiate efforts to find the individuals and link or reengage them in care.
  - Health Insurance Portability and Accountability Act (HIPAA) Compliant Survey Monkey – Survey Monkey is an online survey development program that allows for the creation and analysis on surveys. Using a HIPAA Compliant Survey Monkey template allows for the collection of needs assessment data for PLWHD. This has allowed participants that may not feel comfortable to complete a paper survey in public, due to the possible lack of anonymity, the ability to provide needs assessment information. In addition, online availability allows the ability to reach PLWHD that are not part of the Ryan White system and who may have needs that have not been identified. Furthermore, the use of the online system facilitates rapid data collection and analysis of information.

- Policies that served as barriers to conducting needs assessments including development of the HIV Care Continuum
  - AIDS Drug Assistance Program (ADAP) data – In California, sensitivity to HIV data has created legislation that continues to hamper the planning process. Data associated with ADAP has fallen under policies that do not allow for disclosure of information beyond enrollment workers. Due to this policy, data about individuals who are on Anti-Retroviral Therapies (ART) paid by ADAP is not shared. Therefore, data regarding those on ART, which is required for the HIV Care Continuum, is limited to those individuals are receiving Ryan White-funded medical care. As more individuals access medical care outside of Ryan White, data on ART will continue to be a barrier to identified needs.
  - Medi-Cal data – Medi-Cal (Medicaid in California) only shares information on paid claims that was spent on care for PLWHD. However, this information does not include paid claims for dental, optometry, and lab services. This information lacks the number of total PLWHD in the Medi-Cal system, demographics, retained in care, and other data that can be used to determine the needs of PLWHD and possible gaps in services.
  - Veterans Health Administration (VHA) labs: The VHA directive 2013-008 established mandated reporting of infectious diseases to local public health authorities. However, laboratory results for PLWHD are not consistently reported. This lack of information limits data availability required for the HIV Care Continuum.

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c. **Description of Unavailable Data Needed for Development of Needs Assessment or HIV Care Continuum**

- Pharmacy data - In developing the HIV Care Continuum the hardest data to validate is the number of individuals prescribed ART. If prescription data was available planners would have a better estimate for those on ART. The data could help identify strategies needed to increase support for and access to ART.

- National Behavioral Surveys – Various surveys conducted by the Centers for Disease Control and Prevention (CDC) that do not include data from Orange County and cannot be included in the Orange County planning process but if available would provide useful information are as follows:
  - National HIV Behavioral Surveillance (NHBS) – survey conducted by the CDC targeting individuals at high risk for HIV infection including men who have sex with men and injection drug users. This information is important to understanding high risk population and their potential needs. The survey features information from Los Angeles and San Diego counties, but that information is not reflective of Orange County demographics.
  - Youth Risk Behavior Surveillance System (YRBSS) – survey conducted by the CDC targeting high school age youth that focuses on behaviors around sex, alcohol, drugs, tobacco, diet, and physical activity. This information is important to understanding populations that will make up the high risk population before possible infection. This survey and data is only available for the school districts in Los Angeles, Oakland, and San Diego.
  - Behavioral Risk Factor Surveillance System (BRFSS) – a telephone survey of health related questions including risks, chronic health conditions, and preventive services. The survey has not been conducted since 2012 and only includes data for the cities of Anaheim and Santa Ana. For California, the California Endowment performs a similar survey the California Health Interview Survey (CHIS) that encompasses more information throughout Orange County is conducted in 2014.

- Drawbacks of current data gathering methods - There are drawbacks to the various types of data collected in Orange County that also impacts that data required for conducting needs assessments as follows:
  - RSR – The drawback about RSR data is that it is only as good as the interpretation of the individual entering the data. What this means is that the database does not clearly define every data element option. For example, ARIES requires data on Housing status but does not define the terms that are available to describe one's status leaving the provider to choose from the options listed which has led to inconsistent data being reported. The jurisdiction has defined many of these terms in order to get consistent data from all providers.
  - Surveillance Data – The drawback of surveillance data is the process for reconciliation of cases may cause a delay in data receipt regarding Orange County residents that test positive in another jurisdiction, PLWHD that receive medical care in another jurisdiction, or have established residency outside of the jurisdiction after diagnosis within Orange County. This delay may cause revision in data used for the planning process and the jurisdiction's ability to develop the HIV Care Continuum.
  - Focus Groups – The drawback of focus groups is the inability to follow-up or asked pointed questions that may sway participants in one direction or another. Remarks by a participant may not be validated by the group, but because of lack of voices may be

accepted as the truth. Another drawback of focus groups is that participation is dependent on the ability of people to attend and attendance may not be reflective of the larger community.

- Surveys – The drawback of surveys is that responses are limited to predetermined responses. The responses developed may not lead to breakthroughs in information that arise from open ended questions or interviews. Survey responses are limited to the individuals that were able to obtain a copy and had the time or interest to complete the survey. Survey respondents may not represent the PLWHD population in Orange County. The drawback of the homeless count data is that it relies on self-identification and may not include all PLWHD that are homeless. Additionally, the count is held on one night every two years and concentrates in areas where homeless congregate. This approach may miss individuals that were not homeless during the night of the count or live in areas not surveyed.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

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NHAS Goal:	Reducing New HIV Infections			
2017-2021 Objective 1:	By the end of 2021, increase the percentage of people living with HIV who know their serostatus to at least 91.0 percent (from 91.0%[22] in 2015 to 91.0% in 2021).			
Strategies:	• Promote HIV testing as part of routine health care • Offer targeted HIV testing in non-healthcare settings • Use Partner Services to help HIV-positive individuals disclose their status to sex or needle sharing partners			
Time Frame	**Responsible Parties**	**Activity/Interventions**	**Target Population**	**Data Indicators**
By the end of 2021:	• Health Care Agency • Expanded Testing Providers • Community Based Organizations • Community Based Medical Providers	• Continue routine HIV testing in Orange County Jails, AltaMed, and University of California, Irvine (UCI) clinics and emergency room • Increase routine testing in healthcare settings • Promote routine testing tool kit • Targeted testing at community agencies, events, and nightclubs • Use of both surveillance-based and venue-based Partner Services	• Men who have sex with Men (MSM) • Substance Users • Incarcerated individuals • Partners of people living with HIV disease • Transgender individuals • Sex workers	• Number of HIV tests • HIV positivity rates • Number of partners reached and tested through Partner Services • Number of medical providers who implement routine testing

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[22] The CDC estimate for California is used for Orange County; therefore, Orange County has exceeded the 2021 objective. At this time, the Orange County objective for increasing the percentage of individuals living with HIV who know their serostatus will remain unchanged due to the inability to get Orange County specific data.

NHAS Goal:	Reducing New HIV Infections
2017-2021 Objective 2:	By the end of 2021, reduce the number of new HIV diagnoses from 2015 by 25 percent (from 300 in 2015 to 225 in 2021).
Strategies:	• Implementation of Pre-Exposure Prophylaxis (PrEP) • Provide evidence-based behavioral interventions (EBIs) for HIV-positive individuals • Provide evidence-based behavioral interventions (EBIs) for high-risk populations • Offer condom distribution to HIV-positive and high-risk populations • Provide syringe services programs (Education regarding sharps disposal and cleaning needles for Injection Drug Users, non-prescription sale of syringes, syringe exchange) • Utilize social marketing, media, and mobilization

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations • California AIDS Clearinghouse • California State Office of AIDS	• Implementation of PrEP clinics and PrEP navigation services • Expansion of EBIs targeting PLWHD including CLEAR, Healthy Relationships, and Community Promise • Expansion of EBIs targeting high risk including Mpowerment, Personalized Cognitive Counseling (PCC) , and Community Promise • Condom distribution through community based organizations, clinic, and targeted events • Syringe exchange for injection drug users • Trainings and technical supports for targeted testing providers on the use of social media application platforms	• MSM • Young MSM • PLWHD • High-risk HIV negative individuals • Substance Users • Transgender individuals	• Number of newly identified positive individuals • Number of individuals on PrEP • Number of PLWHD that participate in EBIs • Number of high risk populations that participate in EBIs • Behavior based outcomes from EBIs • Number of trainings/technical assistance provided to community based organizations

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NHAS Goal:	Reducing New HIV Infections
2017-2021 Objective 3:	By the end of 2021, reduce the percentage of young gay and bisexual men who engage in HIV-risk behaviors by at least 10 percent.
Data about risk behaviors among young gay and bisexual men is not available for Orange County. Data is currently gathered using the Youth Risk Behavior Surveillance System (YRBSS) which Orange County schools do not utilize. California's version of the YRBSS used by Orange County schools called the California Healthy Kids Survey (CHKS) would require modifications in order to collect the data required for this indicator.	

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NHAS Goal:	Increase Access to Care and Optimize Health Outcomes for Persons Living with HIV Disease (PLWHD)
2017-2021 Objective 4:	By the end of 2021, increase the proportion of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 50.3% percent (from 38.7% in 2015 to 50.3% in 2021).
Strategies:	• Ensure a network of medical providers serving PLWHD • Educate community medical providers about available services for PLWHD • Offer evidence-based behavioral interventions (EBIs) that link newly diagnosed patients to care • Utilize Partner Services to reach newly identified HIV-positive individuals

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations • Community Based Medical Providers • Insurance networks (i.e., CalOptima, Covered California, etc.)	• Continued collaboration between Ryan White and medical offices to ensure PLWHD are able to access medical care • Implementation of Anti-Retroviral Treatment and Access to Services (ARTAS) as a Linkage to Care (LTC) EBI to assist newly identified positives to quickly engage in care • Continued collaboration between the Health Care Agency surveillance with medical providers to ensure updated information is available to medical providers and their patients • Continue to expand Partner Services through Disease Intervention Specialist (DIS) to reach every new identified positive to engage them in care	• Newly identified HIV -positive individuals	• Reported CD4/Viral Load labs to surveillance • Number of individuals contacted by DIS • Number of PLWHD who participate in LTC services

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NHAS Goal:	Increase Access to Care and Optimize Health Outcomes for Persons Living with HIV Disease (PLWHD)
2017-2021 Objective 5:	By the end of 2021, increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 90 percent (from 76.2% in 2015 to 90.0% in 2021).
Strategies:	• Offer evidence-based behavioral interventions (EBIs) such as the ARTAS strength-based model that assist PLWHD with linkage and retention in care • Expand services that bring individuals back into care • Offer various levels of case management that assist clients to engage in and stay in care • Ensure PLWHD have access to continuum of HIV services

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations	• Implementation of Anti-Retroviral Treatment and Access to Services (ARTAS) as a Linkage to Care (LTC) EBI to assist PLWHD transition payer sources quickly and help them engage and remain in care • Expansion of Outreach Services and Data-to-Care that look for individuals that have fallen out of care and assist in linking them back to care • Continued expansion of Medical Retention Services under Case Management along with other levels of case management that assists PLWHD remain in care • Continued expansion of centralized eligibility and access to services to ensure that every PLWHD has access to Ryan White funded services	• PLWHD	• Reported CD4/Viral Load labs to surveillance • Number of individuals linked to care • Number of PLWHD who are brought back into care

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NHAS Goal:	Increase Access to Care and Optimize Health Outcomes for Persons Living with HIV Disease (PLWHD)
2017-2021 Objective 6:	By the end of 2021, increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80.0 percent (from 66.1% in 2015 to 80.0% in 2021).
Strategies:	• Ensure access to HIV medications • Provide education and support for adherence to medications • Educate HIV specialists about offering treatment based on PHS guidelines • Educate providers about referring to HIV specialists for treatment

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations • State Office of AIDS, AIDS Drug Assistance Program (ADAP)	• Continued expansion of centralized eligibility and screening of all payer sources to guarantee access to medications • Expansion of training opportunities for case managers and other staff on pharmacology and adherence to assist PLWHD • Continued opportunities for provider education (i.e., AIDS on the Frontline Conference) and information packets for medical providers on updated treatment guidelines • Use of Linkage to Care strategies to assist PLWHD navigate medical groups to ensure access to HIV specialist	• PLWHD	• Reported Viral Load labs to surveillance

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NHAS Goal:	Increase Access to Care and Optimize Health Outcomes for Persons Living with HIV Disease (PLWHD)			
2017-2021 Objective 7:	By the end of 2021, Reduce the percentage of persons in Ryan White HIV medical care who are homeless to no more than four (4) percent (from 4.3% in 2015[23] to 4.0% in 2021).			
Strategies:	• Provide access to programs that assist PLWHD with emergency financial assistance for housing needs • Provide on-going housing resources such as transitional housing and linkage to permanent housing • Provide on-going support to individuals with unstable housing • Expand services that bring PLWHD that are out of care and living in unstable housing back into care			
Time Frame	**Responsible Parties**	**Activity/Interventions**	**Target Population**	**Data Indicators**
By the end of 2021:	• Health Care Agency • Community Based Organizations • City of Anaheim	• Continue to provide emergency financial assistance and/or short-term rental assistance on behalf of PLWHD that experience unexpected financial concerns in order to help them stay housed • Provide transitional housing options for PLWHD and develop plans for permanent housing • Assist eligible individuals in obtaining permanent housing options Use of Outreach Services to engage homeless individuals who are out of care	• PLWHD Homeless • PLWHD with unstable housing	• Reported homeless and/or unstable housing in the Housing status section of the ARIES database • Reported homeless based on the Point in Time Homeless Count • Number of homeless individuals in the Homeless Management Information System (HMIS)

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[23] This objective is limited to Ryan White clients because there is no access to homeless data for all PLWHD in HIV medical care for Orange County.

NHAS Goal:	Increase Access to Care and Optimize Health Outcomes for Persons Living with HIV Disease (PLWHD)
2017-2021 Objective 8:	By the end of 2021, reduce the death rate[24] among persons with diagnosed HIV infection by at least 33 percent (from 4.6 in 2015 to 4.2 in 2021).
Strategies:	• Provide access to medical care and medications that extend the life of PLWHD • Provide access to stable housing • Provide access to mental health treatment • Provide access to substance use services

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations • Community Based Medical Providers • Insurance networks (i.e., CalOptima, Covered California, etc.) • State Office of AIDS, AIDS Drug Assistance Program (ADAP) • Mental health providers • Substance use providers	• Implementation of Anti-Retroviral Treatment and Access to Services (ARTAS) as a Linkage to Care (LTC) EBI to assist PLWHD remain in care • Expansion of Outreach Services and Data-to-Care that look for individuals that have fallen out of care and assist in linking them back to care • Continued expansion of case management that assists PLWHD to remain in care • Assistance with access to housing services • Linkage to appropriate mental health and substance use services	• PLWHD out of care • PLWHD with comorbidities	• Death record

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[24] The proposed strategies are intended to reduce HIV-related death rates. The Integrated Plan and resulting strategies are unable to successfully impact all deaths of individuals living with HIV.

NHAS Goal:	Reduce HIV-Related Health Disparities
2017-2021 Objective 9:	By the end of 2021, reduce disparities in the rate of new diagnoses by for the following groups: • Gay and bisexual men (from 40.8 in 2015 to 37.0 in 2021) • Young Black gay and bisexual men (from 100.0 in 2015 to 79.3 in 2021) • Hispanics (from 0.36 in 2015 to 0.33 in 2021) • Transgender Women (Currently, Orange County does not have the ability or data to create a goal or monitor progress for Transgender individuals).
Strategies:	• Provide evidence-based behavioral interventions for HIV-positive individuals that are culturally appropriate • Provide evidence-based behavioral interventions to high-risk populations that are culturally appropriate • Utilize social marketing, media, and mobilization that are culturally appropriate and in languages of targeted groups

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations	• Expansion of EBIs targeting PLWHD including CLEAR, Healthy Relationships, and Community Promise by language or target group • Expansion of EBIs prioritizing high risk populations including Mpowerment, Personalized Cognitive Counseling (PCC) , and Community Promise by language or target group • Trainings and technical supports for targeted testing providers on the use of social media application platforms	• MSM • Young MSM • Black gay and bisexual men • Hispanics • Transgender women	• Number of newly identified positive individuals • Number of PLWHD that participate in EBIs • Number of high risk populations that participate in EBIs • Behavior based outcomes from EBIs • Number of trainings/technical assistance provided to community based organizations

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NHAS Goal:	Reduce HIV-Related Health Disparities
2017-2021 Objective 10:	By the end of 2021, increase the percentage of individuals who are virally suppressed among the following groups: • Youth ages 13-24 (from 59.1% in 2015 to 74.0% in 2021) • Persons who inject drugs (from 50.3% in 2015 to 57.0% in 2021)
Strategies:	• Ensure access to HIV medications • Provide education and support for adherence to medications • Educate HIV specialists about offering treatment based on PHS guidelines • Educate providers about referring to HIV specialists for treatment • Provide access to substance use services including hypodermic syringes

Time Frame	Responsible Parties	Activity/Interventions	Target Population	Data Indicators
By the end of 2021:	• Health Care Agency • Community Based Organizations • State Office of AIDS, AIDS Drug Assistance Program (ADAP)	• Continued expansion of centralized eligibility and screening of all payer sources to guarantee access to medications • Expansion of training opportunities for case managers and other staff on pharmacology and adherence to assist youth and substance users • Linkage to appropriate substance use services • Continued opportunities for provider education (i.e., AIDS on the Frontline Conference) and information packets for medical providers on updated treatment guidelines • Use of Outreach Services to engage active injection drug users out of care, into medical care and substance use programs • Continued expansion of case management that assists PLWHD remain in care	• Youth ages 13-24 • Young MSM • Persons who inject drugs • PLWHD with active substance use	• Reported CD4/Viral Load labs to surveillance

B. Collaborations, Partnerships, and Stakeholder Involvement

a. **Stakeholder Involvement in Plan Development**

- Ryan White Planning Council (Council) – The Council has been responsible for reviewing the Integrated plan as it has been developed. The Council had final approval of the plan prior to submission to HRSA. In addition, the Council will oversee the implementation of the Integrated Plan with on-going monitoring and changes. During the development of the Plan, the Council was comprised of 20 members and two affiliate members (affiliates are persons living with HIV disease (PLWHD) that are non-voting members of the Council unless filling in for an absent PLWHD member). The Council membership was generally reflective of the HIV epidemic in Orange County with the following major exceptions:
  - Over-represented by women with 39% of Council compared to 13% of the epidemic
  - Under-represented by Hispanics with 22% of Council compared to 47% of the epidemic

  The composition of membership met all HRSA required membership categories except Hospital Planning Agency and Non-elected community leader.

- Prevention and Care Strategies Committee (PCSC) – The Council subcommittee, PCSC, led the development of the Integrated Plan. The committee has focused on barriers to and strategies that can impact the entire continuum of care. The committee developed membership seats to ensure a board representation of stakeholder participation. During the development of the Plan, PCSC was comprised of 15 members including service providers for Mental Health Services, Family Planning/STD Treatment, HIV Counseling and Testing, Prevention with Positives, Outreach services, Service provider representatives that prioritize the needs of high-risk populations, MSM, Youth, and Transgender individuals, PLWHD, a representative that provides school-based prevention services, and a local AETC representative. The committee has developed, reviewed, and approved each section for review by the Council. Moving forward PCSC will oversee the implementation of strategies to achieve objectives and track outcomes.

- Health Care Agency: Public Health Services (PHS) – Representatives from PHS have provided support to all meetings held related to the development of the Plan. PHS staff was responsible for gathering and disseminating data for review that included but was not limited to epidemiological data, demographic details, resource inventory data, needs assessment data, and outcome data. PHS staff had the primary responsibility of compiling data and feedback from stakeholders to write the Integrated Plan. PHS, as the Grant Recipient overseeing the contracts for both prevention and Ryan White service providers, will ensure that program deliverables line up with Integrated Plan goals and objectives. PHS will develop on-going reports that will update PCSC and the Council on the progress towards goals and objectives.

b. **Stakeholders Needed to More Effectively Improve Outcomes Along the HIV Care Continuum**

- CalOptima – CalOptima is the organized health system that administers the Medi-Cal (Medicaid in California) insurance program for low-income children, adults, seniors, and those with disabilities in Orange County. As the Affordable Care Act (ACA) has expanded the ability for PLWHD to obtain Medi-Cal, their medical care has been moved from Ryan White providers to CalOptima providers. This means that CalOptima now plays a larger role in the medical care needs of PLWHD as well as high-risk populations who may have had limited

access to medical care prior to ACA. It is important that CalOptima representatives have input into strategies that will positively affect each stage of the care continuum.

- Private Medical Providers or Medical Groups – The majority of medical services for PLWHD and high risk individuals is provided through a health system that is dependent on individual medical providers or medical groups such as community clinics. These providers are integral in the engagement of individuals in prevention and/or care services, ensuring regular screening for sexually transmitted infections and providing necessary treatment, as available, getting PLWHD on anti-retroviral medication, and assisting PLWHD to reach viral load suppression. It is important that providers are updated on care standards and initiatives to help those at high-risk of HIV infection from acquiring HIV disease and for those living with HIV, strategies are implemented to improve viral load suppression rates.

c. **Letter of Concurrence to the Goals and Objectives of the Integrated Plan (See Attachment C for signed letter from Planning Council Chair)**

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C. People Living with HIV (PLWH) and Community Engagement

a. **Description of how the people involved in developing the Integrated Plan are reflective of the epidemic**

The chart below are the totals for the committees that were involved in the development and the approval of the Integrated Plan as of August 29, 2016.

(A)	(B)	(C)	(D)	(E)	(F)
	Orange County Epidemic (PLWHD)	Planning Council	Prevention and Care Strategies Committee (PCSC)	Priority Setting, Allocations, and Planning Committee (PSAP)	*Total Representation (Unduplicated)
Gender					
Male	87%	18 (72%)	9 (60%)	7 (50%)	25 (61%)
Female	12%	7 (28%)	6 (40%)	7 (50%)	16 (39%)
Transgender	1%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Race/Ethnicity					
White	40%	14 (56%)	6 (40%)	10 (71%)	21 (51%)
Hispanic/Latino	47%	10 (40%)	6 (40%)	4 (29%)	17 (41%)
African-American/Black	5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Asian/Pacific Islander	7%	1 (4%)	2 (13%)	0 (0%)	3 (8%)
Mixed	1%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Current Age					
19-25	4%	0 (0%)			
26-35	16%	2 (8%)			
36-45	24%	8 (32%)			
46-55	33%	10 (40%)			
56+	23%	5 (20%)			

* Individuals who participate in multiple committees were only counted once in column (F).

Based on the chart above, the committees were over represented in the categories of female, White, and individuals between the ages of 46 and 55. The committees are underrepresented by male, transgender, African-American/Black, and ages 19 to 35 year olds. The Membership and Training Committee of the Planning Council has continued to outreach to individuals that are young men of color. The most recent members to the Planning Council include men who are Latino and Asian.

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b. **Description of how the PLWHD were involved in the development of the Integrated Plan**

(A)	(B)	(C)	(D)	(E)	(F)
	Orange County Epidemic (PLWHD)	PLWHD on the Planning Council	PLWHD on PCSC	PLWHD on PSAP	*Total PLWHD Representation (Unduplicated)
PLWHD Representation					
Percent of PLWHD on committee		10 of 25 (40%)	3 of 15 (20%)	6 of 14 (43%)	11 of 41 (27%)
Gender					
Male	87%	8 (80%)	3 (100%)	4 (67%)	9 (82%)
Female	12%	2 (20%)	0 (0%)	2 (33%)	2 (18%)
Transgender	1%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Race/Ethnicity					
White	40%	5 (50%)	2 (67%)	4 (67%)	5 (45%)
Hispanic/Latino	47%	5 (50%)	1 (33%)	2 (33%)	6 (55%)
African-American/Black	5%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Asian/Pacific Islander	7%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Mixed	1%	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Current Age					
19-25	4%	0 (0%)			
26-35	16%	1 (10%)			
36-45	24%	2 (20%)			
46-55	33%	5 (50%)			
56+	23%	2 (20%)			

* Individuals who participate in multiple committees were only counted once in column (F).

Based on the chart above PLWHD were over represented in the categories of female, White, Hispanics, and individuals between the ages of 46 and 55. This over representation is similar to the overall committee make-up. PLWHD were underrepresented by male, transgender, African-American/Black, Asian, and ages 19 to 25 year olds. The Membership and Training Committee of the Planning Council has continued to outreach to individuals that are young men of color.

PLWHD is an important voice in the development of the Integrated Plan. They have experience receiving services, many have dealt with the difficulty of staying in care and medication adherent, and they have the ability to communicate with their peers. This voice provides the feedback needed that make the goals and strategies realistic. PLWHD provide strategies to the real world barriers that PLWHD may be facing and provide innovative solutions to addressing those barriers.

c. **Description of Methods Used to Engage PLWHD, High-Risk Populations, and Impacted Populations**

- Planning Committees: The Council and it's subcommittee PCSC that was tasked with the development of the Integrated Plan were open community meetings with a structured membership that allowed for stability in the creation of the Integrated Plan but also allowed

the flexibility for PLWHD, high-risk populations, and subject matter experts to contribute throughout the process without having to be a member. The various committees began to work on the Integrated Plan in July of 2015 and will continue to meet and work on the Integrated Plan after its submission because the intent of the plan is that it will be a working plan that shapes the jurisdiction's reaction to the epidemic moving forward. Some of the work is detailed below:

- Priority Setting, Allocations, and Planning (PSAP) Committee: PSAP has continuously worked on the goals and strategies of NHAS and those developed for the Integrated Plan. PSAP has worked on prioritizing services that align with the Integrated Plan and improve outcomes among the HIV Care Continuum.
- HIV Client Advocacy Committee (HCAC): HCAC has assisted in the development of the needs assessments including the wording and distribution of the needs survey. The work has including selecting topics, developing questions, recruitment, and participation in the focus groups used to develop the needs assessment.
- Prevention Planning Committee (PPC): Before PPC became part of the Prevention and Care Strategies Committee it was a standalone committee that worked on the implementation of the EIIHA Plan, worked on the goals of NHAS, and developed strategies to address health disparities.

- Focus Groups – Focus groups provide qualitative data on a range of topics. Focus groups allowed the Prevention and Care Strategies Committee (PCSC) to obtain information from PLWHD. Focus groups have covered various topics including oral health, barriers to care, case management, and the impact of the Affordable Care Act. Focus group participants are asked about their perceptions, opinions, beliefs, and attitudes towards a service or idea. Data from the focus groups allowed the committee and the Planning Council to determine the voice of these communities and its need are capture in the Integrated Plan.

- Surveys – Orange County has conducted various surveys to obtain information from PLWHD and those at high-risk of contracting HIV including the needs survey, client satisfaction surveys, HIV testing barriers survey, and Pre-Exposure Prophylaxis (PrEP) survey. These surveys are an important tool to capture the voice of those individuals not around the planning table. Surveys are used to describe ideas, attitudes, knowledge, and needs of the larger population, especially if the demographics of individuals who completed the surveys align with the epidemic in Orange County.

d. **Description of How Impacted Communities Were Engaged in the Planning Process**

In the development of the Integrated Plan it was important for PCSC and the Planning Council to engage the various communities that would be impacted by the Integrated Plan. PLWHD and high-risk populations are impacted by the continuum of service delivery and targeted populations. Service provider bring insight on the system, help develop innovative solutions, and can positively impact he strategies in the Integrated Plan that lead to positive outcomes. It was important that the committees have representation among all of the various service categories in order to develop strategies that lead to positive outcomes. In addition, the committee worked with the Ryan White Quality Management committee to ensure that goals and objectives matched those of the Integrated Plan. In addition, Standards of Care include the innovate approaches that lead to better outcomes across the HIV Care Continuum. Collaborations included working with the AETC provider in Orange County on the AIDS on the Frontline

conference to ensure topics like PrEP, linkage to care, navigating ACA are part of the information given to medical providers. Lastly, In+Care newsletters were developed and distributed to PLWHD and service providers including medical staff that spoke about getting involve and providing input to the planning process.

- The Community Includes:
  - Persons living with HIV disease (PLWHD) who are reflective of the HIV epidemic in Orange County
  - Funded Service providers who can help improve outcomes along the HIV Care Continuum
  - Service providers who are not currently funded who can help improve outcomes along the HIV Care Continuum

The table below is a snapshot of the agencies, by service category, that assisted in the development of the Integrate Plan. It was a goal to have all service categories involved in the planning because all of the services assist PLWHD in reaching better health outcomes.

Service Category	Agencies
Outpatient/Ambulatory Medical Health Services	17th Street Clinic AltaMed University of California, Irvine (UCI)
Medical/Non-Medical Case Management (Including Jail Case Management)	17th Street Clinic AIDS Services Foundation (ASF) Delhi Center REACH Shanti OC
Emergency Financial Assistance (EFA) – Medications/Health Insurance Premium	ASF
Oral Health Care	AltaMed HCA Dental Clinic* Private Dental Offices*
Mental Health Services	APAIT ASF Shanti OC The LGBT Center OC
Housing Services – EFA for Housing / Housing Coordination / Transitional Housing: General Population/ Transitional Housing: Substance Users	APAIT ASF Straight Talk, Inc.
Early Intervention Services	AltaMed Health Care Agency (HCA) UCI
Home Health Care / Home and Community–Based Health Services / Hospice / Rehabilitation	ASF
Substance Abuse Services - Outpatient (Narcotic Replacement Program / Detox / Counseling) / Substance Abuse Services Residential	OC Bar Foundation Phoenix House* REACH Straight Talk, Inc.
Medical Nutrition Therapy / Food Bank / Home Delivered Meals / Nutritional Supplements	ASF Shanti OC

Service Category	Agencies
Medical Transportation Services	APAIT ASF Delhi Center REACH
Other Professional Services	Public Law Center (PLC)*
Independent Living Skills [HRSA Category Health Education / Risk Reduction]	ASF OC Bar Foundation
Outreach Services	17th Street Clinic
Prevention with Positives including Education and Prevention for HIV positive individuals [HRSA Category Health Education/Risk Reduction]	17th Street Clinic APAIT ASF The LGBT Center OC
Psychosocial Support Services (support groups and counseling activities)	Delhi Shanti OC The LGBT Center OC

*Not currently on any of the committees but may be contacted to participate.

Section III: Monitoring and Improvement

a. **Describe the Process for Regularly Updating Planning Bodies and Stakeholders on the Progress of Plan Implementation**

The monitoring the progress of the Integrated Plan will be an on-going effort between multiple committees with the Prevention and Care Strategies (PCSC) taking the lead. In addition, the Priority Setting, Allocations, and Priorities (PSAP) Committee, the HIV Client Advocacy Committee (HCAC), the Quality Management (QM) Committee, and the Planning Council will be reviewing data, quality indicators, and strategies associated with the Integrated Plan. The following data will be reviewed throughout the year to determine progress towards the goals of the Integrated Plan:

- January and July: Outcomes for the routine HIV Testing Program
- February and August: Orange County's HIV prevention progress report
- April: Orange County's epidemiological profile
- April: Orange County HIV Care Continuum
- May: Orange County progress toward the goals of the National HIV/AIDS Strategy (NHAS)
- May and June: EIIHA outcomes
- June: Client Focus Group outcomes
- June: Data from the Client Satisfaction Survey
- July and August: Quality Management Outcomes
- August and September: Unmet need estimate and discussion of needs assessment outcomes

(Continue on next page)

Updates on the Integrated Plan progress, including EIIHA updates, is also presented during quarterly provider meetings. All documents produced and presentations given that relate Orange County's efforts are available through the HIV Planning and Coordination website.

b. **Describe the Plan to Monitor and Evaluate Implementation of the Goals and SMART Objectives**

There is an ongoing process to monitoring and evaluating the goals and objectives of the Integrated Plan. Monitoring will consist of gathering data that is specific to the goals. This gathering of data will be done using surveillance data of reported labs and program data. This data will allow committees to get an understanding of the individuals that are newly diagnosed, all PLWHD who are linked and retained in care, and those PLWHD that are virally suppressed. Committees review this data throughout the year as detailed in the section above. In addition, the in+care report a part of the National Quality Center initiative to improve linkage to care, retention in care, and viral load suppression is reviewed quarterly. Additional data will come from the Quality Management reports that providers complete annually. QM reports are based on the quality indicators that align with NHAS strategies, the Integrated Plan, and the HIV Care Continuum. The QM reports along with others will be developed for review by the various committees that will be responsible for the implementation of the Integrated Plan. During the review, the committees will be evaluating implementation strategies, outcomes, and target populations to see if Orange County is on track to reach the goals outlined in the Integrated Plan before the end of 2021.

c. **Describe the Strategy to Utilize Surveillance and Program Data to Assess and improve health outcomes along the HIV Care Continuum**

The following is an example of how HIV Surveillance data is used improve outcomes along the HIV Care Continuum:

- Number and percent of individuals diagnosed with HIV
- Number and percent of individuals diagnosed with AIDS
- Number and percent of individuals who are currently diagnosed with HIV and AIDS (late testers)
- Number and percent of individuals currently living in Orange County with HIV
- Number and percent of individuals who have been linked to care, retained in care, and virally suppressed
- Data to show trends in the epidemic
- Data to show effectiveness of interventions (i.e., linkage to care data, HIV positivity among Partner Services clients, in+care campaign data, etc.)
- Data to show health disparities along the HIV Care Continuum
- Comparison of Ryan White service utilization data to HIV Surveillance data to identify strengths/successes in programs and uncover areas for improvement
- Development of the annual HIV Disease Fact Sheet and the HIV Surveillance Report (completed every five years)

HIV Surveillance data is integral to the planning process. Data is used to develop appropriate

health outcome targets and goals. Data is used to monitor and report successes in improving health in Orange County. Surveillance data is also used to prioritize populations or areas that have significant disparities. This data will also serve as the backbone of future program planning and development. As indicated above surveillance data is shared with almost all committees of the HIV Planning Council (PCSC, PSAP, and HCAC) and is the standard for which the Ryan White QM committee utilizes in its planning for improving health outcomes.

The Integrated Plan will be a working plan or living document that is used as part of the planning process in Orange County at all levels that is consistently reviewed and updated in order to improve the HIV Care Continuum and reach the goals of the National HIV/AIDS Strategy.

Attachment A

Jurisdictional Funding Sources Resource Table																																						
Funding Source	**Estimated 2016 Budget**	**Known Service Providers***	**Core Medical-related Services**	Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management, including Treatment Adherence Services	Substance Abuse Care	**Supportive Services**	Non-Medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	**HIV Testing and Prevention**
	Dollar Amount																																					
Part A / MAI	$6,453,244	17th St Clinic APAIT ASF Delhi Center HCA Dental PLC REACH Shanti OC Straight Talk		x			x	x	x	x	x	x	x	x	x	x		x		x	x		x	x		x	x					x		
Part B	$3,268,300	17th St Clinic HCA Dental		x	x		x	x	x					x	x			x					x				x							
Part C	$690,983	17th St Clinic		x											x			x																
Part D	$114,664	AltaMed		x										x												x								
Part F	$374,000	UCI - AETC																																

*Other providers may have direct funding.

Funding Source	Anticipated 2016 Budget	Funded Service Providers	**Core Medical-related Services**	Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management, Including Treatment Adherence Services	Substance Abuse Care	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	**HIV Testing**
	Dollar Amount																																
CDC	$1,112,569	17th St Clinic APAIT ASF OC Jails The LGBT Center																															x
SAMHSA	$682,499	REACH														x						x							x			x	x
HOPWA	$878,018	APAIT ASF Phoenix House REACH Straight Talk													x					x		x	x									x	
STATE / LOCAL	$3,055,321	Numerous providers including non-RW providers		x						x	x	x	x	x	x	x													x		x	x	x

Attachment B

Overview of Funding for HIV Care Continuum in Orange County

	Funding Sources / Services	ADAP	Expanded Testing	HIV Prevention	HIV/STD Integration	HIV Surveillance	HOPWA	PrEP	Part A	Part B	Part C	Part D	Not Currently Grant Funded
HIV Surveillance	HIV Surveillance					X							
HIV Prevention Services	STD Testing				X			X	X	X	X	X	
	HIV Testing		X	X									
	Prevention Services for High-Risk Individuals			X				X					
	Prevention Services for HIV-Positive Individuals			X									
	Partner Services for HIV-Positive Individuals (Informing partners of exposure to HIV to get tested for HIV)			X	X								
HIV Core Medical Services	Outpatient Ambulatory Health Services; including Treatment Adherence								X	X	X	X	
	AIDS Drug Assistance Program Treatments	X											
	AIDS Pharmaceutical Assistance												X
	Oral Health Care (Dental Services)								X	X		X	
	Early Intervention Services			X					X	X	X	X	
	Health Insurance Premium Payment and Cost-Sharing Assistance	X							X				
	Emergency Financial Assistance for Medications								X				
	Home Health Care (Specialized Care)								X				
	Home and Community Based Health Services (Para-professional Care)								X				
	Hospice Services								X				
	Mental Health Services								X				
	Medical Nutrition Therapy (Nutritional Counseling, Food Bank, Nutritional Supplements, Home Delivered Meals)								X			X	
	Medical Case Management (Linkage to Care and Medical Retention Services)								X	X	X	X	
	Substance Abuse Outpatient Care												X
HIV Support Services	Non-Medical Case Management (Client Support Services, Client Advocacy, Benefits Counseling, and Eligibility Screening)								X	X	X	X	
	Child Care Services												X
	Food Bank/ Home Delivered Meals								X				
	Health Education/Risk Reduction[1]		X	X	X				P	P	P	P	
	Other Professional Services (Legal Services)								X				
	Linguistic Services[1]	P	P	P	P		P	P	P	P	P	P	
	Medical Transportation								X				
	Outreach Services								X	X			
	Psychosocial Support Services												X
	Referral for Health Care and Support Services[1]		P	P	P		P	P	p	p	p	p	
	Rehabilitation Services								X				
	Respite Care								X				
HIV Housing Services	Emergency Financial Assistance for Housing						X		X	X			
	Life skills Workshops						X						
	Substance Abuse Services-Residential (Residential Treatment and Medical Detox)						X						
	Transitional Housing (General Population and Substance Users)						X		X				

[1] Services are "Provided" (P) for clients, as necessary, but is not funded separately from the service category the client is accessing.

Attachment C

HIV Planning Council

September 14, 2016

LCDR Jose A. Ortiz, MPH
Public Health Analyst
Western Branch, Division of Metropolitan HIV/AIDS Program
Health Resources & Services Administration
U.S. Department of Health & Human Services

Dear LCDR Ortiz:

The Orange County HIV Planning Council (Council) concurs with the following submission by the Orange County Health Care Agency in response to the guidance set forth for health departments and HIV planning groups funded by Health Resources Services Administration's (HRSA) HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Council has reviewed the Integrated HIV Prevention and Care Plan submission to HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Ryan White HIV/AIDS Program legislation and program guidance.

The Council and its subcommittee, the Prevention and Care Strategies Committee (PCSC), have led the development and approval of the Integrated Plan. Plan development was done in an open community meeting structure that allowed for the participation and input of people living with HIV disease (PLWHD), high-risk populations, subject matter experts, and other community stakeholders. Various committees and task forces worked on the development of the Integrated Plan since July of 2015. These committees include the HIV Client Advocacy Committee (HCAC), the Priority Setting, Allocations, and Planning (PSAP) Committee and the Ryan White Quality Management (QM) Committee. Along with PCSC, these committees assisted in the development of goals, objectives, strategies, and target populations. PCSC will oversee the implementation of strategies to achieve objectives and track outcomes. Outcomes will also reviewed by the Council, PSAP, HCAC, and the Ryan White Quality Management Committee.

The signature below confirms the concurrence of the Council with the Integrated HIV Prevention and Care Plan.

Sincerely,

Bobby Avalos
Chair, Orange County HIV Planning Council