

Los Angeles County Comprehensive HIV Plan (2017-2021)

September 2016



*LOS ANGELES COUNTY
COMMISSION ON HIV*



Author:

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Acknowledgements:

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Prologue

This *Los Angeles County Comprehensive HIV Plan (2017-2021)* is Los Angeles County's second integrated HIV services plan. Led by the Los Angeles Commission on HIV's Comprehensive HIV Plan (CHP) Task Force, this plan was developed in partnership with the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP) and innumerable community and organizational partners. It presents a blueprint for HIV services along the entire spectrum of HIV prevention and care. This plan responds to the June 2015 integrated guidance disseminated by the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) to directly-funded health jurisdictions. It also presents a road map for achieving the goals of the *National HIV/AIDS Strategy Updated to 2020* (NHAS).

There has been a great deal of change that has occurred in the HIV landscape since 2013 when Los Angeles County's last plan was completed. Nationally, the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) was fully implemented on January 1, 2014; the National HIV/AIDS Strategy was updated in July 2015; and the ban on use of federal funding for syringe services programs was lifted in January 2016. In California, basic adult benefits for Denti-Cal services were reinstated on May 1, 2014 and effective June 2015, and the California AIDS Drug Assistance Program (ADAP) expanded eligibility not to exceed 500% of the federal poverty level (FPL). Locally, Los Angeles County developed and expanded the Medical Care Coordination (MCC) model of services for persons living with HIV (PLWH) with complex health needs and is expanding access to pre-exposure prophylaxis (PrEP) to high risk populations. Now referred to as the "HIV Care Continuum," the HIV treatment cascade developed in 2011 has become a cornerstone for national, state, and local planning. This is certainly not an exhaustive list but represents key initiatives that impact persons living with and at risk for acquiring and/or transmitting HIV in Los Angeles County.

Over the past 30+ years, the HIV epidemic has changed from an acute, life-threatening disease, to a manageable chronic condition. Science has shown us that an undetectable viral load diminishes the risk for transmitting HIV dramatically and that the use of antiretroviral therapy (ART) as pre-exposure or non-occupational post exposure prophylaxis is effective. However, the CDC has demonstrated that over 90% of HIV transmission occurs from PLWH who are not in medical care and persons who are not diagnosed and remain unaware of their HIV positive status. The CDC has also proven the strong correlation between new HIV diagnoses and various social determinants of health such as poverty, low educational attainment, and unemployment. Stigma and fear of discrimination continue to impact vulnerable communities, impeding access to necessary life-saving services and treatments. Communities of color in Los Angeles County, especially Latinos, Blacks/African Americans, and American Indians/Alaska Natives continue to be severely and/or disproportionately impacted by HIV. Men who have sex with men (MSM), especially young MSM 18-29 years old (YMSM) is the largest population of PLWH who are newly diagnosed. Los Angeles County's total population of PLWH are aging and are experiencing other co-morbid health conditions associated with aging such as heart disease, diabetes, and high blood pressure. Lastly, more PLWH have access to health insurance in Los Angeles County than ever before, but the complexity of navigating this system has also increased.

Los Angeles County has cause for hope. The end of HIV in our lifetime is possible. Transmission can be curtailed through viral suppression and use of ART for PrEP. However, the work of the county needs to be strategic and focused—get persons diagnosed who are unaware of their HIV disease, get PLWH who are out of care into care, get persons at high-risk of HIV onto PrEP, mitigate the impact of HIV and related stigma, and provide the necessary education and services to prevent future HIV transmission and that support retention of PLWH in medical care and the continuum of HIV services.

Letter of Concurrence



LOS ANGELES COUNTY COMMISSION ON HIV

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September 6, 2016

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Dear Messrs. Ramos and Ortiz:

As the Co-Chairs of the Los Angeles County Commission on HIV (Commission), we are pleased to provide this letter of support and concurrence with the Los Angeles County Comprehensive HIV Plan 2017-2021.

The Los Angeles County Comprehensive HIV Plan (2017-2021) represents the work of an integrated HIV prevention and planning body. In 2013, the Prevention Planning Committee and the Commission merged as one planning body for Los Angeles County. In this role, the Commission adheres to the guidelines set forth by the CDC and HRSA and ensures that all community stakeholders are fully engaged in creating a Comprehensive HIV Plan (CHP) that recognizes the full continuum of prevention, care and treatment. The CHP represents the collective efforts of Commissioners, service consumers, community members, academic experts, practitioners and providers, and Division of HIV and STD Programs (DHSP) staff.

Los Angeles County's 2017-2021 CHP development was spearheaded by the CHP Task Force which was comprised of commissioners and the public. The CHP Task Force began meeting on a monthly basis in August 2015 through July 2016 with a total of over 50 participants engaging the CHP development process. In addition, to ensure broad and meaningful community participation in the planning process, the Commission convened the Community Engagement Workgroup to seek additional community input from several key populations to understand

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community needs, challenges, and opportunities for improvement around HIV prevention and care. These community listening sessions attracted over 50 community members and their perspectives complemented the quantitative data presented in the plan. Moreover, regular CHP updates were provided at the monthly meetings of the Commission.

A Goals and Objectives Workgroup was also convened to develop this particular section of the CHP. The goals and objectives (also referred to as the “work plan”) will drive the work of the Commission moving forward and aims to improve inter- and intra- agency coordination efforts to maximize resources and, ultimately, the effectiveness of services delivered to individuals at high-risk for contracting and transmitting HIV. In all, there were over 50 meetings with strong community presence in the planning and development of the CHP.

Throughout the planning process, the CHP Task Force relied on local epidemiologic data, research presentations, geo-mapping, syndemic cluster analysis, linear and multivariate modeling, financial and policy forecasting, community input and feedback, and other methods to formulate this road map for a bold HIV prevention, care and treatment response unique to Los Angeles County.

Recognizing the importance of a data-driven community planning process, the CHP, in collaboration with DHSP, hosted a Data Summit in April 2016 to educate Commissioners and the community-at-large about local HIV/STD data and gain practical knowledge in understanding how to interpret and use data in community planning and deliberations. Specific topics covered during the Data Summit included an introduction to epidemiology; understanding sources and forms of information/data; describing the complexity, limitations, and uses of each data source and determining which data sources are most appropriate for a particular activity or question.

To align planning efforts with the California Department of Public Health, Office of AIDS (OA), the Commission Co-Chairs and DHSP senior leadership participated in a stakeholder meeting convened by OA in Sacramento on April 11, 2016 to brainstorm on goals, objectives, strategies, and activities for a statewide plan. In addition, the Commission co-hosted the Southern California regional stakeholder meeting on May 9, 2016 to build upon the work that was initiated in Sacramento. Members of the Commission participated and facilitated the break-out sessions at the Southern California meeting.

The Commission concurs that the CHP details existing prevention programmatic resources to be allocated locally to the areas with the greatest HIV disease burden as it addresses the spectrum of HIV services identified in the local, state and national Continuum of HIV Care and Prevention; from low- and high-impact prevention activities, testing and diagnosis, linkages to care, and care/treatment and adherence efforts, while expanding strategies to address co-morbidities, comorbid conditions and/or co-occurring disorders; to respond to the needs of identified and

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emerging key/priority populations; and to recognize and respond to social determinants and reduce and remove disparities and inequities in access, knowledge, health care and related conditional, demographic, and economic circumstances.

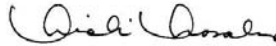
The Los Angeles County CHP 2017-2021 is aligned with the overarching goals of the National HIV/AIDS Strategy (NHAS). The Commission will continue to collaborate with DHSP, OA, and other regional, state, and national partners to advance the goals of NHAS.

We appreciate this opportunity to express our concurrence with the local HIV prevention planning efforts and activities, and do so without reservation. If you need further information or have any additional request or questions, please do not hesitate to contact us.

Sincerely,



Bradley Land, Co-Chair



Ricky Rosales, Co-Chair

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I. NEEDS ASSESSMENT

Introduction:

This Needs Assessment is comprised of five major sections: (A) epidemiologic overview; (B) HIV Care Continuum data for Los Angeles County overall and demographic subpopulations; (C) financial resources inventory and a brief discussion of workforce capacity; (D) service needs, gaps, and barriers to accessing them for persons living with and at high risk of HIV; and (E) data used in compiling this information, as well as data-related needs.

Regarding Terminology: There are many terms that are used throughout this document that may be new to the reader and others that may be better known. To the extent possible, terms that are used are intended to be inclusive and reflect current terminology being used in the field. They are also intended to be culturally sensitive to the group(s) they represent. For example, in the past plan, the term/acronym “SIP” was used to identify persons who ‘share injection paraphernalia.’ This term has been replaced in this plan with the acronym “PWID” to represent ‘persons who inject drugs.’ This latter term has become more widely used in the substance use disorder literature. It is intended to lessen stigma that may be associated with injection drug use (IDU) and also mitigate a negative connotation associated with IDU that IDU refers to illegal drug use. PWID may share needles to inject steroids, hormones, and vitamins among other substances. However, the term IDU will be used to describe the transmission risk of persons living with and at risk for HIV. This is the term still used in all HIV surveillance reports locally, statewide, and nationally. To summarize, PWID will be used to describe the population and IDU to describe the HIV risk behavior.

In this document, the word “cisgender” will be used to identify male and female persons who are not transgender persons. The short forms ‘cismale’ and ‘cisfemale’ or ‘cismen’ and ‘ciswomen’ will also be used. The term ‘transwomen’ refers to transgender persons who were assigned a male sex at birth and their gender identity is now female, and ‘transmen’ refers to persons who were assigned a female sex at birth but now identify as male. However, most public health and population based datasets do not capture gender identity but only sex assigned at birth. Thus, using these new terms can become confusing. For example, the United States (U.S.) Census Bureau does not capture “gender identity,” only “sex assigned at birth.” Los Angeles County HIV surveillance data includes “transgender” in some tables/reports but not in all, which makes descriptions of the epidemic for this population challenging. Due to small sample sizes, it is often difficult to analyze and/or present transgender data in the same way as data for cismales and cisfemales. Where possible, the data presented in this plan include transgender persons. However, there are some exceptions if the dataset described does not include transgender persons. In these instances, sex assigned at birth is used and data for transgender persons is stated as “not available.”

Lastly, in 2009, HIV planners discussed terminology related to race and ethnicity at great length. At that time the consensus was to use “Latino/Hispanic” to describe persons of Hispanic origin and Black/African American to describe persons who may be Black and born in Africa (or another country outside the U.S.), as well as African Americans who are Black and born in the U.S. These terms are used in this plan throughout. However in the U.S. Census data, the terms used are solely Black and Hispanic. Although there was not a discussion regarding the best terminology for describing American Indians/Alaska Natives (also referred to as Native Americans), the author conducted a web search of how Native people refer to themselves. There is no consensus, and while some individuals prefer the term Native American, others prefer American Indian. Thus, for the purposes of this plan, the term used by the U.S. Census—American Indians/Alaska Natives—will be used throughout this document. Due to the large Latino/Hispanic population in Los Angeles County, data presented for all races represent the non-Hispanic population of that race unless stated otherwise.

The extensive epidemiologic data, and data and analysis of available resources, as well as needs, barriers, and gaps in services presented in Section I, provide the foundation for the integrated plan. The actual plan is described in Section II and is the centerpiece of the Comprehensive HIV Plan. The monitoring of the plan is outlined in detail in Section III. As a living document, each of these components will have pieces that are updated yearly to reflect the most current data available, which in turn informs Los Angeles County's community planning process. These updates will ensure that Los Angeles County is responsive to needs of persons living with and at risk for HIV as well as changes in the environment that impact the services designed to address them.

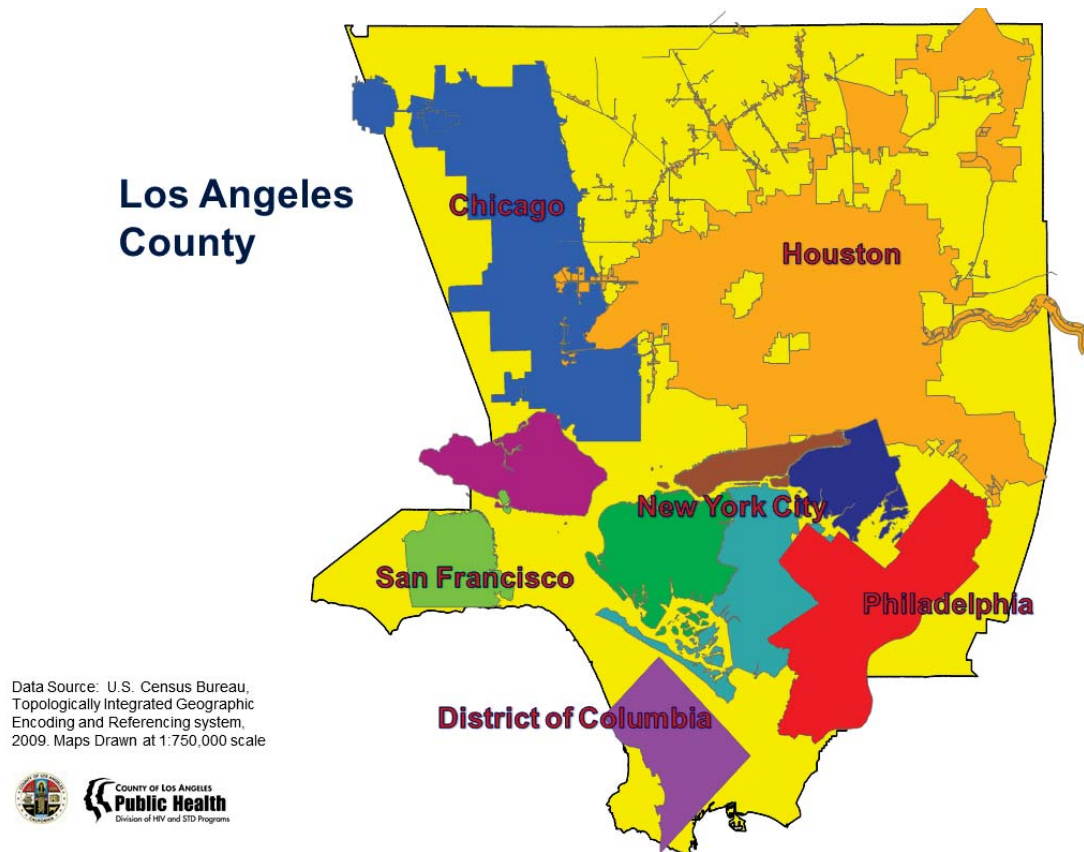
A. EPIDEMIOLOGIC OVERVIEW

a. Communities Affected by HIV in Los Angeles County

1. Geography of Los Angeles County's HIV Epidemic

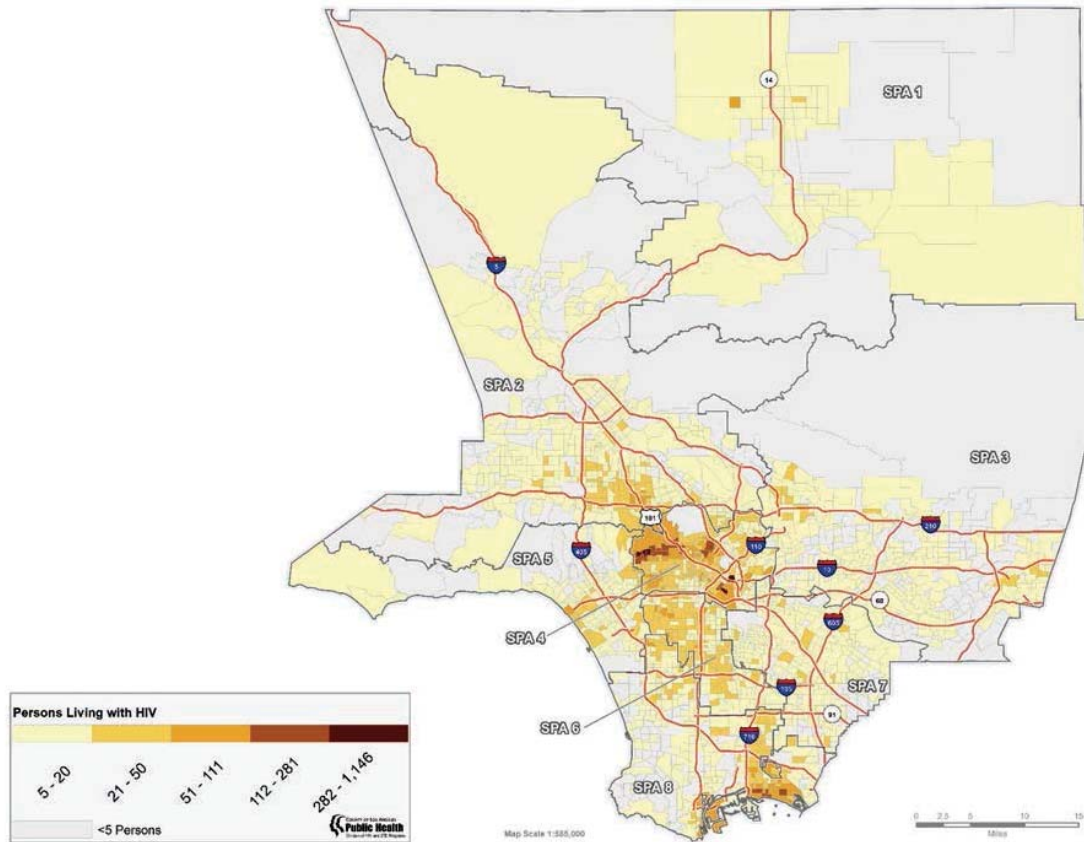
Los Angeles County, California spans 4,084 square miles. This region is comprised of both urban and rural areas, including 88 incorporated cities and approximately 140 unincorporated areas [1]. As seen in Figure 1, the geography of Los Angeles County is significantly larger than six major cities in the United States (U.S.) also heavily burdened by HIV and other sexually transmitted infections (STIs) [2].

Figure 1. Geographic Comparison of Los Angeles County with Six U.S. Cities



In terms of the local communities within Los Angeles County impacted by HIV, HIV prevalence and incidence are not evenly distributed across the county's geography. Rather, there are geographic hotspots within Los Angeles County where there is a greater burden of HIV. This burden is clearly seen in Figure 2, which depicts the total number of people living with HIV (PLWH) by census tract. The darker areas represent larger numbers of PLWH.

Figure 2. Persons Living with a Diagnosis of HIV Infection as of 12/31/14 by Census Tract & Service Planning Area (SPA), Los Angeles County



¹Census tract information is based on person's most recent address as of 12/31/2014. In the case of an unavailable street address, the most recent zip code is used. Map does not include 144 (0.3%) of persons with insufficient location information. Census Tract Data, 2010 U.S. Census Tract U.S. Department of Commerce. 2013 data are provisional due to reporting delay.

2. Service Planning Areas

In 1993, the Los Angeles County Board of Supervisors approved the aggregation of the county's 26 health districts into eight service planning areas (SPAs). The intent of this project, spearheaded by the Los Angeles County Children's Planning Council, was to make public health planning more responsive to local needs. The eight SPAs include: (1) SPA 1: Antelope Valley, (2) SPA 2: San Fernando Valley, (3) SPA 3: San Gabriel Valley, (4) SPA 4: Metro, (5) SPA 5: West, (6) SPA 6: South, (7) SPA 7: East, and (8) SPA 8: South Bay.

As will be discussed later, the largest number of PLWH live in SPA 4, followed by SPAs 8 and 2. In terms of HIV prevalence, SPA 4 is the SPA most disproportionately impacted with the highest rate of HIV per

100,000 population, followed by SPAs 8 and 6. When looking at new diagnoses, SPA 4 also has the highest rate of HIV per 100,000 population, followed by SPA 6 and 8. Thus, there is a new shift in the epidemic, with a growing population of newly diagnosed persons in SPA 6. See *I. A. c. Burden of HIV* for a more complete discussion of the geographic burden of HIV.

3. Los Angeles County's Syndemic Communities

To better understand the shifting epidemic, geographic SPA-based planning evolved in Los Angeles County, especially for HIV prevention services. Prior to 2009, the Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP), then the Office of AIDS Programs and Policy (OAPP), identified geographic "hotspots" based on HIV prevalence and HIV behavior risk data obtained through the Los Angeles Coordinated HIV Needs Assessment (LACHNA) and HIV testing data. The hotspots represented geographic areas where there was a higher risk for HIV based on HIV prevalence as well as high-risk drug and sexual risk behaviors. OAPP used these hotspots to target resources for HIV prevention services, including HIV testing services (HTS).

In 2009, as one of the demonstration sites for the Centers for Disease Control and Prevention's Enhanced Comprehensive HIV Prevention Planning (ECHPP), Los Angeles County's planning efforts continued to evolve. DHSP began examining newly diagnosed cases of HIV in combination with new cases of syphilis, gonorrhea, and chlamydia based on a person's residence address. This syndemic lens (i.e., examining multiple diseases together) allowed DHSP to identify the individual census tracts most impacted by HIV and other sexually transmitted diseases (STD). This planning resulted in the identification of five syndemic cluster areas: North (Lancaster/Palmdale), Northeast (San Fernando Valley), Central (Metro and portions of South Los Angeles), East (Pomona), and South (City of Long Beach and portions of South Los Angeles). DHSP spearheaded this effort. They found that 82.3% of all new HIV cases were located in one of the five cluster areas, with the largest number in the Central and South Clusters [3].

This geographic approach is aligned with the tenets of the National HIV/AIDS Strategy (NHAS): "...the HIV epidemic is concentrated in key populations and geographic areas [4]." Since 2009, DHSP has continued to develop and refine the cluster areas and used them in planning in order to best target services and resources. In 2015, for the first time, DHSP gained access to STI data from the City of Long Beach Health Department, which is located in SPA 8 and is part of the current South Cluster area [5]. Currently, this data is being incorporated into the Los Angeles County dataset in order to refine the cluster areas further.

When this analysis is complete, which is expected in late 2016, the revised cluster areas will completely replace SPA-based HIV and STD planning in the county. Specific HIV and STI incidence data and HIV prevalence data will be available by cluster area, as well as data on social determinants of health. The continued refinement of Los Angeles County's geographic planning approach represents the county's best effort to identify HIV and STI geographic disease burden. Ending HIV in Los Angeles County is inextricably linked to effective geographic planning, which includes targeting of programs, interventions/services, and resources. However, for this plan, SPA-based data will be used to describe the geographic distribution of HIV until DHSP has completed revision of the new syndemic cluster areas. That data will be included in the first update of this plan in 2017.

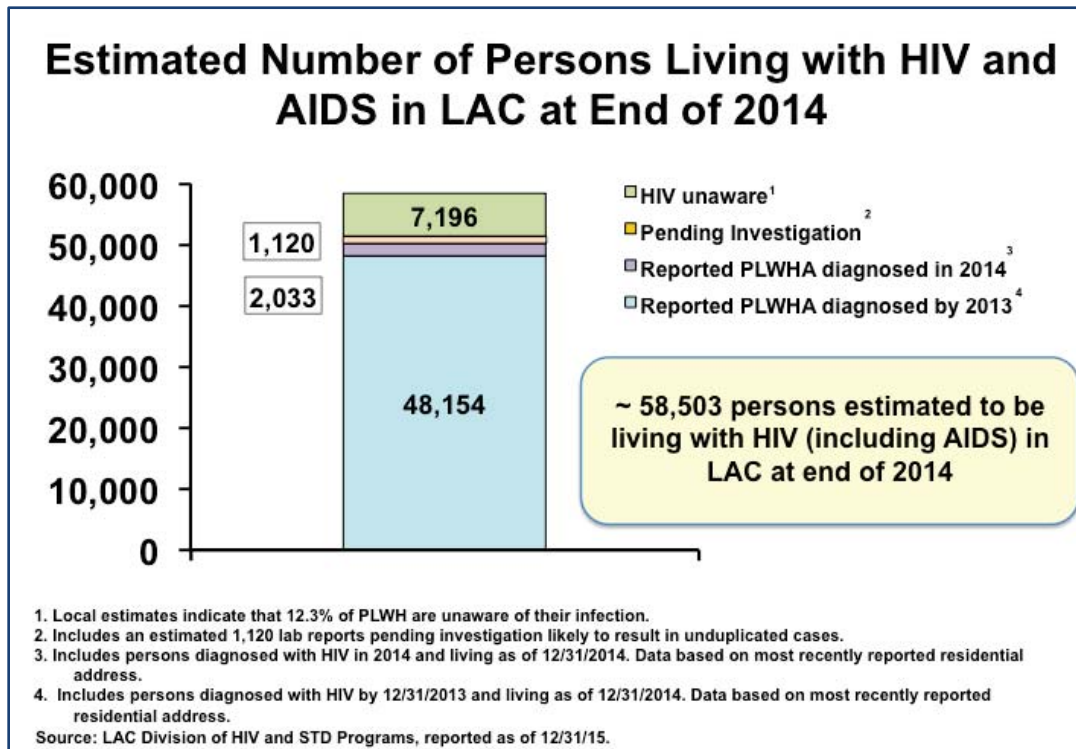
b. Socio-Demographic Characteristics of Persons Living with HIV

1. Los Angeles County’s HIV Epidemic

Estimate of Persons Living with HIV in Los Angeles County

Since the beginning of the epidemic, Los Angeles County continues to have the second largest number of persons living with HIV (PLWH), including AIDS, in the U.S. Figure 3 depicts the total estimate of PLWH. At the end of 2014, DHSP estimates there were approximately 58,503 PLWH in the county, including 7,196 persons who were undiagnosed and unaware of their HIV infection. Undiagnosed persons represent approximately 12.3% of total PLWH.

Figure 3. Estimated Number of Persons Living with HIV and AIDS in Los Angeles County at The End of 2014



Demographic Characteristics of Persons Living with HIV and Recently Diagnosed

Examining the demographic characteristics of PLWH and those who are recently diagnosed provides key insight into the populations most at risk for HIV. Los Angeles County utilizes the enhanced HIV/AIDS Reporting System (eHARS) to collect demographic information based on mandatory case reports for all persons diagnosed with HIV in Los Angeles County. Table 1 includes the demographic characteristics of all PLWH as of December 31, 2014 and the aggregated number of recently diagnosed persons during the five-year period from 2009 to 2013. The demographic characteristics of persons who are recently diagnosed also serves as a surrogate for persons who are at high risk for HIV. Percentages for comparable population groups within the general population are presented to allow for comparison. Data for the general population is based on estimates from the U.S. Census Bureau’s American Community Survey. Table 1 excludes the undiagnosed population and cases pending investigation. The total number of PLWH differs from that reported in Figure 1 due to data extraction on a different date.

As of December 31, 2014, there were 48,908 reported PLWH in Los Angeles County [6]. Of that number, 20.9% (10,223) were diagnosed within the past five years [6]. As seen in Table 1, except for age and transmission categories, the demographic characteristics are similar for all PLWH and recently diagnosed

persons. Los Angeles County’s HIV epidemic is predominantly cismale (87.5% of all PLWH and 87.6% of recently diagnosed PLWH). This is dramatically higher than the proportion of cismales in the general population (49.3%) [7]. The majority of PLWH are from communities of color, especially Latino/Hispanic (41.8% all PLWH and 46.2% of recently diagnosed) and Blacks/African Americans (20.2% all PLWH and 22.8% of recently diagnosed). Latinos/Hispanics comprise 48.2% and Blacks/African Americans 8.6% of the general county population in 2014 [7]. In terms of age, PLWH are older with the largest proportion between 40 and 59 years old (60.1%). Recently diagnosed PLWH are younger, with the majority (61.3%) between 20 and 39 years old. Nearly one third (32.6%) of all recently diagnosed persons are young adults 20-29 years old.

Table 1. Demographic Characteristics of Los Angeles County’s 2014 General Population, Persons Living with HIV as of December 31, 2014 and Recently Diagnosed Persons (2009-2013)

Characteristic	2014 Population	Persons Living with HIV		2009-2013 HIV Diagnoses	
	Number / Percent ¹	Number	Percent ¹	Number	Percent ¹
Total	10,069,036	48,908	100%	10,223	100%
Gender Identity					
Cismale	49.3%	42,792	87.5%	8,958	87.6%
Cisfemale	50.7%	5,501	11.2%	1,119	10.9%
Transgender	0.1% ²	615	1.3%	146	1.4%
Race/Ethnicity³					
Latino/Hispanic	48.2%	20,454	41.8%	4,720	46.2%
White	28.4%	15,891	32.5%	2,478	24.2%
Black/African American	8.6%	9,875	20.2%	2,326	22.8%
Asian/Pacific Islander	14.6%	1,687	3.4%	444	4.3%
American Indian/Alaska Native	0.2%	239	0.5%	62	0.6%
Other/Unknown	0%	762	1.6%	0	0.0%
Age					
<13	16.6%	34	0.0%	17	0.2%
13-19	9.7%	140	0.2%	350 ⁴	3.4%
20-29	15.3%	3,954	8.1%	3,333	32.6%
30-39	14.4%	8,671	17.7%	2,930	28.7%
40-49	14.0%	14,307	29.3%	2,256	22.1%
50-59	13.0%	15,062	30.8%	1,054	10.3%
60+	17.3%	6,740	13.8%	283	2.8%
Transmission Category⁵					
MSM	not available	38,009	77.7%	8,488	83.0%
Heterosexual	not available	5,072	10.4%	995	9.7%
MSM/IDU	not available	2,935	6.0%	326	3.2%
IDU	not available	2,471	5.1%	392	3.8%
Perinatal	not available	275	0.6%	17	0.2%
Other/Unknown	not available	146	0.3%	0	0%

¹All percentages may not add to 100 due to rounding.

²The percentage presented is based on 2016 estimate of 13,788 transgender persons living in Los Angeles County from An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.

³ Does not include persons of more than one race or unknown race/ethnicity.

⁴ Represents age at time of diagnosis and not current age.

⁵ Transmission category estimates for the general population are not possible. Data not available or too small to include.

Sources: (1) 2014 Population estimates provided by Los Angeles County Internal Services Department and contracted through Hedderson Demographic Services; (2) Los Angeles County Department of Public Health Division of HIV and STD Programs 2014 HIV STD Surveillance Report.

In terms of risk for transmission, Los Angeles County’s HIV epidemic is similar to that of California and other western states. Men who have sex with men (MSM) account for more than three-quarters (77.7%) of all PLWH and 83.0% of recently diagnosed PLWH. Together with the MSM/injection drug use (IDU), MSM, including MSM/IDU accounts for 83.7% of all PLWH and 86.2% of recently diagnosed PLWH. Heterosexual contact accounts for 10.4% all PLWH, and 9.7% of recently diagnosed persons. IDU as a

sole transmission risk category represents 5.1% of all PLWH and 3.8% of newly diagnosed persons. This pattern is significantly different from the national epidemic where MSM, including MSM/IDU account for only 58.3% of HIV transmission risk [8]. Heterosexual transmission accounts for a significantly larger proportion (25.9%) of all PLWH in the U.S. and IDU accounts for 11.3% of all transmission risk [8].

Geographic Distribution of HIV Across Los Angeles County

The number of persons who are recently diagnosed and living with HIV are not evenly distributed across the county. There are areas that have a disproportionate burden of HIV when compared to other areas (i.e., percent of PLWH and/or recently diagnosed PLWH by SPA is larger than proportion of the general population by SPA). Table 2 shows the geographic distribution of PLWH as of December 31, 2014 and recently diagnosed persons (2009-2013) by SPA in comparison to the estimated 2014 general population by SPA. [Note: Disproportionate burden by rates per 100,000 population are discussed later in this section].

Table 2. Geographic Distribution of Los Angeles County’s General 2014 Population, Persons Living with HIV as of December 31, 2014, and Recently Diagnosed Persons with HIV (2009-2013)

Geographic Region	2014 Population		Persons Living with HIV		2009-2013 HIV Diagnoses	
	Number	Percent ¹	Number	Percent ¹	Number	Percent ¹
Total	10,069,036	100%	48,908	100%	10,223	100%
Service Planning Area (SPA)						
SPA 1: Antelope Valley	392,730	3.9%	695	1.4%	218	2.1%
SPA 2: San Fernando Valley	2,190,397	21.8%	6,861	14.0%	1,347	13.2%
SPA 3: San Gabriel Valley	1,783,038	17.7%	3,418	7.0%	809	7.9%
SPA 4: Metro	1,149,688	11.4%	18,480	37.8%	3,529	34.5%
SPA 5: West	652,160	6.5%	2,693	5.5%	502	4.9%
SPA 6: South	1,033,672	10.3%	5,216	10.7%	1,303	12.7%
SPA 7: East	1,312,015	13.0%	3,202	6.5%	811	7.9%
SPA 8: South Bay	1,555,336	15.4%	8,042	16.4%	1,619	15.8%
SPA unknown			301	0.6%	85	0.8%

¹All percentages may not add to 100 due to rounding.

Sources: (1) 2014 Population estimates provided by Los Angeles County Internal Services Department and contracted through Hedderson Demographic Services; (2) Los Angeles County Department of Public Health Division of HIV and STD Programs 2014 HIV STD Surveillance Report.

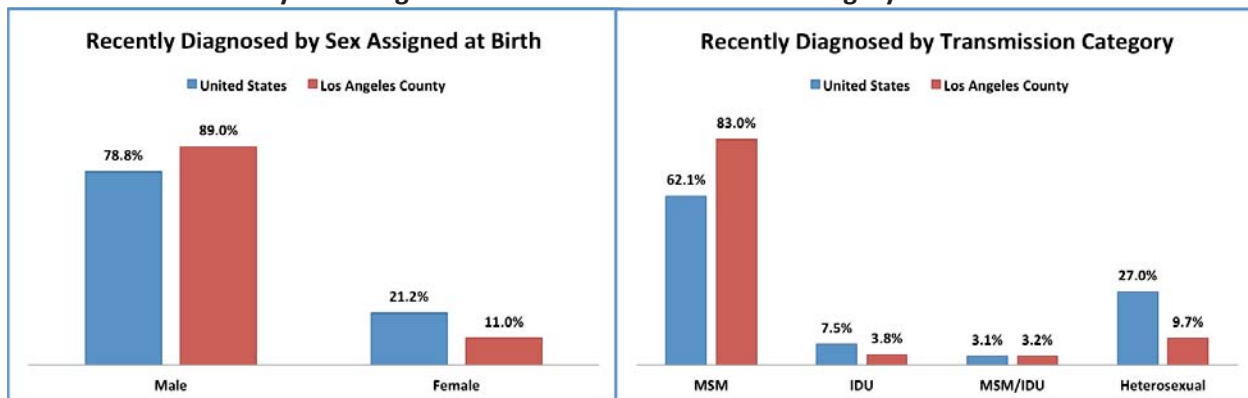
As seen, SPA 4 has the largest number and percentage of PLWH (37.8%) and recently diagnosed persons (34.5%) in the county. This is disproportionate to the size of SPA 4’s general population, which is 11.4% of Los Angeles County’s total population. In terms of the largest number of PLWH and recently diagnosed PLWH, SPA 8 ranks second to SPA 4 (16.4% of all PLWH and 15.8% of recently diagnosed persons) and SPA 2 ranks third (14.0% of all PLWH and 13.2% of recently diagnosed PLWH). In terms of all PLWH, the proportion in SPA 8 (16.4%) is larger than its proportion of the general population in the county (15.4%). In terms of recently diagnosed persons, SPA 6 is home to 12.7% of recently diagnosed persons and represents only 10.3% of Los Angeles County residents. The burden of HIV in SPA 6 is more clearly seen later in this section when rates per 100,000 population are discussed.

Comparison of Los Angeles County and the United States Epidemic

Los Angeles County has a very different demographic profile than that of the HIV epidemic in the U.S. Figures 4-6 below compares selected demographic characteristics of recently diagnosed persons (2009-2013) in the U.S. and Los Angeles County.

Examining recent diagnoses provides insight into the direction and trend of both the U.S. and Los Angeles County epidemic. As seen in Figure 4 in terms of sex assigned at birth, the U.S. has a much larger proportion of recently diagnosed (2009-2013) females (21.2%) than does Los Angeles County (11.0%). This has been a long-standing difference between the U.S. and Los Angeles County epidemic. It sheds light on the drivers of the epidemic, which is seen in differences in transmission category. MSM is the primary source of HIV transmission in Los Angeles County, accounting for 83.0% of recently diagnosed persons. However, in the U.S., MSM account for a significantly smaller proportion of transmission (62.1%) among recently diagnosed persons. Due to the larger proportion of females* among recently diagnosed persons in the U.S., heterosexual contact accounts for nearly three times the transmission risk in the U.S. (27.0%) than in Los Angeles County (9.7%). Injection drug use also accounts for twice as many recent diagnoses in the U.S. (7.5%) than in Los Angeles County (3.8%). Persons who have the dual risk category of MSM/IDU are about the same in both regions.

Figure 4. Comparison of Recently Diagnosed Persons in the United States and Los Angeles County, 2009-2013 by Sex Assigned at Birth¹ and Transmission Category



Sources: CDC, HIV Surveillance Report, 2013; Los Angeles County Department of Public Health, Supplemental Tables for HIV Surveillance Summary Report—2014, February 2016.

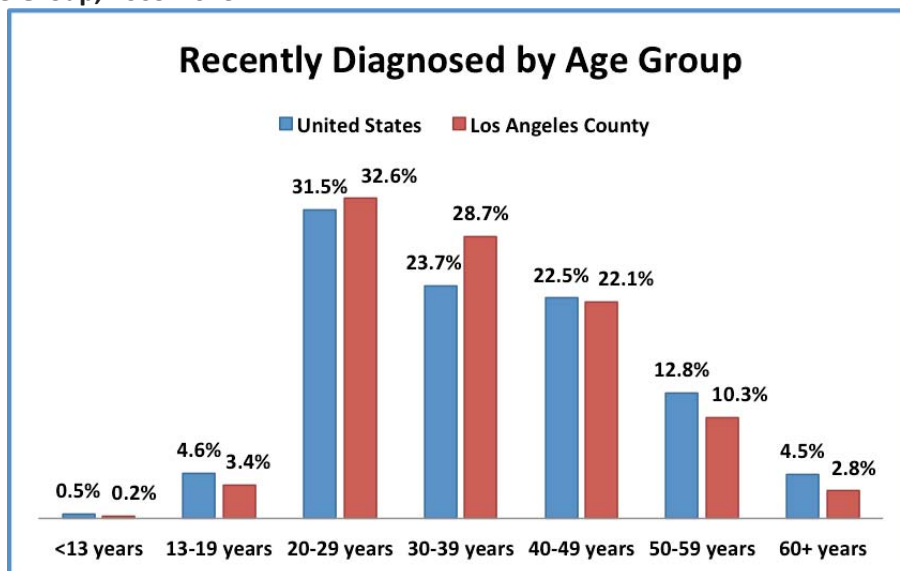
¹ Estimate of new diagnoses among transgender persons is not available in the CDC’s annual surveillance report; U.S. data for sex at birth excludes children <13 years old.

Figure 5 shows the differences by age group. Although there is a higher proportion of very young people (<20 years old) recently diagnosed in the U.S. (5.1%) compared to Los Angeles County (3.6%), Los Angeles County’s recent diagnoses are younger overall. From 2009-2013, 61.3% of Los Angeles County’s new diagnoses were between the ages of 20-39 years old, compared to 55.2% in the U.S. The 40-49 year old age group is nearly the same in both regions. The U.S. has a larger proportion of recent diagnoses among persons 50 years and older (17.3%) compared to Los Angeles County (13.1%).

In terms of race/ethnicity (Figure 6), the most significant difference in Los Angeles County is that 46.2% of recent diagnoses are Latino/Hispanic compared to 21.1% of recent diagnoses in the U.S. However, these proportions are nearly reverse for Blacks/African Americans, 46.6% of recent diagnoses in the U.S. compared to 22.8% of recent diagnoses in Los Angeles County. Los Angeles County also has a larger proportion of recently diagnosed Asians/Pacific Islanders (4.3%) than in the U.S. (1.8%).

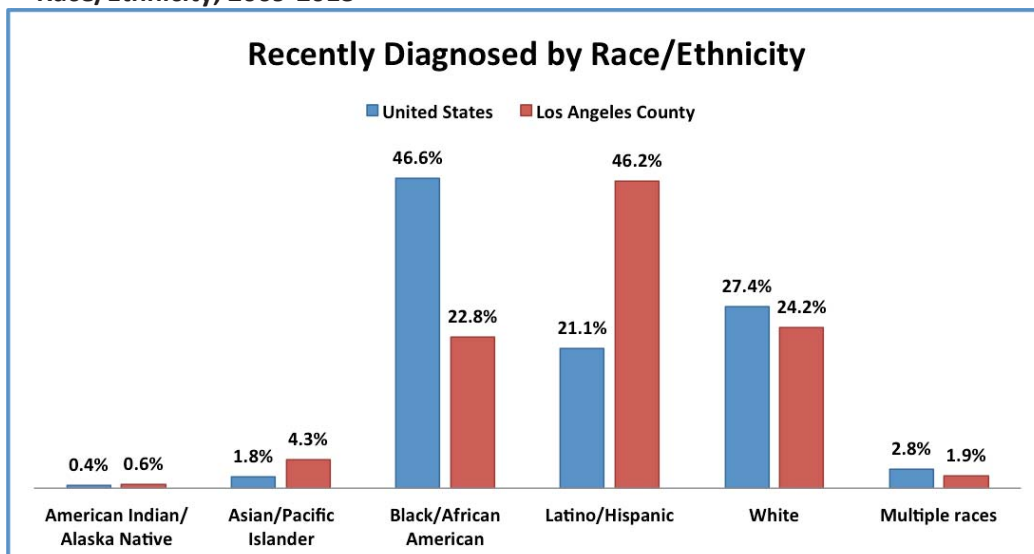
* Sex assigned at birth. The CDC’s HIV surveillance data does not report transgender data.

Figure 5. Comparison of Recently Diagnosed Persons in the United States and Los Angeles County by Age Group, 2009-2013



Sources: CDC, HIV Surveillance Report, 2013; Los Angeles County Department of Public Health, Supplemental Tables for HIV Surveillance Summary Report—2014, February 2016.

Figure 6. Comparison of Recently Diagnosed Persons in the United States and Los Angeles County by Race/Ethnicity, 2009-2013



Sources: CDC, HIV Surveillance Report, 2013; Los Angeles County Department of Public Health Division of HIV and STD Programs 2014 HIV STD Surveillance Report.

c. Burden of HIV

Much of the data presented creates a clear picture of communities and populations severely and/or disproportionately impacted by HIV. Table 1 depicts the demographic characteristics of all PLWH and recently diagnosed (2009-2013) PLWH in Los Angeles County in comparison to the general population. Thus, populations that have the largest number of PLWH, including newly diagnosed persons are severely impacted by HIV. Populations where the percentage of PLWH and/or newly diagnosed persons

exceeds their representation in the general population (i.e., percentage), these populations are disproportionately impacted by HIV. Another way to compare populations with each other is to use rates per 100,000 population. This allows small populations to be compared with large populations in order to understand the disease burden in each population. An important limitation when using rates is that a denominator is required to calculate the rate. The denominator is the total number of persons in a particular subpopulation or geographic region. It is not possible to calculate rates in populations that do not have a denominator (i.e., transgender persons, transmission risk categories). As a result, HIV burden needs to be examined through multiple lenses.

Table 3 presents the rates per 100,000 population for selected demographic and geographic characteristics for five key measures that help assess the burden of HIV in the selected populations.

Table 3. Rates per 100,000 Population for Selected Demographic/Geographic Categories for Reported Persons Living with HIV (PLWH), 2013 New HIV Diagnoses, Reported Persons Living with AIDS (PLWA), 2013 New AIDS Diagnoses, and 2013 Deaths (all causes)

Population Category / Geographic Region	PLWH	2013 New HIV Diagnoses	PLWA	2013 New AIDS Diagnoses	2013 Deaths (all causes)
Gender Identity					
Cismale	874	33	489	17	9
Cisfemale	108	2	59	2	1
Transgender ¹	-	-	-	-	-
Age Group					
<13 ²	2	-	1	-	-
13-19	14	7	5	1	1
20-29	256	39	60	11	7
30-39	600	35	231	19	10
40-49	1,014	27	584	19	9
50-59	1,151	15	779	13	5
60+	394	4	282	3	2
Race/Ethnicity					
White	556	15	306	7	5
Black/African American	1,139	52	618	24	16
Latino/Hispanic	421	17	250	9	3
Asian/Pacific Islander	115	5	60	3	1
American Indian/Alaska Native	1,192	36	588	31	36
SPA					
Antelope Valley [1]	177	8	93	3.6	
San Fernando Valley [2]	313	11	173	6.4	
San Gabriel Valley [3]	192	9	110	4.4	
Metro [4]	1,607	54	866	25.8	
West [5]	413	13	223	6.3	
South [6]	505	24	286	13.8	
East [7]	244	11	144	5.8	
South Bay [8]	517	18	321	8.5	

Source: Los Angeles County Department of Public Health, 2014 Annual HIV/STD Surveillance Report; Los Angeles County Department of Public Health, Los Angeles County Department of Public Health, Supplemental Tables for HIV Surveillance Summary Report—2014, February 2016.

¹ Size of transgender population is unknown and therefore there is no denominator to calculate a rate.

² In some categories, numbers are too small to calculate rates.

As seen, the five measures examined include:

1. Persons living with HIV, including AIDS (PLWH) as of December 31, 2014,
2. Persons living with AIDS (PLWA) as of December 31, 2014,
3. 2013 New HIV diagnoses,
4. 2013 New AIDS diagnoses, and
5. 2013 Deaths (all causes).

Rates that are highlighted in bold signify the top two rates within the category. As seen, three populations (cismales, Blacks/African Americans, and American Indians/Alaska Natives) have the highest rates in the county across all measures; SPA 4 has the highest in all measures where data is available.

Table 4 presents the estimated HIV prevalence among adults/adolescents for selected populations along with estimated size of the population, number of PLWH as of December 31, 2013, and percent of PLWH as of December 31, 2013. Although the estimated HIV prevalence presented here does not include persons living with undiagnosed HIV infection, it does clearly show the dramatic differences of estimated HIV prevalence in different populations. Blacks/African Americans have the highest estimated HIV prevalence among MSM (40.5%), cismales (0.6%), and transgender persons (26.5%). Among youth, YMSM have the highest estimated HIV prevalence (1.8%) compared to all youth (0.1%). American Indian/Alaska Native transgender women also have a high estimated HIV prevalence (25.6%).

Table 4. Estimated Adult/Adolescent PLWH for Selected Populations and Subpopulations

Populations/ Subpopulations ¹	Estimated Size of Population ²	Estimated Number of Persons Living with HIV in 2013 ³	Estimated HIV Prevalence ⁴	Estimated Percent of 2013 Adult/Adolescent PLWH in Los Angeles County N=47,628
MSM⁵	216,885	39,793	18.4%	83.6%
Black/African American	17,226	6,973	40.5%	14.6%
Latino/Hispanic	106,541	16,245	15.3%	34.1%
Cismales	3,451,251	5,387	0.2%	11.3%
Black/African American	305,870	1,905	0.6%	4.0%
Latina	1,661,205	2,407	0.1%	5.1%
Youth (13-24 years)	1,721,454	1,335	0.1%	2.8%
MSM ⁵	55,416	995	1.8%	2.1%
Transgender Persons⁶	13,788	1,206	8.8%	2.5%
Women	6,894	1,152	16.7%	2.4%
Men	6,894	54	0.8%	0.1%
American Indian/Alaska Native	207	53	25.6%	0.1%
Black/African American	1,268	336	26.5%	0.7%
People Who Inject Drugs⁷	70,990	5,357	7.6%	11.3%

¹ Categories are not mutually exclusive

² 2013 Department of Finance data used to estimate the size of the populations (among persons who are 15-64 years of age). Accessed at <http://www.dof.ca.gov/research/demographic/DRU/>.

³ Based on 2013 HIV Surveillance data reported as of 03/31/2015. Estimates do not include persons unaware of their diagnosis except where noted.

⁴ Estimated HIV prevalence=Estimated number of PLWH/Estimated size of the population.

⁵ Based on estimate that MSM represent 6.3% of male population (calculated by averaging CDC's 2012 estimate (4.4%) and Lieb et al's 2011 estimate (8.2%).

⁶ Based on estimate that transgender persons represent 0.2% of the population. See Los Angeles County Transgender Population Estimates 2012 for methodology.

⁷ Population estimate based on Tempalski et al. 2013

Source: Division of HIV and STD Programs, Los Angeles County Department of Public Health, An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.

A complete discussion of disease burden would also include a demographic estimate of persons who are living with undiagnosed HIV infection. They represent the 7,196 estimated persons in Figure 3 and are part of the total population of PLWH. The CDC recognizes that persons who are undiagnosed are not evenly distributed across all population categories and there are significant differences [9]. Although local estimates of Los Angeles County’s undiagnosed population are not available at this time, DHSP does participate in the CDC’s HIV incidence surveillance project to develop estimates of incidence (i.e., new HIV infection) based on diagnosed and undiagnosed persons (Table 5).

Table 5. Estimated Number, 95% Confidence Interval and Rate (per 100,000) of Estimated New HIV Infections by Demographic and Risk Behavior Group, Los Angeles County HIV Incidence Surveillance, 2010-2013¹

		2010		2011		2012		2013	
		N (95% CI)	Rate	N (95% CI)	Rate	N (95% CI)	Rate	N (95% CI)	Rate
Gender	Male	1,919 (1,460-2,379)	48	1,904 (1,452-2,356)	48	2,126 (159-2,661)	53	1,624 (1,218-2,031)	40
	Female	234 (92-377)	5	211 (74-349)	5	232 (60-404)	6	241 (90-391)	6
Age Group	18-24 years	463 (283-643)	41	510 (313-707)	48	566 (311-822)	53	466 (243-690)	44
	25-29 years	377 (229-525)	55	356 (214-497)	47	472 (276-667)	62	378 (237-520)	50
	30-34 years	367 (208-526)	57	545 (362-728)	39	365 (168-561)	50	308 (164-453)	41
	35-39 years	313 (154-471)	43	283 (165-400)	38	270 (126-414)	39	204 (93-314)	29
	40-49 years	406 (216-596)	26	262 (134-390)	33	438 (224-652)	31	302 (167-437)	22
	50+ years	196 (75-316)	7	230 (65-396)	8	209 (62-356)	7	174 (78-270)	6
Race/ Ethnicity	White	667 (391-943)	26	463 (270-655)	19	659 (407-908)	27	503 (326-680)	21
	Black/AA	332 (181-483)	46	491 (287-694)	72	427 (209-646)	63	383 (215-551)	55
	Latino/ Hispanic	935 (661-1209)	24	1,004 (703-1,304)	27	1,111 (767-1,455)	30	844 (581-1,106)	22
	A/PI¹	-	-	-	-	-	-	-	-
	AI/AN¹	-	-	-	-	-	-	-	-
Mode of Transmission	HET	202 (64-340)	2	171 (23-319)	2	-	-	-	-
	IDU¹	-	-	-	-	-	-	-	-
	MSM	1,841 (1,410-2,272)	798	1,864 (1,415-2,313)	861	2,063 (1538-2588)	946	1,574 (1,165-1,983)	763

¹Incidence estimates are calculated separately for each demographic group. Therefore, numbers in the breakdown may not add up to annual total; Data completeness or sample size did not meet the criteria to calculate a stratified incidence estimate for transgender individuals, IDU, Asian/Pacific Islanders or American Indian/Alaskan Native.

Source: Division of HIV and STD Programs, Los Angeles County Department of Public Health, An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.

Although these estimates have limitations, they provide insight into the direction of Los Angeles County’s epidemic. They are the best source at this time for identifying persons who are most at risk for

HIV in Los Angeles County. As seen in Table 5, the populations with the highest rates for every year from 2010 to 2013 are males (sex assigned at birth), Blacks/African Americans, and MSM. Except for 2011, 25-29 year olds have the highest estimated HIV incidence rate, followed by 18-24 year olds. In 2011, this pattern is reversed and 18-24 year olds have the highest rate followed by 25-29 year olds.

DHSP also estimated HIV incidence rates by SPA for 2013. Not surprising, the estimated rate per 100,000 population is highest in SPA 4 (87/100,000) followed by SPA 6 (43/100,000), SPA 8 (20/100,000), SPA 2 (16/100,000), SPA 7 (15/100,000), and SPA 3 (11/100,000) [10]. DHSP was not able to calculate an estimate for SPAs 1 and 5 due to small sample size or they did not meet criteria to create the estimate. Another indicator of HIV burden is the number of persons who are diagnosed with HIV but who are not in medical care, as evidenced by an HIV laboratory test in the previous 12 months. Persons without a laboratory test are considered to be 'out of care.' This population is referred to by the Health Resources and Services Administration (HRSA) as PLWH with 'unmet need,' (i.e., they have an unmet need for HIV medical care). Understanding which populations are not in care provides another lens through which to examine the total picture.

DHSP conducted a recent analysis of PLWH who are not in care using multiple data sources, including HIV surveillance data. They found that in 2013, 28.7% or 13,295 PLWH were identified as not in care through the surveillance data [11]. They examined the demographic characteristics of this population and found that several populations had a much higher proportion of PLWH within the population who were considered out of care. These included: American Indians/Alaska Natives (45.3%), persons who inject drugs (36.1%), Blacks/African Americans (32.1%), cisfemales (31.3%), and Latinos (29.8%) [11]. Populations with the largest number of PLWH estimated to be out of care include in the following order: cismales (11,602), PLWH aged 25-49 years (8,212), MSM (8,169), Latinos (5,675), and PLWH aged 50-64 years (4,129) [11].

1. HIV Burden in Los Angeles County

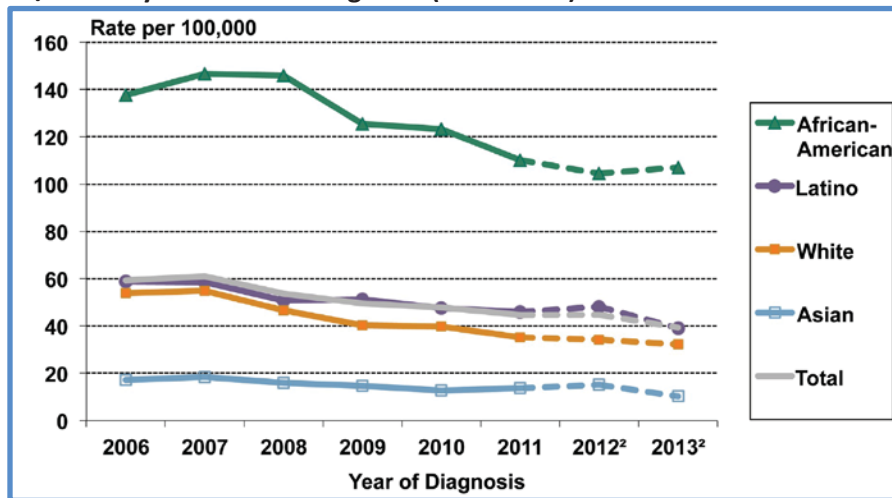
HIV BURDEN BY GENDER IDENTITY

As seen in Table 3, cismales are the most burdened gender group across every measure presented and have the highest rate per 100,000 population for total PLWH, 2013 HIV diagnoses, PLWA, 2013 AIDS diagnoses, and 2013 deaths. This is consistent with the data presented earlier in Table 1. As seen in Table 1, transgender persons comprise an estimated 0.1% of the general population in Los Angeles County. However, they comprise 1.3% of all PLWH and 1.4% of recently diagnosed persons.

Table 4 shows the estimated HIV prevalence in 2013 within selected subpopulations. As seen, MSM have the highest estimated HIV prevalence in Los Angeles County (18.4%), followed by transgender persons (8.8%), and ciswomen (0.2%). That is, nearly 1 in 5 MSM in Los Angeles County are HIV positive. About 1 in every 11 transgender persons are living with HIV, and so on. However, a greater HIV burden is revealed when specific subpopulations within these categories are examined. Among MSM, Black/African American MSM have the highest estimated HIV prevalence in Los Angeles County (40.5%), followed by Black/African American transgender persons (26.5%), and American Indian/Alaska Native transgender persons (25.6%). Transgender women have an estimated HIV prevalence of 16.7% compared to transgender men (0.8%). Among ciswomen, Black/African American ciswomen have the highest estimated HIV prevalence (0.6%). Although Latinas have a significantly lower estimated HIV prevalence (0.1%), they have the largest estimated number of PLWH among ciswomen, in 2013 (2,407) (Table 4).

Figures 7 and 8 present the rate of new HIV diagnoses over time for both males (sex assigned at birth) and females (sex assigned at birth) by race/ethnicity in Los Angeles County. As can be seen, new diagnoses of HIV for both adult/adolescent males and females is highest among Blacks/African Americans and has been so since at least 2006, followed by Latinos (both male and female). A limitation of the data presented below is that rates for American Indians/Alaska Natives and Pacific Islanders are not included due to small numbers that may cause unstable estimates. As seen, the rates for Blacks/African Americans are significantly higher than other races/ethnicities for both sexes assigned at birth.

Figure 7. Rate of Male (Sex Assigned at Birth) Adult/Adolescents Diagnosed with HIV by Race/Ethnicity and Year of Diagnosis (2006-2013)^{1,2}

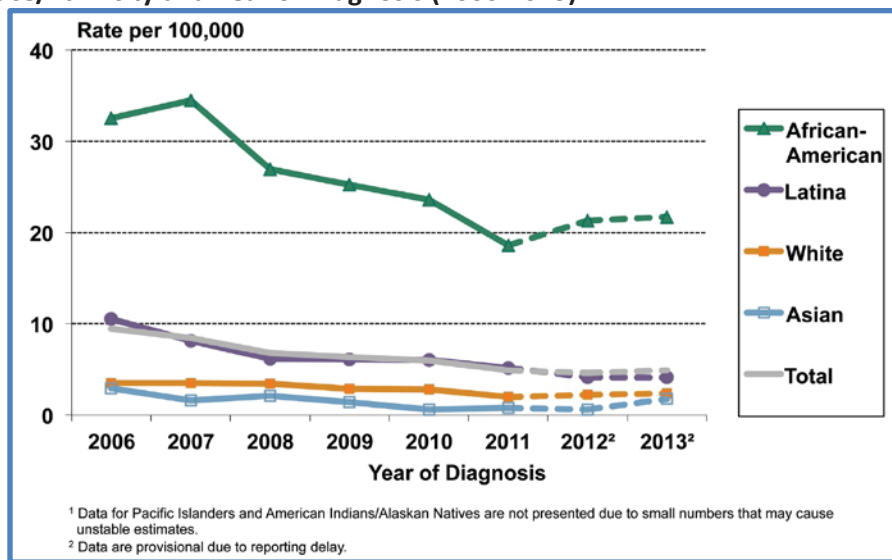


¹ Rates for Pacific Islanders and American Indian/Alaska Natives are unstable and therefore not presented.

² Data are provisional due to reporting delay (2012-2013).

Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, 2014 Annual HIV/STD Surveillance Report, February 2016.

Figure 8. Rate of Female (Sex Assigned at Birth) Adult/Adolescents Diagnosed with HIV by Race/Ethnicity and Year of Diagnosis (2006-2013)^{1,2}



¹ Data for Pacific Islanders and American Indians/Alaskan Natives are not presented due to small numbers that may cause unstable estimates.

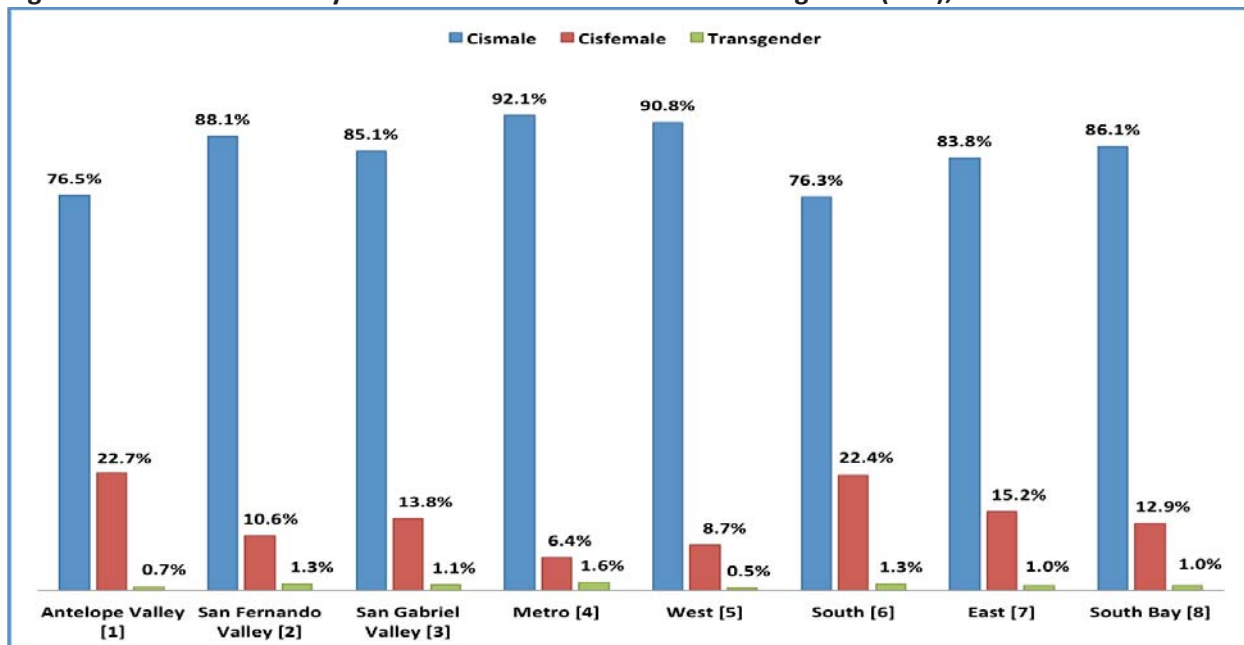
² Data are provisional due to reporting delay.

Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, 2014 Annual HIV/STD Surveillance Report, February 2016.

In terms of estimated HIV incidence (see Table 5), DHSP estimates the rate among males to be 40 per 100,000 population compared to 6 per 100,000 population for females in 2013. The rate for the transgender population is not able to be calculated without a denominator.

Figure 9 shows the gender composition of PLWH within Los Angeles County’s eight SPAs. As seen, SPAs 1 and 6 have the largest proportion of cisfemale PLWH (22.7% and 22.4% respectively), followed by SPA 7 (15.2%). Transgender PLWH comprise 1.6% of SPA 4’s population of PLWH, followed by SPA 2 (1.3%) and SPA 6 (1.3%). SPAs 4 and 5 have the largest concentration of cismale PLWH (92.1% and 90.8% respectively).

Figure 9. Gender Identity of PLWH within Each Service Planning Area (SPA), 2014



Males Living with HIV

[Note: In the description that follows, the available HIV surveillance data blends information available for cismales (i.e., males who are not transgender men) with data available for males (sex assigned at birth). To minimize confusion, the term “male” will be used only when the data available is for sex assigned at birth. The term “cismale” will be used to identify males who are not transgender, when there is data available for transgender persons.]

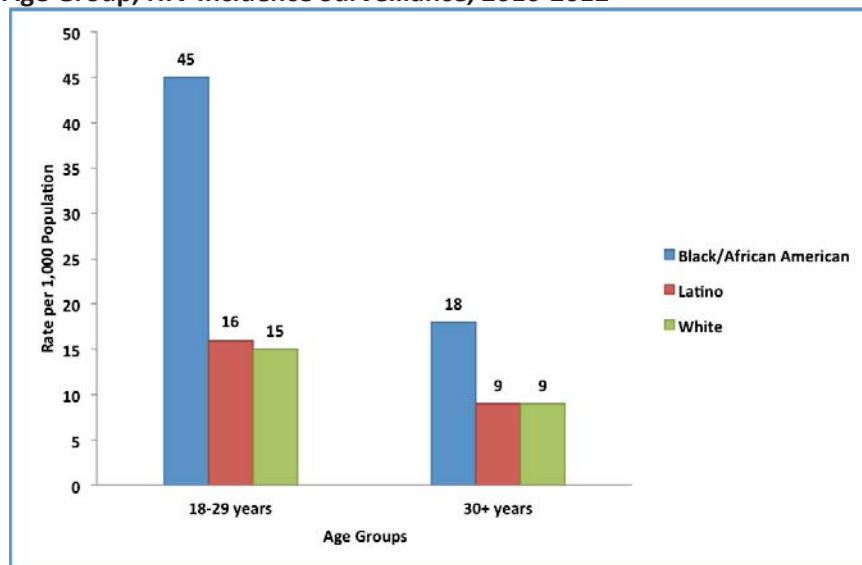
As of December 31, 2014, there are 42,792 PLWH who are cismale, 87.5% of all PLWH and 8,958 (87.6%) recently diagnosed persons from 2009 to 2013 (see Table 1). The rate per 100,000 population of HIV among cismales is 862 compared to 108 for women [6]. As seen in Figure 3, DHSP estimates there are 7,196 persons who are undiagnosed. Using the proportion of recent diagnoses (87.6%), there may be as many as 6,304 undiagnosed cismales. In a recent analysis of persons out of care using 2013 HIV surveillance data, DHSP estimates that 86.6% (11,602) of all persons who know their HIV status and are not in care are cismale [11].

The majority of male PLWH are Latino (41.4%), followed by White (34.7%) and Black/African American (18.3%) [12]. Nearly half (44.9%) of male PLWH are 50 years and older, which shows an aging population [12]. However, White male PLWH are older than either Black/African American PLWH or Latino PLWH. Approximately 59.6% of White male PLWH are 50 years and older compared to 44.4% of Black/African

American male PLWH and 33.8% of Latino male PLWH [12]. The primary transmission category for male PLWH is MSM (87.6%); another 6.8% of transmission among males is the dual risk category of MSM/IDU [12]. Thus, a total of 94.4% of male PLWH are MSM. IDU accounts for 3.1% of transmission among male PLWH, and heterosexual sex accounts for 2.1%.

Recent diagnoses and evidence from Los Angeles County’s HIV incidence surveillance project (Figure 10) show that young MSM (18-29 years) (YMSM) are driving the county’s current epidemic and account for the majority of new HIV infections. As seen, Black/African American young MSM (18-29 years old) and MSM (30 years and older) have the highest estimated HIV incidence for all races/ethnicities (45 and 18 per 1,000 population respectively). The rates for Latino/Hispanic and White YMSM are nearly the same.

Figure 10. Estimated Rate of New HIV Infection per 1,000 population among MSM by Race/Ethnicity and Age Group, HIV Incidence Surveillance, 2010-2012^{1,2}



¹Data is provisional due to reporting delay;

²Incidence estimates for Black/AA and Latino/Hispanic MSM aged 18-29 years and for Black/AA MSM aged 30+ years compared with Latino/Hispanic and White MSM differ significantly ($p < 0.01$).

Source: DHSP, Los Angeles County Department of Public Health; data as May 12, 2015

At the end of 2014, there are 3,422 YMSM (18-29 years) living with HIV; they represent 8.4% of all male PLWH who report MSM and MSM/IDU transmission categories [13]. More than one-quarter (27.4%) of YMSM, including YMSM/IDU are 18-24 years old and 72.6% are 25-29 years old [13]. Almost half (48.1%) of YMSM are Latino/Hispanic; nearly a third (29.3%) are Black/African American; 15.5% are White; 4.3% are Asian; and 0.2% are American Indian/Alaska Native [13]. This is a very different racial profile than all male PLWH who are 41.4% Latino/Hispanic, 34.7% White, and 18.3% Black/African American [12].

Females Living with HIV

[Note: In the description that follows, the available HIV surveillance data blends information available for cisfemales (i.e., females who are not transgender women) with data available for females (sex assigned at birth). To minimize confusion, the term “female” will be used only when the data available is for sex assigned at birth. The term “cisfemale” will be used to identify females who are not transgender, when there is data is available for transgender persons.]

As seen in Table 1, cisfemales comprise approximately 50.7% of the general population. Thus, cisfemales are not disproportionately impacted by HIV as they represent 11.2% of all PLWH and 10.8% of all PLWA [12]. Among recently diagnosed persons from 2009-2013, females represent 10.9% of recent HIV

diagnoses and 10.1% of recent AIDS diagnoses [12]. In DHSP's analysis of PLWH who are not in care, cisfemales represent 12.2% of PLWH who are not in care, slightly higher than their proportion of total PLWH (11.2%) [11]. In 2013, cisfemales represent about 11.7% of all deaths among PLWH [6]. Using the proportion of recently diagnosed HIV cases among females (10.9%) and applying that to the estimated undiagnosed population from Figure 3 (7,196), there may be as many as 784 females estimated to be living with HIV who remain undiagnosed.

Examining cisfemale PLWH by subpopulation reveals differences among cisfemales living with HIV. As seen in Table 1, as of December 31, 2014, there were 5,501 cisfemale PLWH [6]. Overall, female PLWH are slightly younger than male PLWH; 28.3% are less than 40 years old compared to 25.9% of male PLWH [6]. Approximately 20.3% of cisfemale PLWH reported living as of December 31, 2014 were diagnosed during the five-year period from 2009-2013 (Table 1) [6].

In terms of race/ethnicity, like male PLWH, female PLWH are predominantly Black/African American (35.4%) or Latina/Hispanic (44.8%) [12]. As Blacks/African Americans comprise only 8.6% of the general population, they are very disproportionately impacted by HIV [14]. The proportion of female Latina/Hispanic PLWH is slightly less than their representation in the general population (48.2%) [14]. Although not disproportionately impacted, they represent the largest number of female PLWH in the county. The remaining proportion of female PLWH are White (14.9%), American Indian/Alaskan Native (0.5%), and Other (2.9%) [12]. None of these racial/ethnic groups are disproportionately impacted.

When examining transmission category of female PLWH, two are predominant. IDU accounts for 20.7% of all transmission among female PLWH; this compares to 3.1% of transmission among male PLWH [12]. In total number, females comprise nearly half (46.4%) of all HIV positive IDUs. The other major transmission category for female PLWH is heterosexual contact (75.7%) [12]. Female PLWH account for 82.4% of all heterosexual transmission among PLWH [12].

Transgender Persons Living with HIV

The burden of HIV on the transgender community in Los Angeles County is profound. Although a small population in size, they are very disproportionately impacted. DHSP's 2014 estimate of the size of the transgender population is 13,788 persons; approximately half (6,894) are estimated equally to be transmen and transwomen [10].

There have been longstanding challenges with having accurate data on this population. DHSP notes:

Historically, transgender women (male-to-female) and transgender men (female-to-male) have been ignored in population records such as the U.S. Census. Gender reporting options to include transgender persons in the enhanced HIV/AIDS Reporting System (eHARS) have only been used in LAC since July 2002, and these data have yet to be evaluated for completeness and accuracy [10].

Table 6 presents the current demographics of transgender PLWH in Los Angeles County as of December 31, 2014. When compared to the general population in Table 1, three racial/ethnic populations are disproportionately impacted: Latinos/Hispanics, Blacks/African Americans, and American Indians/Alaska Natives. Latinos/Hispanics also represent more than half (55%) of all transgender PLWH. In terms of age groups, three age groups are disproportionate to their representation in the general population as depicted in Table 1; they include: 30-39 years, 40-49 years, and 50-59 years. As seen earlier, Figure 9 presents the geographic distribution of PLWH by gender, including transgender PLWH.

Table 6. Transgender Persons Living with HIV in Los Angeles County as of December 31, 2014 by Race/Ethnicity and Age Group

Demographic Characteristic	Number	Percent
Total Transgender PLWH	615	100.0%
Race/Ethnicity		
Latino/Hispanic	338	55.0%
Black/African American	174	28.3%
White	52	8.5%
Asian	23	3.7%
American Indian/Alaska Native	13	2.1%
Other/Unknown	15	2.4%
Age		
<30 years	98	15.9%
30-39 years	139	22.6%
40-49 years	209	34.0%
50-59 years	135	22.0%
≥60 years	34	5.5%

Source: Los Angeles County Department of Public Health DHSP, HIV surveillance data through eHARS, July 2016

Table 7 presents selected HIV-related measures specifically for transgender persons. As seen, although they represent about 0.1% of the general population, they represent 1.3% of all PLWH and 1.4% of recent diagnoses (2009-2013). Although fewer transgender PLWH are estimated to be out of care (1.2%) in comparison to their total percentage among PLWH (1.3%), a slightly higher proportion (1.4%) are represented among 2013 deaths (all causes) of PLWH.

Table 7. Representation of Transgender Persons across HIV-Related Measures

	2014 PLWH ¹	Recent HIV Diagnosis ¹ (2009-2013)	2014 PLWA ²	Recent AIDS Diagnosis ¹ (2010-2013)	2013 Unmet Need ³ (out of care)	2013 HIV Deaths ¹ (all causes)
Transgender	1.3%	1.4%	1.4%	1.3%	1.2%	1.4%

¹ Los Angeles County Department of Public Health, 2014 Annual HIV/STD Surveillance Report.

² Los Angeles County Department of Public Health. Supplemental Tables for HIV Surveillance Summary Report—2014, Feb 2016.

³ DHSP, Persons Living with HIV and AIDS with Unmet Need in Los Angeles County, August 2015.

As seen earlier in Table 4, HIV does not impact transgender persons equally. DHSP estimates the HIV prevalence among transgender persons overall to be 8.8% [10]. However, transwomen are most at risk for HIV; they represent about 96% of all HIV infections among transgender PLWH and have an estimated HIV prevalence of 16.7% compared to 0.8% HIV prevalence among transmen [10]. When examined by race/ethnicity, both American Indian/Alaska Native and Black/African American transgender persons are disproportionately impacted. DHSP estimates the HIV prevalence in these two populations to be 25.6% and 26.5% respectively; approximately 1 in 4 persons are infected [10]. The HIV prevalence for American Indian/Alaska Native and Black/African American transwomen is even higher (50% and 51% respectively) [10]. Thus, 1 in 2 American Indian/Alaska Native and Black/African American transwomen are infected with HIV.

HIV BURDEN BY AGE GROUP

When looking at age, HIV burden varies across measures. The rate of total PLWH and PLWA is highest in the two age groups, 40-49 and 50-59 years old. This is not surprising since HIV is in its fourth decade. The advances in HIV medications, especially antiretroviral therapy (ART), have shifted HIV from a once acute illness to a chronic disease. Thus, PLWH and PLWA are living longer and Los Angeles County has a

growing population of long-term survivors. However, although the rate of new HIV diagnoses is not the highest in these two age groups, it is third highest for 40-49 year old persons. As seen in Table 1, 40-59 year old persons account for nearly one third (32.4%) of recently diagnosed persons. As seen in Table 3, 30-39 year olds and 40-49 year olds have the highest rate of new AIDS diagnoses in 2013 (19 per 100,000 population). These same two age groups (30-39 and 40-49 years old) also have the highest rate of death (all causes) among all PLWH (10 and 9 per 100,000 population respectively) (Table 3).

Lastly, in terms of new HIV diagnoses, younger people are the most heavily burdened and have the highest rate of new HIV diagnoses in 2013. The highest rate is found in persons who are 20-29 years old (39 per 100,000) and the second highest rate is in persons 30-39 years old (35 per 100,000). These age groups are the leading edge of Los Angeles County's HIV epidemic where it is growing. Table 1 depicts the demographic characteristics of persons diagnosed with HIV during the recent five-year period from 2009-2013. Sixty-one percent (61.3%) are between the ages of 20 and 39 years old [6].

HIV BURDEN BY RACE/ETHNICITY

There are three racial/ethnic groups most burdened by HIV in Los Angeles County. As seen in Table 3, Blacks/African Americans and American Indians/Alaska Natives have either the first or second highest rate per 100,000 population across all five measures presented. In terms of new HIV diagnoses, Blacks/African Americans rank first (52 per 100,000) and Native Americans rank second (36 per 100,000). This is also true for total PLWA; Blacks/African Americans have the highest rate (618 per 100,000) followed by American Indians/Alaska Natives (588 per 100,000). In the other three measures, total PLWH, new AIDS diagnoses, and deaths, Native Americans have the highest rate followed by Blacks/African Americans (Table 3). Both populations have disproportionate HIV-related morbidity and mortality.

Due to the sheer size of the Latino/Hispanic population in Los Angeles (48.2%), the burden of HIV on Latinos/Hispanics is not disproportionate, so examining rates does not demonstrate the impact. Latinos/Hispanics represent the largest number and proportion of HIV cases across every category. They comprise 41.8% of all PLWH and 46.2% of persons recently diagnosed (see Table 1). Among the county's 27,602 PLWA, Latinos/Hispanics represent 43.9% of all PLWA and 46.7% of recently diagnosed AIDS cases from 2009-2013 [12]. Latinos/Hispanics comprise approximately one-third of deaths (all causes) in 2013 among PLWH (n=162) followed by Whites (n=147), and Blacks/African Americans (n=134) [12].

HIV BURDEN BY TRANSMISSION CATEGORY

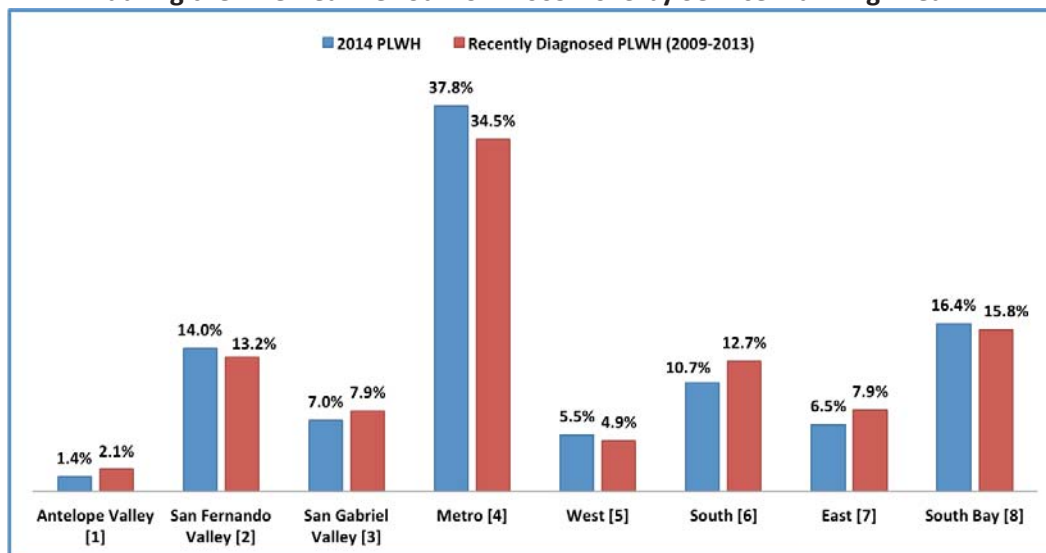
As seen in Table 1, MSM account for 77.7% of transmission for all PLWH and 83% of recently diagnosed persons, approximately eight in every ten persons diagnosed. The dual MSM/IDU transmission category accounts for an additional 6% of transmission among all PLWH and 3.2% of recently diagnosed persons. Heterosexual contact accounts for the second largest proportion of infection, 10.4% of all PLWH and 9.7% of recently diagnosed persons. As discussed earlier, this varies considerably by gender. People who inject drugs (PWID) or IDU represent 5.1% of all PLWH (Table 1). They account for a slightly lower proportion transmission risk among recently diagnosed persons (3.8%) (Table 1). Perinatal transmission has not been completely eliminated in Los Angeles County and represents 0.2% of recently diagnosed persons (Table 1).

HIV BURDEN BY GEOGRAPHY

As discussed at the outset of this section, Los Angeles County has done a considerable amount of work creating syndemic cluster area maps that represent the geographic convergence of HIV, syphilis, gonorrhea, and chlamydia. The current maps, included in the Attachments, depict the county's five

syndemic cluster areas (Central, South, East, Northwest, and North). However, DHSP is currently in the process of updating these maps based on new available data, including STD data from the City of Long Beach and Pasadena, to inform future planning. Once they are complete, local planners will use them to target more precisely both HIV prevention and care services. Until then, SPA data is presented here to demonstrate the geographic burden of HIV. Figure 11 depicts the geographic distribution of PLWH as well as recently diagnosed persons.

Figure 11. Percentage of Total PLWH as of December 31, 2014 and Persons Recently Diagnosed with HIV during the Five-Year Period from 2009-2013 by Service Planning Area



Source: Los Angeles County Department of Public Health, Supplemental Tables for HIV Surveillance Summary Report—2014, February 2016.

Note: PLWH with unknown residence are excluded from the figure (0.6% PLWH and 0.8% recently diagnosed).

As seen, SPA 4 has the largest proportion of PLWH (37.8%) and recently diagnosed persons (34.5%) followed by SPA 8 and SPA 2. However, there are slight shifts occurring in the epidemic. While the proportion of recently diagnosed persons is similar to the proportion of PLWH across SPAs, there are areas where HIV may be increasing, specifically in SPAs 6, 3, 7, and 1. Though recent diagnoses may not necessarily represent new HIV infections, recent diagnoses represent the future faces of Los Angeles County’s growing epidemic. Table 8 presents the estimated incidence of HIV by SPA. In the county’s HIV incidence estimates, SPA 4 continues to have the highest rate per 100,000 followed by SPA 6 and SPA 8.

Recognizing that SPAs are very large geographic areas, it is important to note that there are dramatic differences in the rates per 100,000 population for local communities within each SPA. Table 8 presents the overall rate per 100,000 population for each SPA as well as the top two communities within each SPA. A more detailed presentation of all communities is presented in An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.

Table 8. Number and Rate¹ of Reported Diagnoses of HIV infection in 2011-2013² and Persons Living with Diagnosed HIV³ at Year-End 2014 for Select Cities/Communities⁴ within SPAs⁵

<i>SPA/City or Community</i>	<i>New HIV diagnoses in 2011-2013^{1,2,4,6}</i>		<i>PLWH at year-end 2014^{1,2,3,4,6}</i>	
	<i>N</i>	<i>Avg. Rate/yr.</i>	<i>N</i>	<i>Rate</i>
SPA 1 Total	106	9	972	247
<i>Lancaster</i>	53	11	455	284
<i>Lake Los Angeles, Uninc.⁷</i>	<5	-	29	221
SPA 2 Total	783	12	7093	324
<i>Toluca Lake⁷</i>	6	-	87	1075
<i>Valley Village⁷</i>	19	28	237	1031
SPA 3 Total	484	9	3513	197
<i>Pasadena</i>	59	14	546	387
<i>Pomona</i>	64	14	501	330
SPA 4 Total	1949	58	18205	1583
<i>West Hollywood</i>	231	223	2216	6309
<i>Wholesale District</i>	196	173	1841	4955
SPA 5 Total	290	15	2571	394
<i>Venice</i>	23	23	250	750
<i>Beverly Crest⁷</i>	6	-	91	745
SPA 6 Total	756	25	5633	545
<i>Baldwin Hills</i>	38	44	352	1209
<i>Alsace⁷</i>	6	-	122	1000
SPA 7 Total	485	12	3369	257
<i>Signal Hill⁷</i>	10	-	96	836
<i>Huntington Park</i>	40	23	266	450
SPA 8 Total	931	20	7848	505
<i>Long Beach</i>	488	35	4709	1000
<i>Athens-Westmont, Uninc.</i>	46	38	312	756

¹Average annual rates per 100,000 population for new HIV diagnoses in 2011-2013 are based on population estimates for 2012 and rates for PLWH at year-end 2014 are based on population estimates for 2014. Rates for areas based on observations fewer than 12 and/or <5,000 population are not displayed.

²Data are provisional due to reporting delay.

³PLWH include persons who were diagnosed with HIV regardless of current stage of the disease and living in Los Angeles County at year-end 2014 based on most current residential information.

⁴The assignment of city or community boundaries for each person is based on the available geo-coordinates (X,Y) of the residence and the April 2015 version of LA County Board Approved Statistical Areas (BASA) shapefile. The residence at diagnosis is used to obtain the aggregated HIV diagnosis rates at the city or community level while the most current residential information is used for the rate of PLWH. Additionally, for PLWH only, when street address information is not available, city or ZIP Code of residence is used to approximate the city/community location.

⁵Service Planning Area boundaries are based on the definition as of 2012.

⁶Data reported as of December 31, 2014.

⁷Rates are based on areas with <25,000 population and may not be reliable due to unstable estimates of the underlying population; Uninc.=Unincorporated area.

d. Social Determinants of Health

Front line staff and HIV planners have long understood that poverty, educational attainment, unemployment, and housing status, among other social/economic issues, disproportionately impact PLWH. The World Health Organization (WHO) spearheaded efforts examining the relationship between social/economic indicators and health, coining the term ‘social determinants of health.’ The Centers for Disease Control and Prevention (CDC) defines *social determinants of health* as “the overlapping social structures and economic systems (e.g., social environment, physical environment, health services, and

structural and societal factors) that are responsible for most health inequities [15]. In 2013, the CDC published its first report analyzing the association between HIV and social determinants of health examining HIV surveillance data from 2005-2009 [16]. In its three published reports, the most recent in 2015, the CDC examined four social determinant of health indicators – poverty, median household income, education, and unemployment. In 2015, the CDC added health insurance status. In short, the CDC has found that there is a strong correlation between new HIV diagnoses and communities, which are poor, less educated, unemployed, and uninsured; these communities have a higher proportion of newly diagnosed PLWH [17].

The following narrative examines selected social determinants of health (SDH) indicators (i.e., poverty, educational attainment, employment status, health insurance status, and homelessness) in Los Angeles County. The first four indicators are those included in the CDC’s surveillance data analysis that demonstrates the relationship between HIV and social determinants of health. Housing status and homelessness are also discussed as social determinants of health. The National HIV/AIDS Strategy calls for the creation of new models of care that address HIV while also addressing basic needs such as housing [4]. A 2015 report in Los Angeles County succinctly describes the relationship between health and homelessness: *Poor health is a major cause of homelessness and homelessness itself leads to poor health* [18]. Thus, examining patterns of unstable housing and homelessness among PLWH is essential to improving their overall health. Table 9 presents SDH data for PLWH receiving Ryan White services.

Table 9. Ryan White-funded Services: Socio-economic Data, 2013-2014 (N = 18,134)

Characteristic	Overall		≤ Federal Poverty Level		Homeless		No Insurance		Incarcerated ≤ 24 mo.	
	n	% ¹	n	%	n	%	n	%	n	%
Total	18,134	100.0	12,178	67.2	1,115	6.1	8,343	46.0	2,305	12.7
MSM²	9,419	51.9	6,065	64.4	569	6.0	4,085	43.4	1,252	13.3
Black/AA MSM	1,859	19.7	1,432	77.0	209	11.2	529	28.5	379	20.4
Latino/Hispanic MSM	4,727	50.2	3,134	66.3	187	4.0	2,763	58.5	502	10.6
Women	2,119	11.7	1,745	82.4	138	6.5	935	44.1	192	9.1
Black/AA	754	35.6	634	84.1	65	8.6	214	28.4	83	11.0
Latina	1,051	49.6	891	84.8	49	4.7	625	59.5	61	5.8
Youth (13-24 years)	763	4.2	612	80.2	90	11.8	335	43.9	132	17.3
MSM	426	55.8	333	78.2	54	12.7	192	45.1	80	18.8
Transgender Persons	305	1.7	256	83.9	23	7.5	172	56.4	56	18.4
Transwomen	303	99.3	256	84.5	23	7.6	170	56.1	55	18.2
Transmen	<5	-	-	-	-	-	-	-	-	-
Persons who Share Injection Paraphernalia³	907	5.0	749	82.6	123	13.6	295	32.5	316	34.8

Data Source: Casewatch as of 03/01/2015

¹Column percentage

² Includes males who reported 'Male Sex with Male' as their primary mode of HIV exposure

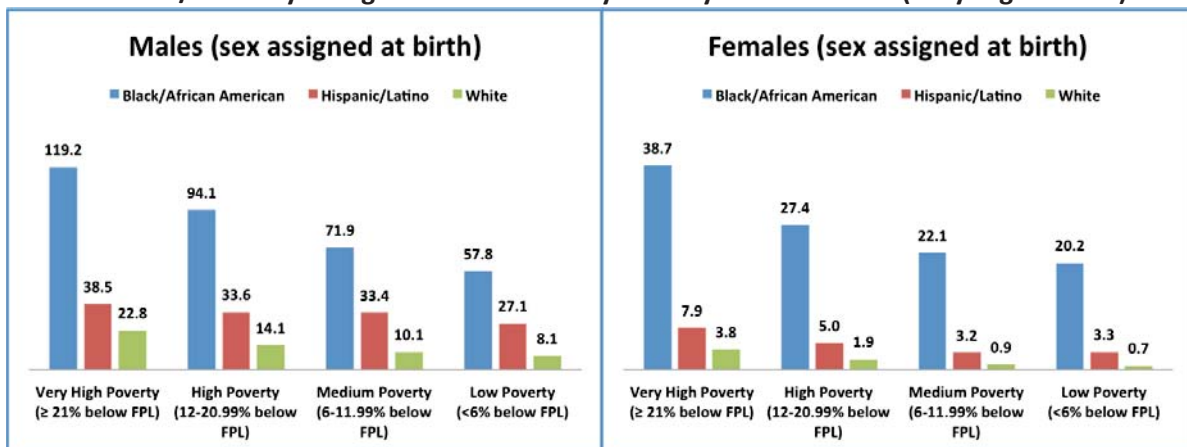
³ Includes persons who reported 'Injection Drug Use' as their primary mode of HIV exposure

Poverty

The intersection between HIV and poverty is pronounced. In its examination of 2013 HIV surveillance data, the CDC found that census tracts with the highest level of poverty also had the highest rate per 100,000 population of new HIV diagnoses [17]. When examining the data for men, census tracts with less than 6% of the population living below 100% of the federal poverty level (FPL) had the lowest rate of new HIV infection (12.9 per 100,000) [17]. However, census tracts with 21% or more of the population living below 100% FPL had a rate of new HIV diagnoses four times higher (50.5 per 100,000) [17].

The CDC further examined these differences by sex and race. As seen in Figure 12, Black/African American men were the most disproportionately impacted population by HIV regardless of the level of poverty. In census tracts with less than 6% of residents living in poverty, the rate of new HIV diagnoses per 100,000 population among Black/African American males was 57.8 compared to 27.1 for Latino/Hispanic males and 8.1 for White males. In high poverty areas with more than 21% of the population living in poverty, the rate of new HIV diagnoses per 100,000 population among Black/African American males was 119.2, more than double their rate in lower poverty areas compared to a rate of 38.5 for Latino/Hispanic males and 22.8 for White males [17]. Although the rate of new HIV diagnoses was less for females, this exact same pattern occurred and Black/African American females had a higher rate of new HIV diagnoses than either Latina or White females [17]. An important limitation of this analysis is that the CDC did not examine these patterns among Asian and Pacific Islanders or American Indians/Alaska Natives.

Figure 12. Rate of New HIV Diagnoses among Males and Females (sex assigned at birth) by Race/Ethnicity Living in Census Tracts by Poverty Concentration (Very High to Low)



Source: CDC, Social determinants of health among adults with diagnosed HIV in 11 states, District of Columbia, and Puerto Rico, 2013.

- **Poverty in Los Angeles County**

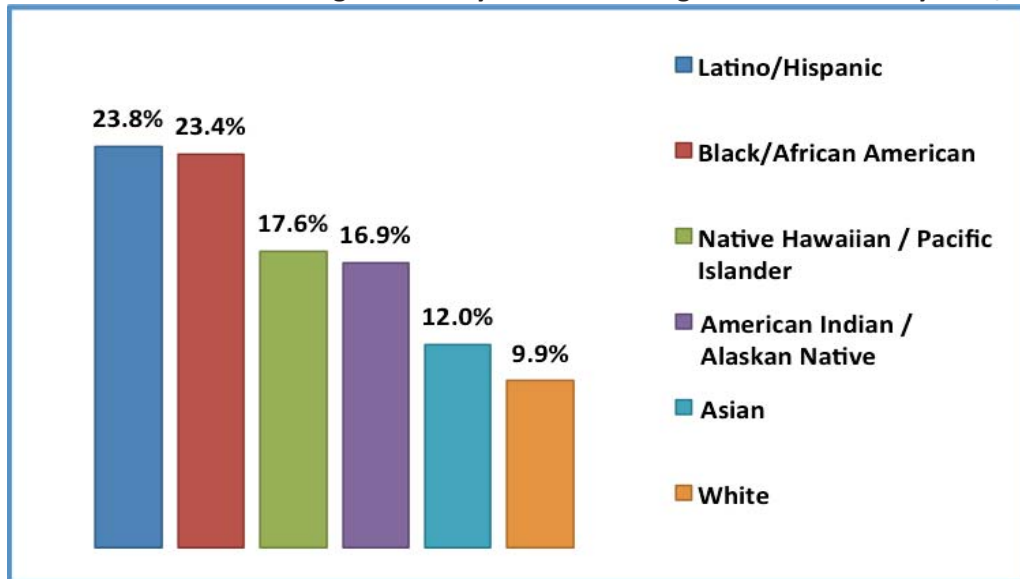
In 2014, an estimated 18.1% of Los Angeles County residents live below 100% of the federal poverty level (FPL) [14]. This compares to 15.6% of U.S. residents and 16.4% of Californians [19]. However, poverty does not impact all populations equally. Figure 14 depicts poverty by race/ethnicity and Figure 15 depicts the percentage of persons living below 100% FPL by educational attainment.

As seen in Figure 13, Latinos/Hispanics (23.8%) and Blacks/African Americans (23.4%) have the highest level of poverty across all racial/ethnic groups. Whites (9.9%) have the lowest level of poverty. These populations have a higher level of poverty than the county (18.4%) overall. As seen in Figure 14, Los Angeles County residents with less than a high school education have the highest rate of poverty for all educational levels (26.9%). Persons with a bachelor’s degree or higher have the lowest rate of poverty (6.5%) [19].

Although not depicted, more than one quarter (26%) of children less than 18 years old are living in poverty; this compares to 16.5% of adults 18-64 years, and 13.4% of seniors 65 years and older [19].

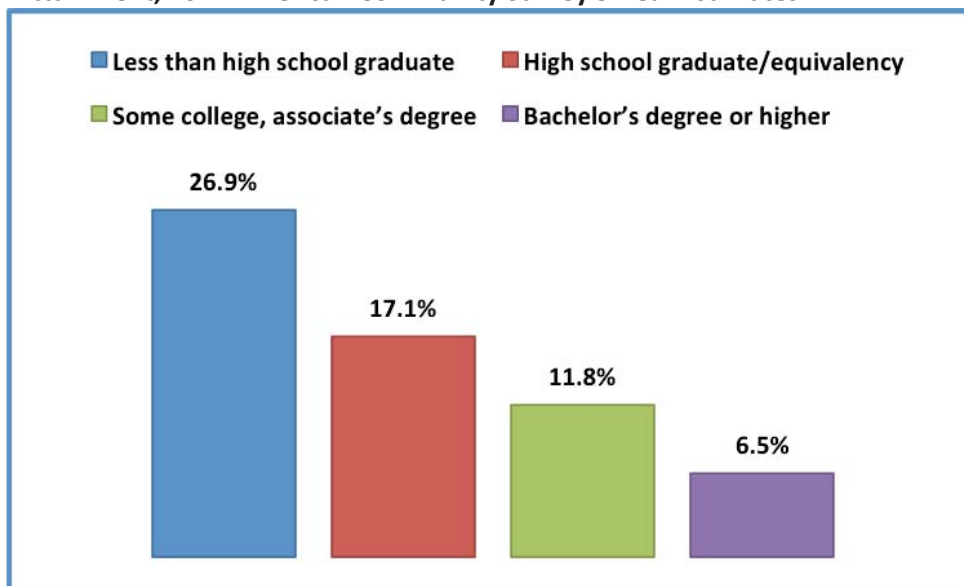
Females (19.7%) are also more likely than males (17.1%) to be living below 100% FPL [19].[†]

Figure 13. 2014 Estimate of Los Angeles County Residents Living Below 100% FPL by Race/Ethnicity



Source: Population and poverty estimates provided by Los Angeles County Internal Services Department and contracted through Hedderson Demographic Services.

Figure 14. Poverty Rate of Los Angeles County Residents 25 Years and Older by Educational Attainment, 2014 American Community Survey 5-Year Estimates



Source: 2014 American Community Survey 5-Year Estimates, Table S1701: Poverty Status in the Past 12 Months.

- **Poverty Among Ryan White Program Clients in Los Angeles County**

As payer of last resort, Ryan White clients are not reflective of the entire population of PLWH. However, they represent a substantial number (18,134 in the 2013/2014 fiscal year) of PLWH in Los Angeles County. As seen in Table 10, 67.2% of PLWH receiving Ryan White-funded services live at or below 100%

[†] Sex assigned at birth. This data is from the U.S. Census Bureau, which does not collect data by gender identity.

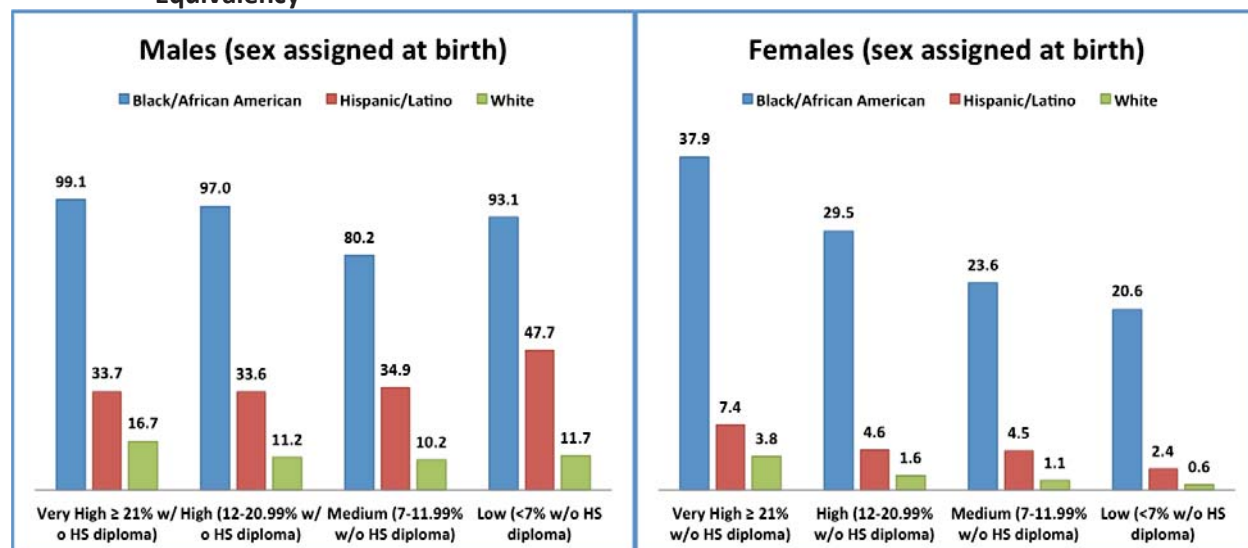
of the FPL [21]. An additional 22.9% live between 100-200% FPL, totaling 90.1% of Ryan White clients that live below 200% FPL [21]. As seen in Table 10, poverty is even greater for cisfemale and transgender PLWH (82.4% and 83.9% respectively) and youth 13-24 years old (80.2%). Persons who share injection paraphernalia receiving Ryan White services are also more likely to live in poverty (82.6%). Latinas/Hispanics have the highest level of poverty (84.8%) of all groups, followed by transwomen (84.5%).

DHSP is currently conducting the 2016 Los Angeles Coordinated HIV Needs Assessment. DHSP is using a random sample of HIV surveillance data, which will result in a more accurate estimate of PLWH living below 100% FPL. The methodology being used will be generalizable to all PLWH in the county. The final report is expected to be available by late 2016 and will inform the 2017 update of this plan.

Educational Attainment

Similar to poverty, the CDC also found high rates of HIV diagnosis in geographic areas where there was a high proportion of the population with less than a high school diploma. Among men, in census tracts with at least 21% or more of the population without a high school diploma, the rate of HIV was 40.2 per 100,000 population [17]. This is twice as high as census tracts with less than 7% of the population without a high school diploma/equivalency (19.7 per 100,000 population) [17].

Figure 15. Rate of New HIV Diagnoses among Males and Females (Sex Assigned at Birth) by Race/Ethnicity in Census Tracts by Percent of Population without a High School Diploma or Equivalency



Source: CDC, Social determinants of health among adults with diagnosed HIV in 11 states, District of Columbia, and Puerto Rico, 2013.

As seen in Figure 15, Black/African American males[‡] (99.1 per 100,000 population) and women (37.9 per 100,000 population) have the highest rates of new HIV diagnoses than either Latinos/Hispanics or Whites. For females, across all racial/ethnic groups there is a clear increase in new HIV cases from areas with a higher educational attainment (i.e., <7% without a high school diploma) to very low educational attainment regions (i.e., ≥21% without a high school diploma). However for men, there is considerable variation. Oddly, among male Latinos/Hispanics, the highest rate of new HIV diagnoses occurred in census tracts where less than 7% of the population did not have a high school diploma (i.e., more

[‡] Sex assigned at birth for all references to males and females in this section as data is from the CDC, which does not yet report HIV transmission by gender identity.

educated communities).

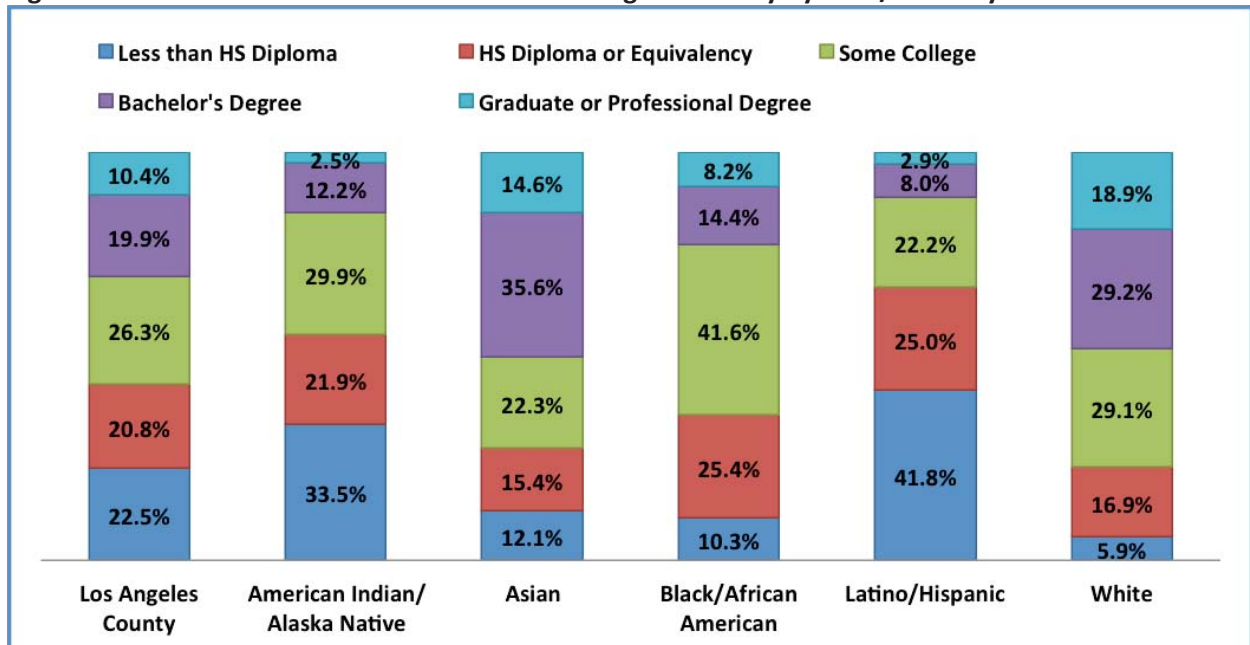
When examined by age group (not depicted), youth 18-24 years old without a high school diploma had the highest rate of HIV diagnosis in all geographic areas ranging from a rate of 29.5 per 100,000 population in census tracts with less than 7% having a high school diploma to a rate of 65.2 per 100,000 population in areas with 21% or more residents without a high school diploma [17]. Similar high rates were experienced by young adults (25-34 years old): HIV diagnosis rates ranging from 36.8 to 62.0 per 100,000 population in all census tracts [17]. The highest rates were in areas with the highest proportion of residents without a high school diploma or equivalency.

- **Educational Attainment in Los Angeles County**

Nearly one-quarter (23.2%) of Los Angeles County residents 25 years and older have less than a high school education compared to 13.6% of the total U.S. population and 18.5% of California’s population [20]. Youth (18-24 years old) have very low educational attainment; 43.1% do not have a high school or equivalent education [20]. As discussed earlier, there is an inverse relationship between poverty and educational attainment; as educational attainment increases, poverty decreases (Figure 14). Thus, as a person gains a higher level of education, s/he is able to get better paying jobs, often with better benefits. Without an education, a person has difficulty competing for higher wage jobs and often has to settle for low-skilled, low wage jobs. The American Community Survey reports that the median income of Los Angeles County residents without a high school education was \$18,350 [20]. This progressively increases by level of education and jumps 43.2% (about \$8,000 increase) annually for residents with a high school diploma or equivalency to \$26,289.

Figure 16 depicts the differences of educational attainment by race/ethnicity in Los Angeles County. As seen, 41.8% of Latinos/Hispanics have less than a high school education, followed by American Indians/Alaska Natives (33.5%), Asians (12.1%), and Blacks/African Americans (10.3%).

Figure 16. 2014 Educational Attainment in Los Angeles County by Race/Ethnicity



Source: 2014 American Community Survey 1-Year Estimates, Table S0201: Selected Population Profile

Note: Race data is for non-Hispanic population except for American Indian/Alaska Native as non-Hispanic data is not available for this population.

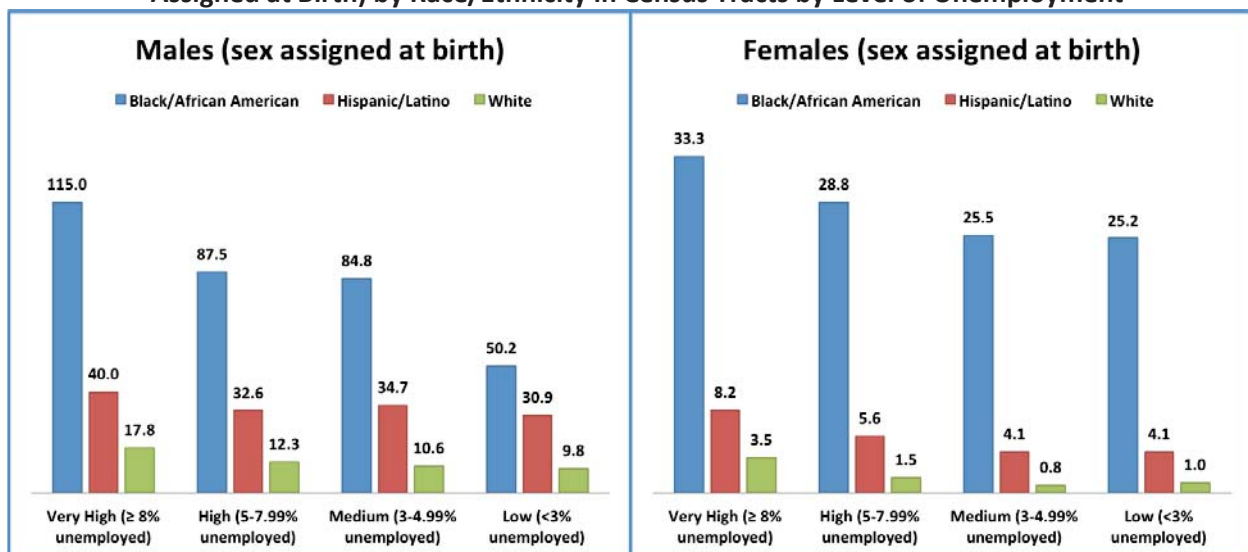
- **Educational Attainment Among Ryan White Program Clients in Los Angeles County**

As already discussed, PLWH who receive services through the Ryan White Program (RWP) are very poor (67.2% live at or below 100% FPL). Although not generalizable to the entire population of PLWH, given the connection between poverty and educational attainment, it is not surprising that 30.5% of the 2011 Los Angeles Coordinated HIV Needs Assessment-Care (LACHNA-CARE) respondents, who are PLWH receiving services through the RWP, had less than a high school education [22]. This is higher than the 26.9% for the 2014 general population [20].

Employment Status

The CDC also found higher rates of new HIV diagnoses in geographic areas where there were higher rates of unemployment [17]. Figure 17 depicts differences by race/ethnicity and gender. As seen, although the same general pattern occurs here for both males⁵ and females, the rates of new HIV diagnoses for Blacks/African Americans are much higher than either Latinos/Hispanics, or Whites. The rate of new HIV diagnoses is highest in areas with the highest level of unemployment, regardless of race/ethnicity.

Figure 17. Rate per 100,000 Population of New HIV Diagnoses among Males and Females (Sex Assigned at Birth) by Race/Ethnicity in Census Tracts by Level of Unemployment



Source: CDC, Social determinants of health among adults with diagnosed HIV in 11 states, District of Columbia, and Puerto Rico, 2013.

For males 18-64 years old, the rate of HIV diagnoses ranged from 16.1 per 100,000 population in areas of low unemployment to 51 per 100,000 population in areas of high unemployment [17]. For females 18-64 years old, this range was 3.0 to 14.0 per 100,000 population, respectively. The highest rates of new HIV diagnoses were found in census tracts with 8% or more unemployment [17].

- **Unemployment in Los Angeles County**

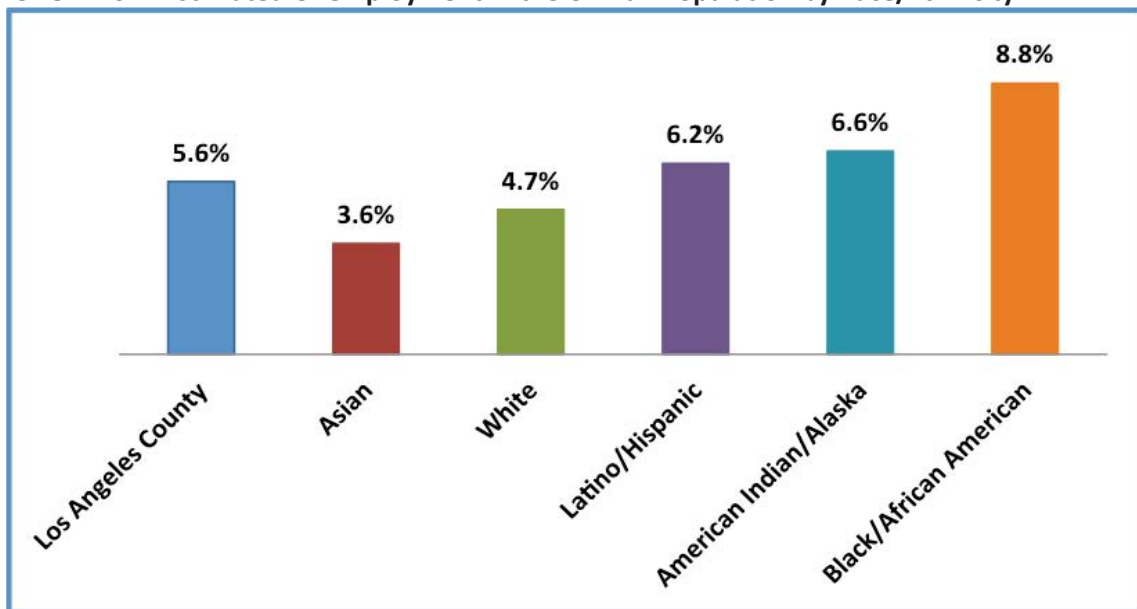
The [U.S. Department of Labor Bureau of Labor Statistics](#) tracks unemployment on a monthly basis, as does the [State of California Employment Development Department](#) (EDD). However, California data is only available at a county level and not a sub-county level or for specific subpopulations. Thus, it does

⁵ Sex assigned at birth for both males and females throughout this section. Data is from the CDC.

not allow comparison across different groups (e.g., by race/ethnicity, age, gender). Although data from the 2014 American Community Survey's 5-Year estimates are already dated and actual unemployment has decreased, it allows some comparison across different geographies and populations. According to the EDD, the March 2016 seasonally adjusted unemployment rate for Los Angeles County is 5.4%, which compares to 5.4% in California and 5.0% in the U.S. [23]. Thus, Los Angeles County is only slightly higher than the U.S. and on par with California overall.

Although this does not show current unemployment rates, the intent of presenting this data is to show how unemployment impacts different population groups; there is not an equal distribution of unemployment. According to the 2014 American Community Survey 1-Year estimates, 5.6% of all county residents are unemployed (Figure 18) [24]. Like poverty, Blacks/African Americans experience the highest rate of unemployment (8.8%) across all racial/ethnic populations. Unemployment is lowest among Asians (3.6%) followed by Whites (4.7%). Despite their overall lower educational attainment (Figure 16), Latinos/Hispanics have a higher participation in the workforce and only 6.2% are unemployed (Figure 18).

Figure 18. 2014 Estimated Unemployment in the Civilian Population by Race/Ethnicity



Source: 2014 American Community Survey 1-Year Estimates, Table S0201: Selected Population Profile

Note: Race data is for non-Hispanic population except for American Indian/Alaska Native as non-Hispanic data is not available for this population.

- **Unemployment among Ryan White Program Clients in Los Angeles County**

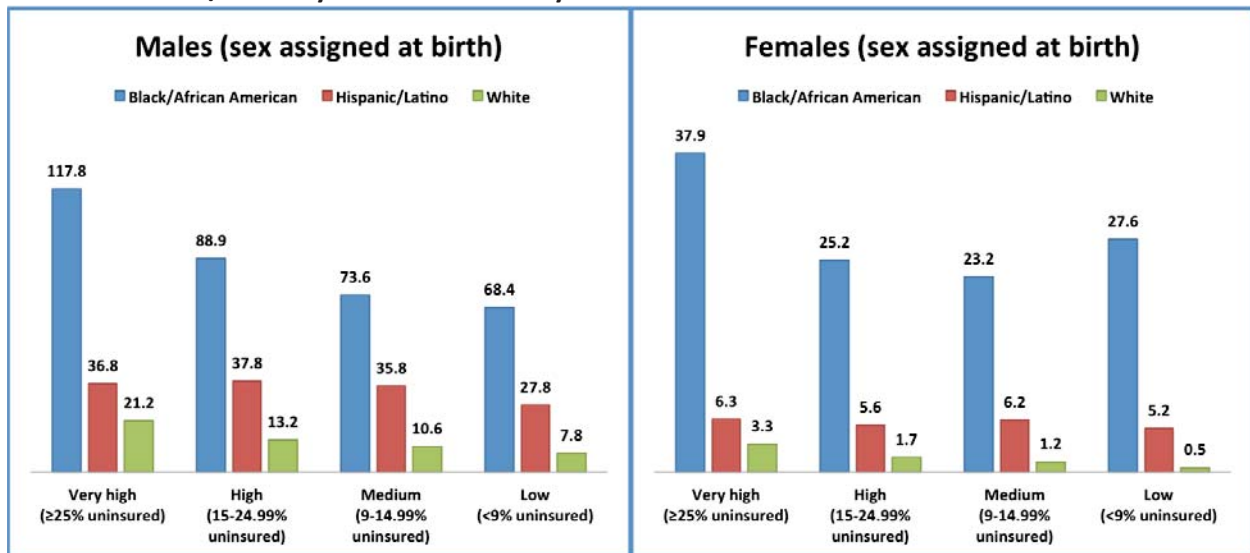
Among the 450 respondents to the 2011 LACHNA-CARE, only 7.8% of respondents were employed full-time (35 hours or more per week) and another 18% were employed part-time (<35 hours). A total of 37.8% were unemployed: 22.7% reported that they were unemployed and 'looking for work' and another 15.1% stated they were employed and 'not looking for work.' The remaining 36.4% of respondents, reflective of Ryan White clients, reported being retired, disabled, a homemaker, a student, or other [22].

Health Insurance Status

The CDC also examined the relationship between health insurance status and new HIV diagnoses. Figure 19 presents their findings for males and females** by race/ethnicity. Similar to the findings for poverty and unemployment, the data suggest there is an association between health insurance status and new HIV diagnoses. The highest proportion of new HIV diagnoses is found in the census tracts with the highest proportion of uninsured residents.

As seen in Figure 19, there are some slight differences between race/ethnicity and sex assigned at birth. Black/African Americans have the highest HIV prevalence in every category and for all races/ethnicities and gender. Their rate of new HIV diagnoses is at least double that of Latino/Hispanics and in most cases, six times greater than Whites across all census tracts. Among Black/African American males, there is a dramatic increase of HIV incidence from 68.4 per 100,000 population in areas with fewer uninsured persons to 117.8 per 100,000 population in areas with a greater proportion of uninsured persons [17]. Latino/Hispanic men are 1.5 to 3.5 times more likely than Whites to have a high rate of new HIV diagnoses across all census tract areas with low or high percentages of uninsured persons. The rates for Latinos/Hispanics are fairly steady across all census tracts regardless of the proportion of uninsured persons. This may be because even after the expansion of the Affordable Care Act, 15.8% of Latinos/Hispanics in California remain uninsured, compared to 11.4% of Californians overall [25]. They represent 57.4% of the remaining uninsured persons in the state and continue to be the most likely racial/ethnic group to be uninsured [25]. This may be due to a large undocumented population who are not eligible for publicly-funded programs.

Figure 19. Rate of New HIV Diagnoses among Males and Females (sex assigned at birth) by Race/Ethnicity in Census Tracts by Uninsured Level



Source: CDC, Social determinants of health among adults with diagnosed HIV in 11 states, District of Columbia, and Puerto Rico, 2013. Rates are per 100,000 population.

Age is also a key factor with health insurance. For both males and females (not depicted),^{††} the highest rate of new HIV diagnoses is found in census tracts with the highest proportion of uninsured persons;

** Sex assigned at birth throughout this section when referencing the CDC data.

†† Sex assigned at birth throughout this discussion as data is from the CDC.

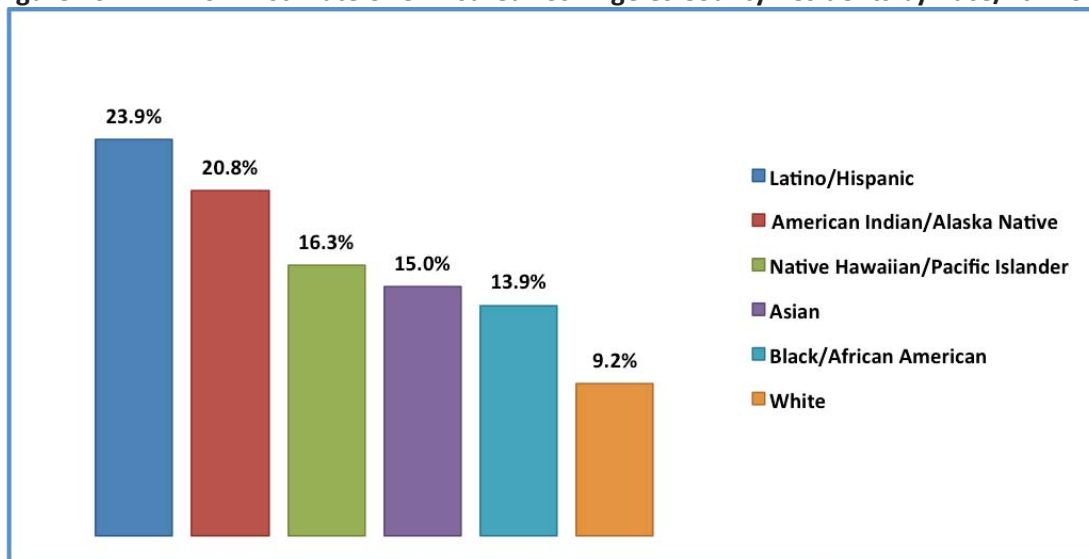
the rate for males (18-64 years old) is 45.9 per 100,000 population in census tracts where 25% or more persons are uninsured and 12.1 per 100,000 population for females in the same age range [17]. Among males, young males (18-24 and 25-34 years) have the highest rates of new HIV diagnoses in all census tracts [17]. In general for males, the rate of HIV increases as health insurance decreases. However, for females, the 25-34 year old group has the highest rate of new HIV diagnoses across all census tracts except for one. In census tracts where 9-14.99% of residents are uninsured, the highest HIV incidence is among females 35-44 years old [17].

- **Uninsured Persons in Los Angeles County**

To understand health insurance status in Los Angeles County, it is important to acknowledge that California was an early adopter state for the Affordable Care Act (ACA) and its bridge to healthcare reform began in 2012; full implementation nationally began January 1, 2014. California is also a Medicaid (i.e., Medi-Cal) expansion state, which increased financial eligibility thresholds to 133% of the FPL for adults. Medi-Cal also extended coverage to all adults 18 to 64 years old who were previously ineligible. Lastly, the ACA also allows parents to provide health insurance to uninsured children through age 26.

Los Angeles County estimates that 17% or 1.2 million county residents are uninsured in 2014 [14]. Figure 20 presents Los Angeles County’s 2014 estimate of residents without health insurance by race and ethnicity [14]. As seen, Latinos/Hispanics (23.9%) and American Indian/Alaskan Natives (20.8%) are more likely to be uninsured than other races [14]. Persons who are not a U.S. citizen, including undocumented individuals, are not eligible for publicly funded insurance programs (i.e., Medi-Cal and Medicare). Approximately 1.8 million Los Angeles County residents (18.2% of the total Los Angeles County population) are not a U.S. citizen [26]. The Public Policy Institute of California estimates that Los Angeles County is home to 814,000 undocumented immigrants, a majority from Central America [27]. Thus, it is not surprising that Latino/Hispanics have the largest proportion of uninsured persons given the large proportion of undocumented persons.

Figure 20. 2014 Estimate of Uninsured Los Angeles County Residents by Race/Ethnicity



Source: 2014 Population estimates provided by Los Angeles County Internal Services Department and contracted through Hedderson Demographic Services.

Table 10 presents uninsured estimates for other selected populations in Los Angeles County. Adults 18-64 years old have the largest proportion of uninsured persons (24.2%) across age groups. This is not surprising given the health insurance programs available for children and seniors (e.g., Children’s Health Insurance Program and Medicare). Males (19.1%) are more likely than females (16.1%) to be uninsured. Twenty-four percent of persons who live at or below 133% FPL are uninsured.

In terms of geographic regions of the county, the areas with the largest proportion of uninsured persons are SPA 6 (20.6%), followed by SPA 7 (20.1%) and SPA 4 (19.1%). Specific health districts within these SPAs are most impacted. These include the Central (20.8%) and Northeast (20.7%) health districts within SPA 4; the East Los Angeles (22.3%), San Antonio (22.1%), and Whittier (19.4%) health districts in SPA 7; and the Inglewood (18.6%) health district in SPA 8 [14].

Table 10. Estimated Percent of 2014 Population in Los Angeles County Who Are Uninsured by Selected Characteristics

	Category	Percent
	Total	17.6%
Age	Under 18 years	7.2%
	18-64 years	24.2%
	65 years and older	2.1%
Sex	Female	19.1%
	Male	16.1%
Service Planning Area	SPA 1: Antelope Valley	16.6%
	SPA 2: San Fernando Valley	16.1%
	SPA 3: San Gabriel Valley	17.5%
	SPA 4: Metro	19.1%
	SPA 5: West	13.1%
	SPA 6: South	20.6%
	SPA 7: East	20.1%
	SPA 8: South Bay	16.7%
Poverty	Living at or below 100% FPL	24.0%
	Living at or below 133% FPL	24.0%

Source: 2014 Population estimates provided by Los Angeles County Internal Services Department and contracted through Hedderson Demographic Services.

- **Uninsured Ryan White Program Clients in Los Angeles County**

In 2011, an overwhelming 61.2% of respondents to the 2011 LACHNA-CARE reported that they were uninsured [22]. As 2011 was prior to the early ACA expansion in California, it represents a pre-ACA baseline. Fiscal Year 2013-2014 Ryan White data (Table 9), which is post-ACA, shows that 46.0% of PLWH receiving Ryan White services are uninsured. This varies by subpopulation. Latino/Hispanic MSM (58.5%) and Latina/Hispanic women (59.5%) are the most likely to be uninsured, followed by transgender persons (56.4%) and YMSM (45.1%).

Housing Instability and Homelessness

The 2015 update to the National HIV/AIDS Strategy (NHAS) emphasizes the importance and potential impact of basic needs and housing status on a PLWH’s health. It states:

Finally, successful access to care is often precluded by unmet basic needs such as housing. Supplementing care services with robust policies in support of basic needs is crucial for timely linkage to and retention in HIV care. (NHAS Updated to 2020, p. 5)

The NHAS Updated to 2020 explicitly calls for a comprehensive approach to service delivery that includes linkages to basic services, including housing [4]. To ensure measurement, the NHAS Updated to 2020 also includes a specific indicator to decrease homelessness among PLWH [28].

There is a growing body of evidence that shows that housing assistance improves health outcomes along the HIV continuum of care [29, 30]. The U.S. Department of Housing and Urban Development (HUD) is now using the HIV care continuum to demonstrate the positive impact that housing assistance makes on persons living with HIV [31]. Some argue that housing status itself is a predictor of better health outcomes [32]. One study reports that half of all PLWH experience housing instability or homelessness after their diagnosis [33].

In 2015, New York City (NYC) completed an HIV care continuum analysis that compared HIV care continuum data of its total population of PLWH with recipients of Housing Opportunities for People with AIDS (HOPWA) services [34]. The findings presented in Table 11 clearly show that across all indicators, HOPWA recipients had better health outcomes. As seen, NYC HOPWA program clients have the best outcomes across every category. This data clearly shows the benefits of a housing program for PLWH in a major metropolitan area.

Table 11. HIV Continuum of Care Indicators for all PLWH in NYC and NYC HOPWA Recipients, 2013

	Ever HIV diagnosed	Ever linked to HIV care ¹	Retained in care in 2013	Presumed ever started on ART	Suppressed viral load in 2013
NYC PLWH	100%	86%	63%	60%	50%
NYC HOPWA	100%	99.5%	96%	91%	71%

Sources: Wiewel EW and Rojas J. The HIV continuum of care for housing program clients and persons living with HIV/AIDS overall; Los Angeles County Department of Public Health, 2014 Annual HIV/STD Surveillance Report.

¹Refers to lifetime linkage to care.

- **Housing and Homelessness in Los Angeles County**

HIV positive individuals who are homeless or unstably housed face numerous challenges to being retained in medical care and adherent to treatment regimens and ultimately achieving viral load suppression. Thus, understanding homelessness in Los Angeles County’s general population and among PLWH specifically is vital. Table 12 presents homeless count data for 2015 for the Los Angeles Continuum of Care (CoC), and the Cities of Glendale, Long Beach, and Pasadena.

Table 12. 2015 Homeless Count for General Population and PLWH in the Los Angeles Continuum of Care, and Cities of Glendale, Long Beach, and Pasadena

Homeless Count	2015					
	Total	Percent	Sheltered	Percent (within city)	Unsheltered	Percent (within city)
LA CoC	41,174	92.8%	12,226	29.7%	28,948	70.3%
Glendale	208	0.5%	86	41.3%	122	58.7%
Long Beach	2,345	5.3%	832	35.5%	1,513	64.5%
Pasadena	632	1.5%	190	30.1%	442	69.9%
<i>Total County</i>	<i>44,359</i>	<i>100.0%</i>	<i>13,334</i>		<i>31,025</i>	
HIV Positive	Total	Percent	Sheltered	Percent	Unsheltered	Percent
LA CoC	757	93.2%	245	32.4%	512	67.6%
Glendale	<5	<1.0%	not available	not available	not available	not applicable
Long Beach	43	5.3%	30	70.0%	13	30.0%
Pasadena	8	1.0%	<5	25.0%	6	75.0%
<i>Total County</i>	<i>812</i>	<i>100.0%</i>	<i>277</i>		<i>531</i>	

Sources: (1) 2015 Greater Los Angeles Homeless Count; (2) 2015 City of Glendale Homeless Count; (3) City of Long Beach Department of Health and Human Services Homeless Services Division Biennial Homeless Count Comparison; (4) 2015 City of Pasadena Homeless Count and Subpopulation Survey: Final Report.

Each of the four jurisdiction’s homeless count is a point-in-time estimate. That means that on any given day in 2015 there were estimated 44,359 homeless persons in Los Angeles County, of whom 812 (1.8%) were HIV positive. HIV positive individuals overall were slightly more likely to be sheltered (34.1%) than the general homeless population (30.1%). It is important to note that the homeless count does not estimate the cumulative total of everyone who may have experienced homelessness during the year.

Housing unaffordability contributes to homelessness as well as housing instability. The accepted public policy measure that indicates a problem is when 30% or more of household income is spent on housing [35]. In 2014 in Los Angeles County, nearly half of all homeowners (45.3%) and 60.1% of all renters paid more than 30% of their income on their housing [36]. This high cost of housing in Los Angeles County contributes to housing instability and homelessness.

- **Homeless Ryan White Program Clients in Los Angeles County**

The 2011 LACHNA-CARE reported that 6.2% of the 450 respondents were currently homeless at the time of the survey and 16.7% stated that they were chronically homeless during the previous three years [22]. The survey defined chronically homeless as having “at least four episodes of homelessness (primary residence as: a car or other vehicle, abandoned or vacant building, outside (street, park, beach, or underpass), emergency shelter or mission, transitional housing or hotel without a lease) within past three years or living continuously for at least one year at one of these locations” [22].

Table 13. Comparison of Demographic Characteristics of Total Persons Living with HIV as of December 31, 2014 and Homeless 2013 Ryan White Program (RWP) Clients

Characteristic	2013 RWP Clients ¹	2013 Homeless RWP Clients ¹
Total Clients	18,134	1,115
Gender Identity		
Cismale	86.6%	85.6%
Cisfemale	11.7%	12.4%
Transgender	1.7%	2.1%
Race/Ethnicity		
Latino/Hispanic	49.7%	32.6%
White	24.1%	27.2%
Black/African American	22.0%	38.0%
Asian or Pacific Islander	3.7%	1.5%
American Indian/Alaska Native	0.3%	0.4%
Age (years)		
<18	0.3%	0.4%
19-24	4.0%	7.7%
25-29	8.2%	12.7%
30-39	21.9%	24.8%
40-49	33.4%	30.9%
≥50	32.2%	23.5%

Sources: Los Angeles County Department of Public Health Division of HIV and STD Programs 2014 HIV STD Surveillance Report; County of Los Angeles HIV Care and Treatment Service Utilization: 2013 Year-End Report, May 2015.

¹All percentages may not add to 100 due to rounding.

In 2013, 6.1% of RWP clients (n=1,115) stated that they were homeless (i.e., not having a permanent living situation) at some point during the year [21]. Table 13 depicts the demographic characteristics of

2013 RWP clients who were homeless and compares this to the demographic characteristics of all RWP clients in that year. As seen, there is a slightly higher proportion of homeless transgender and cisfemale RWP clients than their proportion of all RWP clients. Thus, these populations are disproportionately impacted by homelessness. In terms of overall number of homeless RWP clients, cisfemale comprise the largest proportion of homeless RWP clients. In terms of race/ethnicity, although Blacks/African Americans represent 22% of all RWP clients in the county, which is already severely disproportionate to their representation in the general population (8.6%), they represent 38.0% of all homeless RWP clients in 2013. In terms of age, Table 14 shows a higher proportion of younger RWP clients who are homeless compared to their proportion among all RWP clients. The largest differences are among (1) youth 19-24 years old who represent 7.7% of all homeless RWP clients and only 4.0% of all RWP clients; and (2) young adults 25-29 years old who represent 12.7% of all homeless RWP clients and only 8.2% of all RWP clients. There is also a slightly higher incidence of homeless clients among RWP clients 30-39 years of age (24.8%) compared to their proportion (21.9%) of all 2013 RWP clients.

e. Indicators of Risk

As seen in the HIV surveillance data already presented, Los Angeles County's HIV epidemic is driven through sexual contact. This is true for cis men, cis women, and transgender persons. Injection drug use (IDU) accounts for a small proportion of Los Angeles County's epidemic. Perinatal transmission continues to account for a very small number of newly diagnosed persons. However, beyond the actual route of transmission, there are a number of other factors that contribute to risk for acquiring or transmitting HIV. These include but are not limited to: HIV positive individuals who remain undiagnosed, HIV positive individuals who are out of care, HIV positive individuals who are not virally suppressed, homelessness, mental illness, non-injection substance abuse, exchange sex, commercial sex work, and incarceration, among others. Already discussed, areas impacted by social determinants of health such as poverty, low educational attainment, unemployment, and lack of health insurance have a higher rate of new HIV diagnoses. Lastly, stigma plays a key role as a barrier to accessing and engaging in services along the entire HIV prevention and care continuum. The following section presents some of the data available regarding risk for HIV, including a discussion about the populations at risk for transmitting HIV.

1. Persons at Risk of Transmitting HIV

A recent analysis of 2009 national data found that HIV positive individuals who are undiagnosed and HIV positive individuals who are not in medical care accounted for 91.5% of new infections (30.2% and 61.3% respectively) [37]. DHSP estimates that 2,000 new infections occur annually in Los Angeles County [10]. Applying the 91.5% to this number yields an estimate of 1,830 new infections that may be attributed to HIV positive individuals who are undiagnosed or not in medical care.

- **Estimate of Undiagnosed HIV Positive Individuals**

Los Angeles County does not have an estimate of undiagnosed persons by demographic categories as presented in Table 1. However, the CDC has found that persons who are undiagnosed are not evenly distributed across demographic categories [38]. In their analysis of national HIV surveillance data from 2005 to 2008, the CDC estimated that numerous populations had a higher proportion of undiagnosed persons than the national average (20.1% in 2008) [38]. Youth 13-24 years old had the highest estimated proportion of undiagnosed HIV (58.9%) across all ages, categories, and young adults 25-34 years old had the second highest estimated proportion of undiagnosed HIV (31.5%) of all age groups [38]. Among MSM, all MSM of color had a higher than average estimated proportion of undiagnosed persons among all racial/ethnic communities, ranging from 22.7% of Native American MSM to 25.7% of Black/African American MSM. In every racial/ethnic group, heterosexual males had a higher than average estimated

proportion of undiagnosed persons, ranging from 23.7% Black/African American to 42.9% American Indian/Alaska Native [38]. [Note: Although the estimated percentage is very high for undiagnosed heterosexual American Indian/Alaska Native males,** the estimated number is small, 150 total in the U.S.] An important limitation of the CDC estimates is that it did not have data available to estimate the proportion of undiagnosed HIV positive transgender persons.

Coupled with the description of recently diagnosed persons from Table 1 using HIV surveillance data, the demographic characteristics of persons who are newly diagnosed with HIV through DHSP-funded test sites provides additional description of this population.

Table 14 presents the demographic characteristics of all persons tested for HIV through DHSP funded HIV routine and targeted testing in 2015.

Table 14. New HIV Positive Rate (self-reported) for DHSP-Funded Routine and Targeted Testing by Demographic Category for Calendar Year 2015

Demographic Category	Tests		Positive		New Positive (self-reported)	
	Number	%	Number	%	Number	%
Race/Ethnicity						
White	37,461	24.6%	358	17.9%	326	19.3%
Black/African American	32,551	21.3%	560	28.0%	444	26.3%
Latino	47,548	31.2%	578	28.9%	500	29.6%
Asian/Pacific Islander	10,089	6.6%	102	5.1%	90	5.3%
American Indian/Alaska Native	828	<1%	16	<1%	15	<1%
Mixed/Other Unknown/Missing	24,010	15.7%	385	19.3%	315	18.6%
TOTAL	152,487	100%	1,999	100%	1,690	100%
Gender identity						
Cismale	105,475	69.2%	1,753	87.7%	1,497	88.6%
Cisfemale	45,437	29.8%	194	9.7%	153	9.1%
Transgender (M to F)	1,407	<1%	47	2.3%	36	2.1%
Transgender (F to M)	126	<1%	<5	<1%	<5	<1%
Unknown	42	<1%	<5	<1%	<5	<1%
TOTAL	152,487	100%	1,999	100%	1,690	100%
Age (Years)						
<18	45	<1.0%	0	0%	0	0%
18-29	59,157	38.8%	725	36.3%	631	37.3%
30-39	38,723	25.4%	521	26.1%	433	25.6%
40-49	25,042	16.4%	381	19.0%	315	18.6%
>49	29,500	19.3%	372	18.6%	311	18.5%
Unknown	20	<1.0%	0	0%	0	0%
TOTAL	152,487	100%	1,999	100%	1,690	100%

Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, 2016

Note: Data excludes 'unknown' cases in all categories.

During this timeframe, there were 1,690 persons newly diagnosed with HIV based on their self reporting. This represents a new positivity rate of 1.1% for DHSP-supported routine and targeted HIV

** Sex assigned at birth. This data is from the CDC.

testing and an overall HIV sero-prevalence of 1.3%. The highest new HIV positive rate is among transwomen (2.6%), followed by American Indians/Alaska Natives (1.8%), Blacks/African Americans (1.4%), and cismales (1.4%). In terms of age, persons 40-49 years old had the highest new HIV positive rate (1.3%). [Note: As these new positive test results are confirmed, the overall and population specific HIV positive rate will go down as seen in Table 16.]

Table 15 below summarizes Los Angeles County’s Early Identification of Individuals with HIV and AIDS (EIIHA) data for three target populations identified in FY 2014 as compared to the overall test events in 2015. The three key EIIHA target populations for FY 2014 were *Latino and African American MSM*, *Young MSM (age 18-29)*, and *transgender individuals*. As seen, the “confirmed” newly diagnosed positive rate is 0.9% for all tests conducted in 2015; this is slightly lower than the over 1.1% rate based on self-reported new diagnoses. However, among Los Angeles County’s highest risk EIIHA target populations, the confirmed new positive rate is significantly higher: 2.5% among Latino and African American MSM, 2.4% among Young MSM (18-29 years old), and 2.4% among transgender persons.

Table 15. EIIHA Data for All HIV Tests, and Tests Conducted for Three EIIHA Target Populations in Los Angeles County (January 1, 2015 – December 31, 2015)

	Overall (%)	Latino & African American MSM (%)	Young MSM (%)	Transgender Persons (%)
TOTAL HIV TEST EVENTS	155,625*	24,593	12,249	1,852
Newly Diagnosed Positive HIV Test Events (Self-Reported)	1,694 (1.1)	613 (2.5)	293 (2.4)	44 (2.4)
Newly Diagnosed Confirmed Positive Test Events	1,349 (0.9)	512 (2.1)	239 (2.0)	34 (1.8)
• Newly diagnosed persons that received partner services	1,201 (89.0)	499 (97.5)	231 (96.7)	31 (91.2)
• Newly diagnosed persons linked to medical care	964 (71.5)	381 (74.4)	190 (79.5)	22 (64.7)
• Newly diagnosed persons referred to prevention services	428 (31.7)	215 (42.0)	104 (43.5)	16 (47.1)
Previously Diagnosed Positive HIV Test Events (Self Report)	314 (0.2)	51 (0.2)	18 (0.1)	13 (0.7)
Previously Diagnosed Positive Test Events (Confirmed)	209 (0.1)	24 (0.1)	6 (0.05)	6 (0.3)
Previously Diagnosed HIV Positive Test Events with Client Interviewed for Partner Services	180 (86.1)	24 (100)	6 (100)	<5 (--)
Previously Diagnosed HIV Positive Individuals Linked to Medical Care	162 (77.5)	18 (75.0)	5 (83.3)	<5 (--)

Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, 2016

*Note: The total number of tests in Tables 14 and 15 are different as the data was run on different dates.

• **PLWH Who Are Not in Medical Care**

DHSP annually estimates the number and percent of persons who are not in HIV medical care as part of its Year 26 Ryan White Part A application. For fiscal year 2016 (March 1, 2016-February 28, 2017), DHSP estimates there are 13,745 (26%) HIV positive individuals who know their HIV status and are not in HIV medical care [39]. Although this is a marked decline from 2011 (33.2%) [39]. It represents a large

number of PLWH who are out of care. The CDC estimates that this population accounts for 61.3% of new HIV infection [37]. Thus, understanding the factors that are associated with being out of care are key.

DHSP completed an analysis of HIV positive persons who are not in care, examining data from five sources: (1) HIV surveillance database (2013); (2) Ryan White (Casewatch) database (2013-2014); (3) Project Engage (2013-2015); (4) Navigation Program (2013-2015); and (5) Medical Care Coordination (MCC) Program (2013) [11]. These data provide key insight into the demographic characteristics of PLWH who are not in medical care as well as some of the key factors associated with being out of care. Among Ryan White clients, there were several key factors that were statistically associated with being out of care. These included: having private or other insurance, living below 100% and 200% FPL, recent homelessness, and recent incarceration [11]. For Ryan White clients, being uninsured was not associated with being out of care. The report suggested that uninsured Ryan White program clients, as well as publicly-insured clients, are able to access medical care and navigate complex health systems. This is reasonable given that as payer of last resort, Ryan White-funded medical care is only available to uninsured PLWH. Ryan White funded medical clinics are also sites for co-located medical care coordination services. Thus, it is not surprising that Ryan White uninsured clients have better access to medical care than those clients with private insurance. The same supports for patient navigation and medical care coordination may not be available through the private health system.

Among Project Engage participants (n=88), 76.1% were homeless in the previous six months, 45.3% uninsured, 28.4% had a history of sex work, 85.2% had a lifetime history of incarceration, and 50% had been recently incarcerated in the past year [11]. Similar characteristics were found in the Navigation Program participants (n=78): 9% reported being homeless in the past six months; 24.4% had a history of incarceration; 7.7% were recently incarcerated in the past year; and 56.6% were uninsured [11].

In a statistical analysis of 1,204 MCC clients, the factors associated with being out of care included living at or below 100% FPL (78%), homelessness in the past six months (17%), currently homeless (9%), and history of incarceration (38%) [11]. The MCC program assesses participants' acuity level to identify their needs and level of services needed. A significantly higher proportion of MCC clients who were transgender, 25-44 years old, living at or below 100% FPL, previously incarcerated, or recently homeless were high or severe acuity ($p < 0.05$) [11].

2. Sexual Risk for HIV

- **Sexually Transmitted Infections**

It is long understood that having a sexually transmitted infection (STI) puts a person at greater risk for acquiring HIV [40]. For example, STIs such as syphilis, herpes, gonorrhea, and chlamydia can facilitate HIV transmission by causing ulcers on the skin as well as other medical complications [10]. "The presence of a sexually transmitted disease is thought to increase the odds of HIV transmission 3 to 5 fold" [10]. Persons who are at risk for STIs are also engaged in the same sexual risk-taking behaviors as persons who are at high risk for HIV, including but not limited to: having sex without a condom, having multiple sex partners, having anonymous sex, having sex under the influence of drugs and/or alcohol, and the possibility of having a sore or other break in the skin that allows HIV to enter the body more easily [41]. The CDC states: "In the United States, people who get syphilis, gonorrhea, and herpes often also have HIV or are more likely to get HIV in the future" [41].

HIV is one of many sexually transmitted infections. Both are evidence of condomless sex. Thus, it is important to understand the magnitude of Los Angeles County's STI incidence. Table 16 presents rates per 100,000 population for selected STIs from 2010 to 2014. This data is inclusive of Los Angeles County's three health departments (i.e., Los Angeles County, and Cities of Pasadena and Long Beach)

that report STI incidence to the State of California. As seen in Table 16, the rate per 100,000 population of total early syphilis, gonorrhea, and chlamydia in Los Angeles County far exceeds that of California.

Table 16. Comparison of California and Los Angeles County Rates per 100,000 Population of Selected Sexually Transmitted Infections, 2010-2014

STI	2010	2011	2012	2013	2014
Total Early Syphilis ¹ - California	10.4	12.0	14.5	16.8	15.8
Total Early Syphilis ¹ – Los Angeles County	16.8	19.4	23.0	25.0	26.4
Gonorrhea – California	71.9	73.2	89.2	100.5	116.8
Gonorrhea – Los Angeles County	102.0	102.3	120.3	130.5	150.3
Chlamydia – California	416.4	438.7	448.4	440.2	453.4
Chlamydia – Los Angeles County	485.3	510.3	519.9	509.0	539.9

Source: California Department of Public Health, STD Control Branch. Available from: <http://www.cdph.ca.gov/data/statistics/pages/stddata.aspx>.

¹ Includes primary, secondary, and early latent syphilis.

Table 17 presents data from the Los Angeles County Health Department on 2014 diagnosed cases of chlamydia, gonorrhea, and early syphilis including number, percent, and rate per 100,000 population.

Table 17. Number, Percent and Rates (per 100,000) of Persons Reported with Chlamydia, Gonorrhea and Early Syphilis by Selected Characteristics, Los Angeles County, 2014¹

	CHLAMYDIA			GONORRHEA			EARLY SYPHILIS		
	N	%	Rate	N	%	Rate	N	%	Rate
Cismale	19,690	38	422	10,315	71	221	2,268	92	49
Cisfemale	32,289	62	674	4,187	29	87	154	6	3
Transgender ³	41	<1	-	39	<1	-	39	2	-
Black/AA	9,229	18	1,174	4,461	31	568	496	20	63
Latino/Hispanic	23,423	45	508	5,220	36	113	1,149	47	25
White	6,705	13	252	3,276	23	123	648	26	24
Asian	2,001	4	147	444	3	33	95	4	7
Pacific Islander	137	<1	719	33	<1	173	9	<1	47
AI/AN ²	98	<1	532	36	<1	195	5	<1	27
Other/Multi ³	787	2	-	214	1	-	15	1	-
0-14 ³ years	238	<1	13	45	<1	2	<5	-	-
15-19 years	9,656	19	1,435	1,697	12	252	75	3	11
20-24 years	18,647	36	2,529	3,822	26	518	324	13	44
25-29 years	10,850	21	1,526	3,254	22	458	421	17	59
30-34 years	5,552	11	794	2,160	15	309	392	16	56
35-39 years	2,967	6	456	1,262	9	194	313	13	48
SPA 1	2,423	5	617	510	4	130	45	2	11
SPA 2	8,260	16	377	1,885	13	86	393	16	18
SPA 3 ¹	6,458	12	394	1,192	8	73	191	8	12
SPA 4	8,961	17	779	4,175	29	363	938	38	82
SPA 5	2,482	5	381	758	5	116	130	5	20
SPA 6	10,261	20	993	3,154	22	305	352	14	34
SPA 7	6,952	13	530	1,215	8	93	216	9	16
SPA 8 ¹	5,391	10	498	1,373	9	127	160	6	15
Missing	910	2	-	293	2	-	37	2	-

¹Data are provisional due to reporting delay and do not include cases reported in the cities of Long Beach and Pasadena. Rates based on observations fewer than 12 may not be reliable.

²American Indian/Alaska Native (AI/AN).

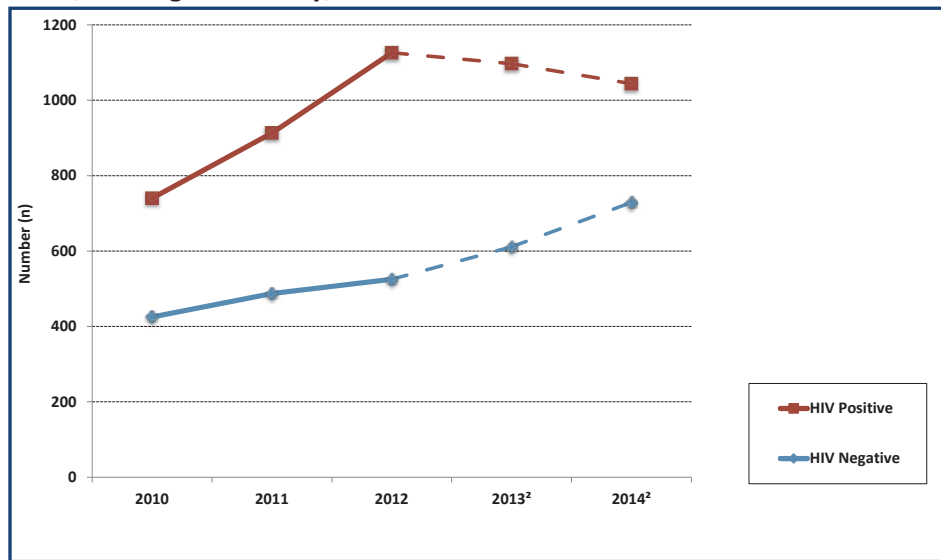
³Rates cannot be calculated due to lack of reliable denominator data.

Syphilis

Data from the Los Angeles County Health Department shows that in 2014 there were 2,462 cases: 92% of all early syphilis (includes primary and secondary and early latent) cases were cismale, 6% cisfemale, and 2% transgender [6]. An overwhelming 67.7% of total early syphilis cases occurred in MSM, including men who have sex with men and women (MSM/W) and 59% of MSM and MSM/W with early syphilis are co-infected with HIV [6]. Geographically, the highest rate of early syphilis is in SPA 4 (82 per 100,000 population) followed by SPA 6 (34 per 100,000 population).

Figure 21 depicts syphilis cases in HIV positive and HIV negative MSM from 2010 to 2014. Since 2012, there has been about a 7.3% decline in syphilis co-infection among HIV positive MSM, from 1,126 cases to 1,044 cases in 2014. However during the same time period, there has been a 37.8% increase of early syphilis cases among HIV negative MSM from 529 in 2012 to 729 in 2014 [10].

Figure 21. Number of Cases of Early Syphilis¹ among Men Who Have Sex with Men (MSM)² by HIV Status³, Los Angeles County, 2010-2014⁴



1. Early syphilis (ES) includes cases stages as primary, secondary, and early latent.
2. Sexual orientation is based on self-report
3. HIV positive status includes cases that were either self-reported and/or laboratory confirmed
4. Data excludes cases in Long Beach and Pasadena; data are provisional due to reporting delay (2012-2014), which are indicated by the dashed line.

Source: Division of HIV and STD Programs, Los Angeles County Department of Public Health, An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.

Gonorrhea

In 2014, there were 14,555 new gonorrhea cases reported by the Los Angeles County Health Department: 71% were cismale; 29% cisfemale, and less than 1% (39 cases) transgender [6]. This represents an overall rate of 154 per 100,000 population [6]. The Los Angeles County Health Department reports that the number of cases has increased each year over the past five years, resulting in a 53% increase overall [10]. As shown in Table 17, the populations most severely impacted by gonorrhea in Los Angeles County in 2014 were males (221 per 100,000), individuals aged 20-24 years of age (518 per 100,000) and Black/African American (568 per 100,000) [10]. In Table 17, geographically, SPA 4 has the highest gonorrhea rate (363 per 100,000 population), followed by SPA 6 (305 per 100,000 population) [10].

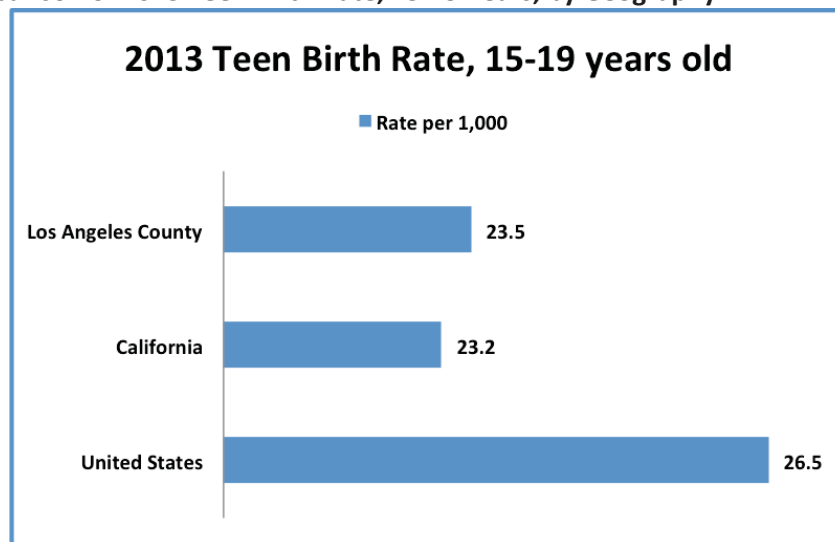
Chlamydia

In 2014, there were 52,098 cases of chlamydia (rate of 551 per 100,000 population) reported by the Los Angeles County Health Department [6]. This represents an increase of about 16.8% from 2010 when the rate was 484 per 100,000 population [10]. Chlamydia has a very different gender profile in Los Angeles County: 62% were cisfemale, 38% cismale, and less than 1% (41 cases) transgender [6]. Thus, cisfemales were the most impacted gender group with a rate of 674 per 100,000 population. The most impacted racial/ethnic group is Black/African American (1,174 per 100,000 population) [10]. About 64% of the 32,289 2014 chlamydia cases among cisfemales were in youth and young adults less than 25 years old [6]. Chlamydia is more evenly distributed across Los Angeles County but the rates are highest in SPA 6 (993 per 100,000 population), SPA 4 (779 per 100,000 population), and SPA 1 (617 per 100,000 population) [6].

- **Births**

The total fertility rate and births in Los Angeles County overall are decreasing [42]. Latinas have the highest birth rate in the county but have also experienced the sharpest decline in total fertility rate [42]. Figure 22 depicts the 2013 teen (15-19 years) birth rate in Los Angeles County as compared to California and the U.S. As seen, Los Angeles County's teen birth rate per 1,000 population is 23.5, slightly higher than California overall (23.2) but lower than the U.S. (26.5).

Figure 22. Comparison of 2013 Teen Birth Rate, 15-19 Years, by Geography



Source: As cited on kidsdata.org, California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; California Dept. of Public Health, Center for Health Statistics, Birth Statistical Master Files; Centers for Disease Control & Prevention, Natality data on CDC WONDER; Martin et al. (2015), Births: Final Data for 2013. National Vital Statistics Reports, 64(1) (Mar. 2015).

Although condoms are used as contraception and protect cisfemale teens from other STIs, other contraceptives are growing in popularity, which do not protect them from HIV and other STIs. These include “the pill,” hormone-based methods, and more recently the “morning after pill” [43]. Together with the high incidence of chlamydia in Los Angeles County, young ciswomen, especially Blacks/African Americans and Latinas, may be at higher risk for HIV.

3. People Who Inject Drugs (PWID)

PWID are also at risk for HIV in Los Angeles County. As discussed earlier, IDU will be used in reference to the transmission risk for HIV, which is reported in national and state datasets. PWID will be used to describe the population.

Los Angeles County has a much smaller proportion of PLWH who report IDU as their mode of transmission than other parts of the U.S., especially when compared to the east coast. As seen in Table 1 in 2014, IDUs account for 5.1% of HIV transmission among all PLWH in Los Angeles County and MSM/IDU account for an additional 6.0% of transmission [6]. In terms of recently diagnosed persons (2009-2013), IDU accounts for an even smaller percentage, 3.8% of PLWH and 3.2% MSM/IDU. However, when examined by gender, IDU has a much greater risk for HIV for females; IDU represents 20.7% of their risk for HIV compared to 3.1% of the risk for males,^{§§} excluding MSM/IDU. The prevalence of IDU risk among the transgender population is not available.

DHSP estimates that the HIV prevalence for this population is 7.6% (see Table 4) [10]. In 2012, Los Angeles County conducted the National HIV Behavioral Surveillance (NHBS) survey with 529 IDUs [10]. NHBS-IDU found that 5% (n=26) of respondents were HIV positive, and this was higher (8%) in both Whites and Black/African American IDUs [10]. Nine of 26 HIV positive respondents (34.6%) were unaware of their HIV infection, and Black/African American respondents (56%) were more likely to be unaware of their HIV infection [10]. Among respondents who were aware of their HIV positive status, 61% were linked to care within three months of their HIV diagnosis and 63% were on ART at the time of the survey [10]. There was a high prevalence of co-morbid hepatitis C virus (HCV) among HIV positive respondents (77%) and even higher among Black/African American PLWH respondents (88%) [10].

PWID receiving Ryan White services in Los Angeles County are significantly impacted by social determinants of health including homelessness (14%), incarceration within past 2 years (35%), and living below 100% FPL (83%) [21]. About 2.2% of Ryan White PWID clients in 2013-2014 reported receiving treatment for mental health issues and 3.9% reported receiving substance abuse treatment [21]. Viral suppression among Ryan White PWID/IDU clients was 64% [21].

4. Risk for HIV Among Selected Populations

- **Men who have Sex with Men (MSM)**

As presented in Table 1, male-to-male sexual contact is the major driver of the HIV epidemic in Los Angeles County for all racial/ethnic groups. According to data from the CDC, the lifetime risk for HIV among MSM is one in six. In 2014, MSM account for 77.7% of all PLWH and an additional 6.0% of PLWH have the dual transmission of MSM/IDU, for a total of 83.7% [6]. Among recently diagnosed persons for the five-year period (2009-2013), MSM and MSM/IDU combined account for 86.2% of recent diagnoses (83.0% and 3.2% respectively) [6]. DHSP estimates that the overall HIV prevalence among MSM is 18.4% (see Table 4) [10]. Black/African American MSM are the most disproportionately impacted racial/ethnic population. Even though Black/African American MSM account for less than 1% of the general population age 15-64 years living in Los Angeles County, they represent approximately 15% of all reported HIV infections and 18% of MSM HIV infections [10]. DHSP estimates that two out of every five Black/African American MSM are infected with HIV, an estimated HIV prevalence of 40% [10]. The

^{§§} Sex assigned at birth for both female and male references.

estimated HIV prevalence among Latino/Hispanic MSM is 15%, nearly one out of every five Latino/Hispanic MSM is estimated to be HIV positive [10].

DHSP surveyed Los Angeles County MSM in 2014 as part of the CDC-funded National HIV Behavioral Surveillance project. Among the 525 respondents, 16% were HIV positive; among Black/African American respondents, 34% were HIV positive [10]. This compares to an HIV prevalence of 9% among White MSM and 15% among Latino/Hispanic MSM [10]. Among the 84 MSM who tested HIV positive, 32% were previously unaware of their HIV infection [10]. Latino/Hispanic MSM were the most likely to be unaware of their HIV positive status (39%), followed by 31% of Black/African American MSM and 21% of White MSM [10]. Among respondents who were previously unaware of their HIV positive status, 33% reported condomless anal sex with a partner who was HIV negative or of unknown status at their last sexual encounter [10]. Among respondents who were aware of their HIV positive status at the time of the survey, 21% reported having had condomless anal sex with a partner who was HIV negative or of unknown status at their last sexual encounter [10].

The National HIV Behavioral Surveillance (NHBS)-MSM 2014 respondents also reported a relatively high number of casual partners during the previous 12 months; 10 casual partners was the median for all respondents [44]. This varied by race/ethnicity; White MSM reported a median of 12 casual partners, Black/African American MSM 11 casual partners, and 7 casual partners for Latino/Hispanic MSM [44]. Overall, 7% of respondents reported exchanging sex for money or drugs; this was highest among Black/African American MSM (13%) and lowest among Latino/Hispanic MSM (5%) [44]. STI prevalence was also highest among Black/African American MSM (24%) compared to 17% among White MSM and 13% among Latino/Hispanic MSM [44]. Sixty-seven percent (67%) of all respondents reported condomless sex with a male partner; this was highest among White MSM (70%) and Latino/Hispanic MSM (69%) and lowest among Black/African American MSM (63%) [44]. Black/African American MSM respondents were the most likely to have had sex with a female (12%), followed by Latino/Hispanics (10%) and Whites (6%) [44].

- **Females and Cisfemales*****

As seen in Table 1, cisfemales represent about 11.2% of all PLWH and 10.9% of recently diagnosed PLWH from 2009-2013. Although the overall proportion of ciswomen living with HIV is relatively small in comparison to cismen, there are significant disparities, particularly among Black/African American ciswomen [10]. One local study found that many females did not believe they were at risk for HIV prior to their HIV diagnosis [45]. Among the 5,526 females living with HIV as of December 31, 2014, more than three-quarters (85.1%) are persons of color: 44.8% Latina/Hispanic, 35.4% Black/African American, 0.5% Native American, and 2.9% other races, including two or more races [12]. DHSP estimates the HIV prevalence for ciswomen is 0.16%; however, the estimates are much higher among Black/African American ciswomen (0.62%) [10]. Black/African American ciswomen have nearly seven times the estimated HIV prevalence of White ciswomen (0.09%) and 4 times that of Latina ciswomen (0.14% - see Table 4) [10].

In 2013, DHSP surveyed 203 ciswomen living in high poverty areas in Los Angeles County through the National HIV Behavioral Surveillance cycle targeting high-risk heterosexual persons [46]. More than half (51%) of respondents were Black/African American and 40% Latina/Hispanic. None were HIV positive. More than three-quarters (78%) of respondents stated that they were aware of their HIV status but only

*** The Los Angeles County data tables cited in this section do not always present information on transgender persons. The use of "female" in this section will refer to sex assigned at birth.

48% were aware of the HIV status of their last sex partner [46]. Overall, there was a high prevalence of having vaginal or condomless anal sex in the previous 12 months, which increased with age: 66% of 18-25 year olds, 73% of 26-49 year olds, and 94% of ciswomen over 50 years of age [46]. Condom use was highest in ciswomen of child-bearing age. About 24% of respondents reported having condomless anal sex with a male in the previous 12 months [46]. Less than one-fifth (19%) of ciswomen reported using a condom during their last sexual encounter [46].

- **Youth (13-24 years)**

Although the estimated HIV prevalence among all youth (13-24 years) is relatively low (0.08%) in Los Angeles County, there has been concern nationwide about increases in HIV infections among youth, specifically MSM youth [47]. DHSP estimates that the HIV prevalence among young MSM (13-24 years) is 1.8% (see Table 4) [10]. However, this varies widely by age group. HIV prevalence is lowest among young MSM ages 13-17 years (0.03%) and highest among young MSM ages 18-24 years (3.7%) [10]. In 2013, there was a total of 350 new diagnoses among 13-24 year olds, 19% of all new diagnoses that year [10]. However, less than 1% of these diagnoses were among youth 13-17 years of age, 18% were among 18-24 year old youth [10]. As part of its HIV incidence surveillance project, DHSP estimated the rate of new HIV infection in youth using 2011-2013 data. They found that the risk of HIV infection was highest in 18-24 year olds (44 per 100,000 population) compared to 13-17 year olds (1 per 100,000 population) [10].

There were 118 young MSM (18-24 years old) who participated in Los Angeles County's 2014 MSM National HIV Behavioral Surveillance project [10]. Eighteen (15%) tested HIV positive and 39% of these individuals were previously unaware of their HIV infection [10].

- **Transgender Persons**

Gender reporting at a national level is virtually non-existent and public datasets compiled by the U.S. Census Bureau, for example, only collect information for the dual sex categories of male and female. Transwomen (male-to-female) and transmen (female to male), as well as a host of other gender identities (e.g., queer, gender non-conforming, etc.) are lacking. The enhanced HIV/AIDS Reporting System (eHARS) began including transgender persons in Los Angeles County in July 2002 [10]. However, the total size of the transgender population is unknown and only rough estimates of both the total size and HIV prevalence in this population are possible at this time. DHSP developed a methodology in 2012 to estimate the size and HIV prevalence of the transgender population [48]. DHSP has recently updated this estimate for 2014 (see Table 4). They estimate there are 13,788 transgender persons living in Los Angeles County with a one-to-one ratio of transmen (6,894) to transwomen (6,894) [10]. Transgender women represent 96% of all transgender PLWH and are at greatest risk of acquiring or transmitting HIV [10]. The estimated HIV prevalence among transgender women is 17% compared to <1% for transgender men [10]. This varies considerably by race/ethnicity. Native American (American Indian/Alaska Native) and Black/African American transwomen are the most disproportionately impacted. The estimated HIV prevalence in these two populations is 25.6% and 26.5% respectively [10]. As seen in Table 1, from 2009-2013, there were 146 transgender persons diagnosed with HIV, representing 1.4% of all recently diagnosed PLWH [6].

In 2009, DHSP conducted a pilot study of Transgender HIV Behavioral Surveillance among Black and Latina transwomen. A total of 101 transwomen were surveyed; 56% Latina and 44% Black/African American [10]. The majority (63%) of respondents were tested for HIV during the previous 12 months, and 28% self-reported as HIV positive [10]. The majority of respondents (64%) reported engaging in condomless anal sex, and 41% reported exchanging sex for money or drugs in the previous 12 months [10]. Nearly half (45%) of respondents reported injecting hormones and 5% reported sharing hormones in the previous 12 months [10].

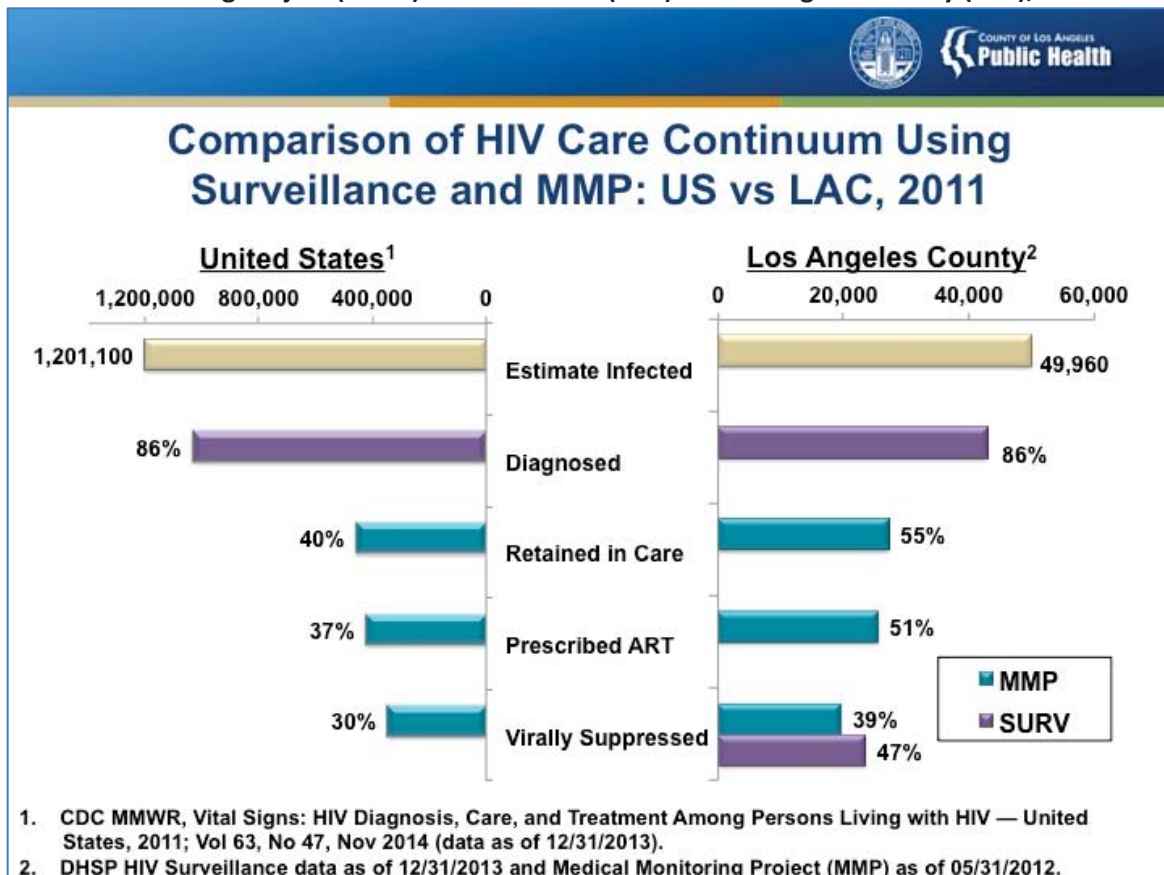
B. HIV CARE CONTINUUM IN LOS ANGELES COUNTY

a. Description of Los Angeles County’s HIV Care Continuum

Los Angeles County has been using the HIV Care Continuum, previously referred to as the “Treatment Cascade” as a framework for planning since 2011 [49]. Except for antiretroviral prescription (i.e., ART prescription), which is part of the national HIV Care Continuum, Los Angeles County has included the HIV Care Continuum indicators in its annual surveillance report since 2013, including both a prevalence-based and diagnosed-based continuum. For local planning, Los Angeles County also measures “engaged in care,” which represents PLWH who have evidence of at least one care visit in the previous 12 months. Figure 23 below compares Los Angeles County’s HIV care continuum in 2011 with the United States (U.S.).

As seen in 2011, Los Angeles County overall is doing much better than the U.S. in achieving improved health outcomes of persons living with HIV (PLWH). Both *retention in care* and *ART prescription* are substantially higher in Los Angeles County (55% and 51% respectively) than in the U.S. (40% and 37% respectively). Whether measured through its Medical Monitoring Project (MMP) data or HIV surveillance data, Los Angeles County is achieving higher viral suppression than the U.S. average. The county’s HIV surveillance data, which provides data on all diagnosed PLWH, shows viral suppression of 47% compared to 30% in the U.S.

Figure 23. Comparison of Prevalence-Based HIV Care Continuum Using Surveillance and Medical Monitoring Project (MMP): United States (U.S.) vs. Los Angeles County (LAC), 2011



Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

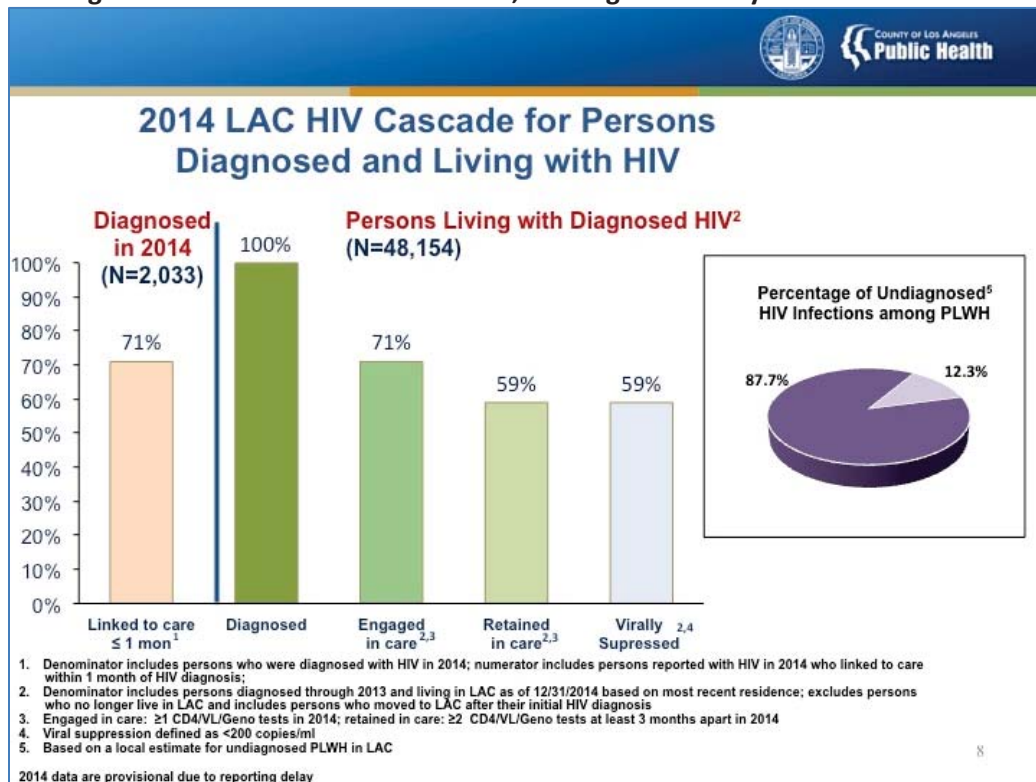
Table 18 presents the description of the numerator and denominator for each indicator presented.

Table 18. Explanation of Numerical Components for Calculation of Diagnosed Based HIV Care Continuum Percentages

Indicator	Numerator	Denominator
HIV Diagnosed	Number of people diagnosed with HIV, excludes individuals who are unaware of their HIV infection	Number of people diagnosed with HIV
Linkage to Care	Persons diagnosed with HIV in 2014 with at least 1 CD4/viral load/genotype test within 1 month of HIV diagnosis	Persons diagnosed with HIV in 2014
Engaged in Care	PLWH with ≥ 1 CD4/viral load/genotype test in 2014	Persons with diagnosed HIV in Los Angeles County through 12/31/2013 and living with HIV at the end of 2014 [Note: Includes over 6,300 persons who moved to Los Angeles County and excludes over 5,700 who moved from Los Angeles County]
Retained in Care	PLWH with ≥ 2 CD4/viral load/genotype tests at least 3 months apart in 2014	
Viral load (VL) suppression	PLWH among whom the last viral load in 2014 was < 200 copies/ml	

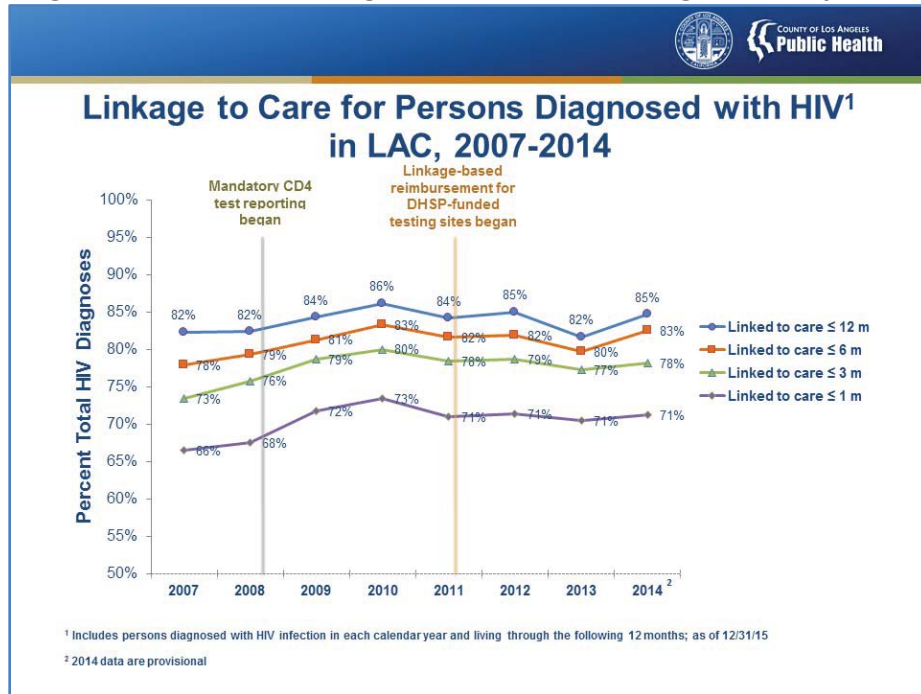
Figure 24 below presents Los Angeles County’s 2014 HIV care continuum, which shows significant improvement in the 2011 health outcome measures in Figure 23. Figures 25 and 26 depict the trend in linkage, retention, and viral suppression over eight years from 2007 to 2014.

Figure 24. Diagnosed-Based HIV Care Continuum, Los Angeles County 2014



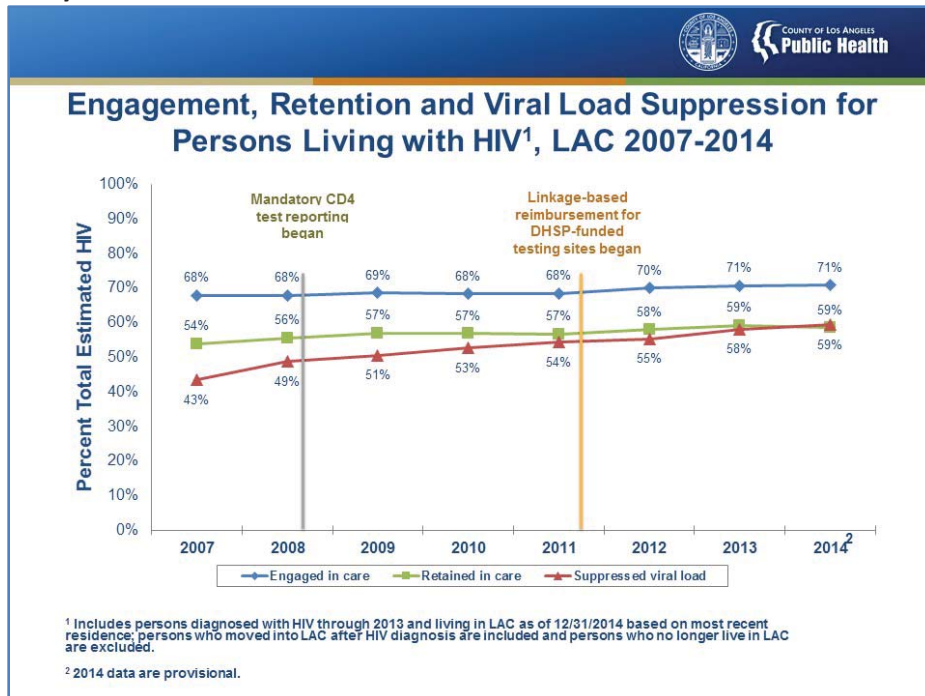
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 25. Linkage to Care for Persons Diagnosed with HIV in Los Angeles County, 2007-2014



Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 26. Engagement, Retention, and Viral Suppression for Persons Living with HIV, Los Angeles County 2007-2014



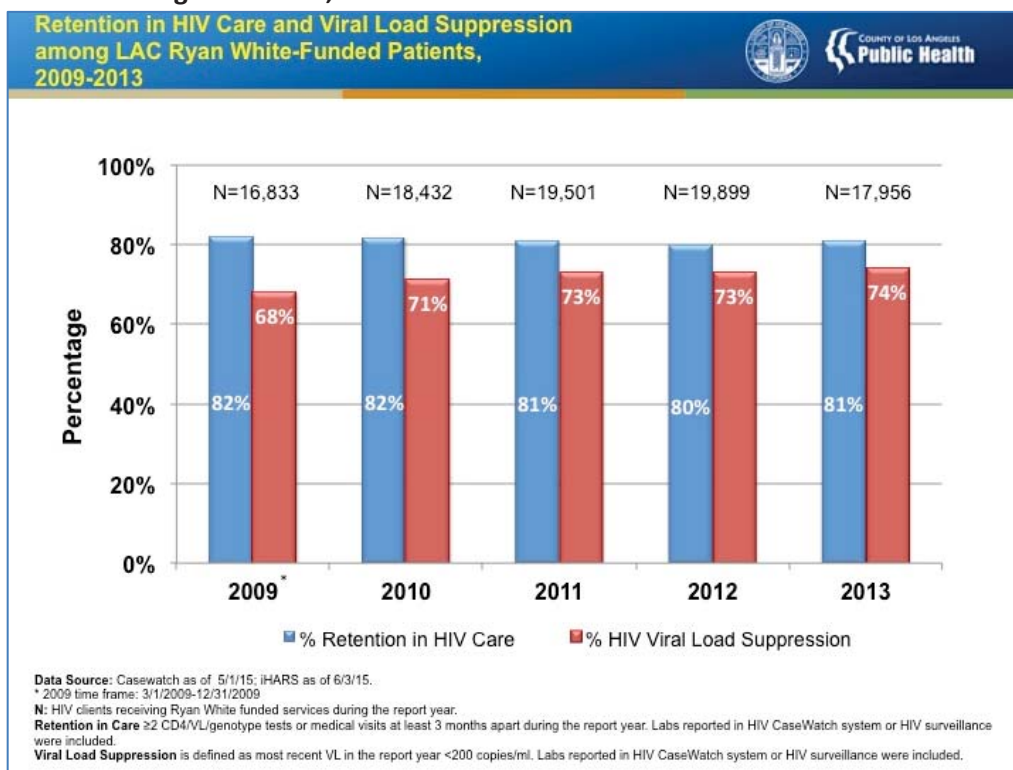
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

As seen in Figure 24, in 2014, 71% of all persons diagnosed with HIV were linked to care within one month of diagnosis. This has remained unchanged since 2011 after having dropped slightly from 73% in

2010 (Figure 25). However, over time, Los Angeles County’s linkage to care progressively increases to 85% in 2014 within one year of diagnosis. Overall engagement in care in 2014 is 71% (Figure 24). This has remained relatively flat since 2012 when it was 70% (Figure 26). A similar pattern is seen in retention in care, which is 59% in 2014 (Figure 24). This has increased gradually since 2007 (54%) and remained relatively flat since 2012 (Figure 26). Los Angeles County has seen the most significant improvement in viral suppression, ranging from a low of 43% in 2007 to its current 59% in 2014 (Figure 26). This is an increase of 37 percentage points over eight years.

2010 was the peak year for all HIV Care Continuum indicators and they have all decreased only slightly from that peak. Although Los Angeles County is ahead of the U.S. in meeting the targets established by the National HIV/AIDS Strategy Update to 2020 (NHAS), the challenge to actually reach these targets remains. Figure 27 depicts the HIV Care Continuum measures for Ryan White Part A clients, demonstrating that the NHAS targets are within reach. As seen, in 2013, 81% of Los Angeles County Ryan White clients were retained in care and 74% achieved viral suppression, percentages just shy of the NHAS Update to 2020 targets of *90% retained in care* and *80% viral suppression* [4].

Figure 27. Retention in HIV Care and Viral Load Suppression among Los Angeles County Ryan White Part A Program Clients, 2009-2013

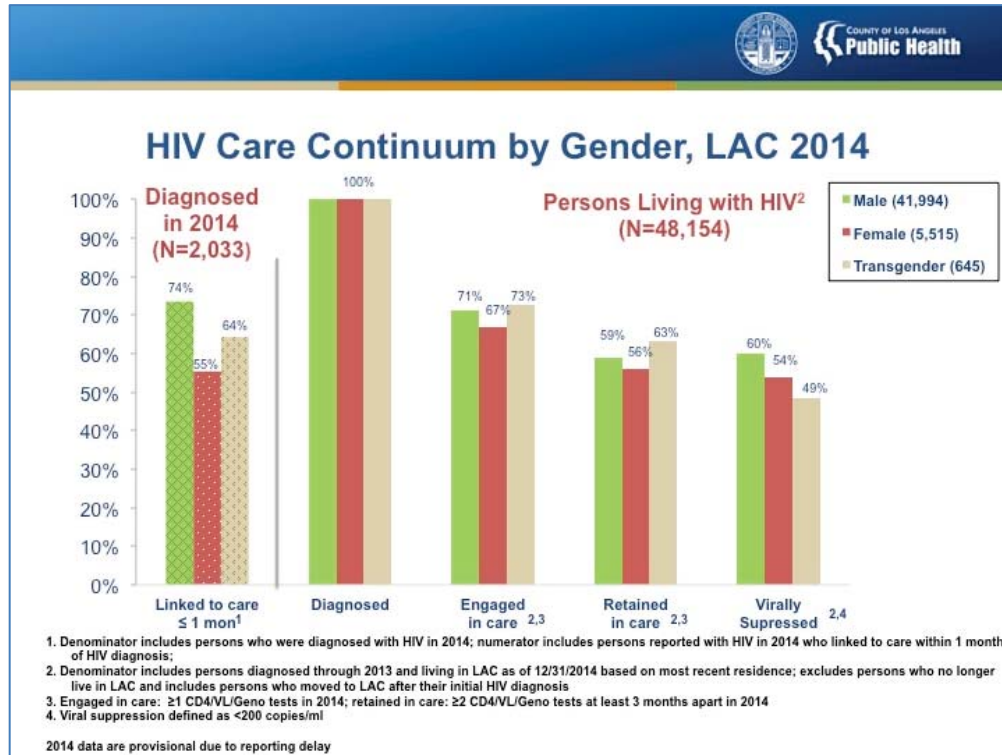


Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

b. Disparities among key populations along Los Angeles County’s HIV Care Continuum

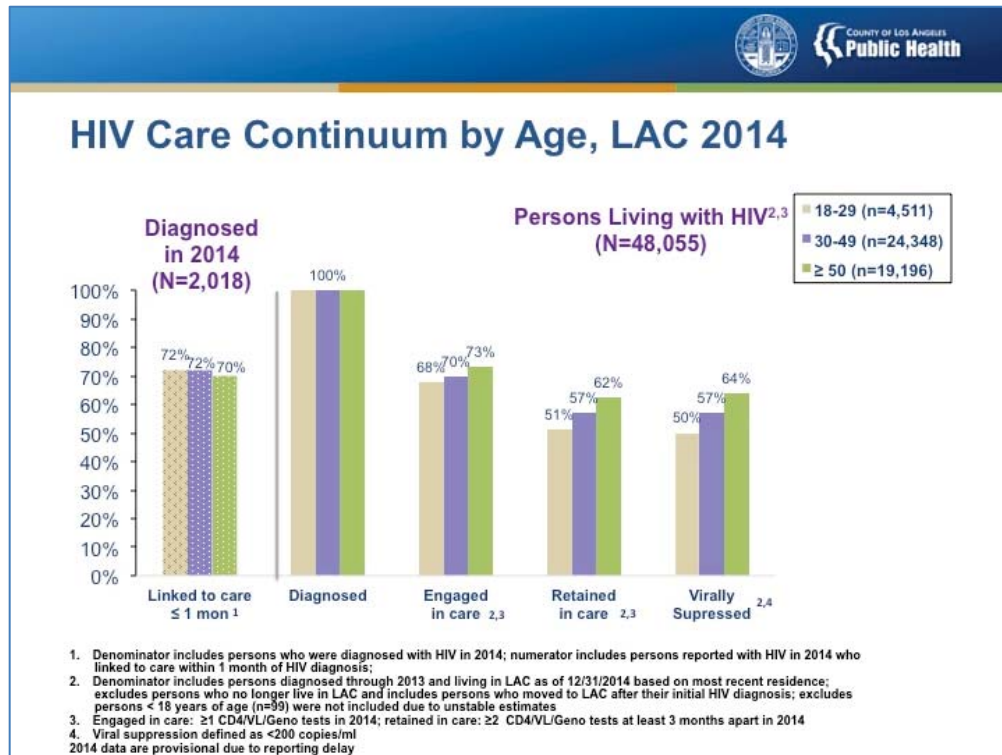
Figure 24 presents the local baseline for Los Angeles County’s HIV Care Continuum measures. Figures 28-35 present the county’s diagnosed HIV Care Continuum data by population group including: gender (Figure 28), age (Figure 29), race/ethnicity (Figure 30), 18-29 year olds (Figure 31), 18-29 year olds by race/ethnicity (Figure 32), Men who have Sex with Men (Figure 33), Men who have Sex with Men (MSM) by race/ethnicity (Figure 34), and Injection Drug Users (Figure 35).

Figure 28. Diagnosed HIV Care Continuum by Gender, Los Angeles County 2014



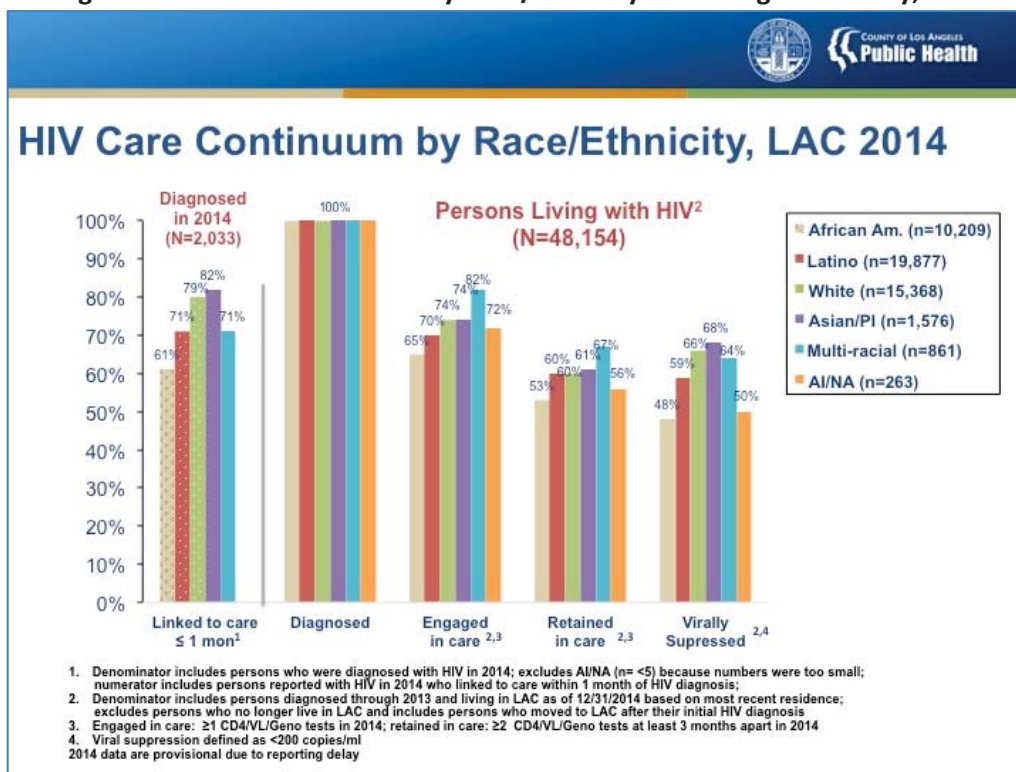
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 29. Diagnosed HIV Care Continuum by Age, Los Angeles County 2014



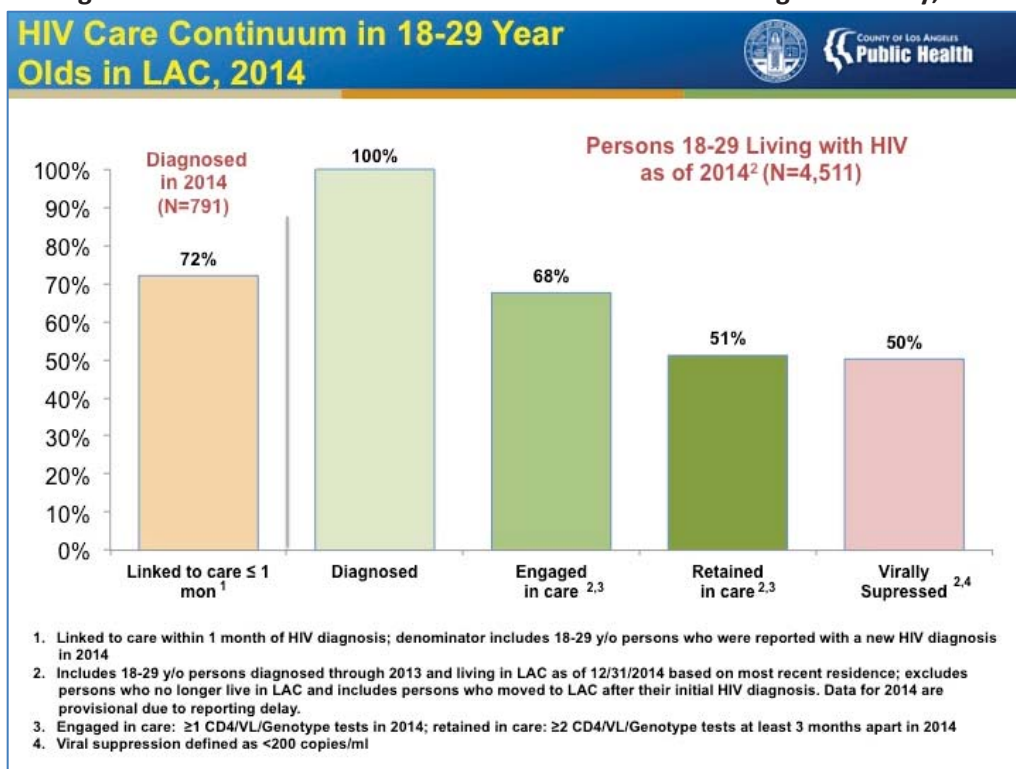
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 30. Diagnosed HIV Care Continuum by Race/Ethnicity in Los Angeles County, 2014



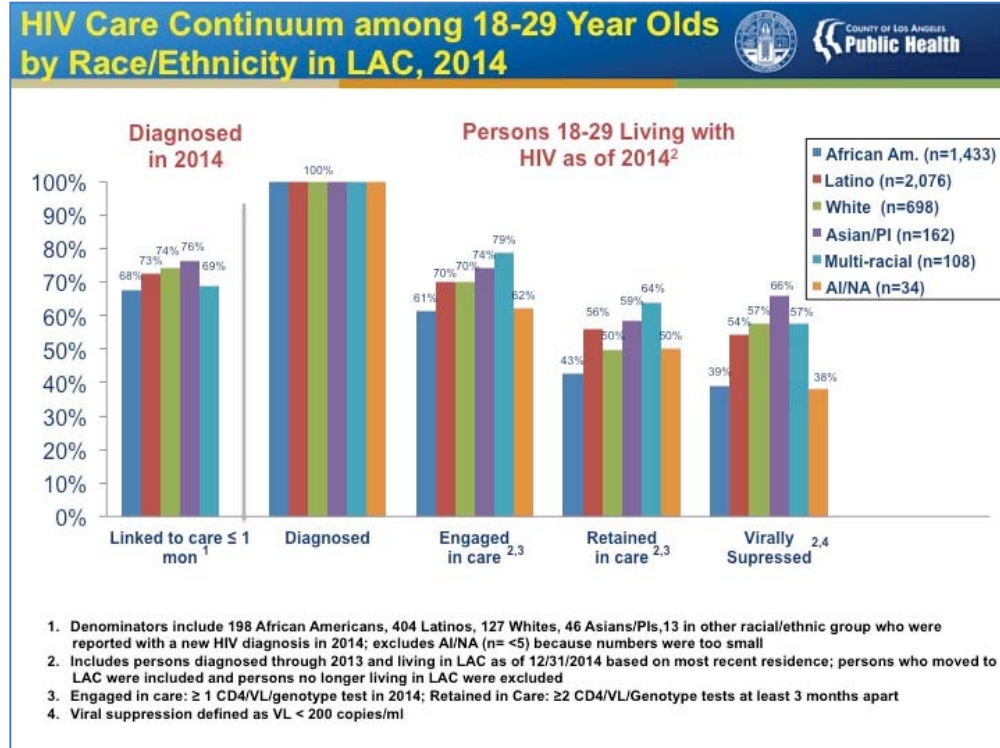
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 31. Diagnosed HIV Care Continuum for 18-29 Year Olds in Los Angeles County, 2014



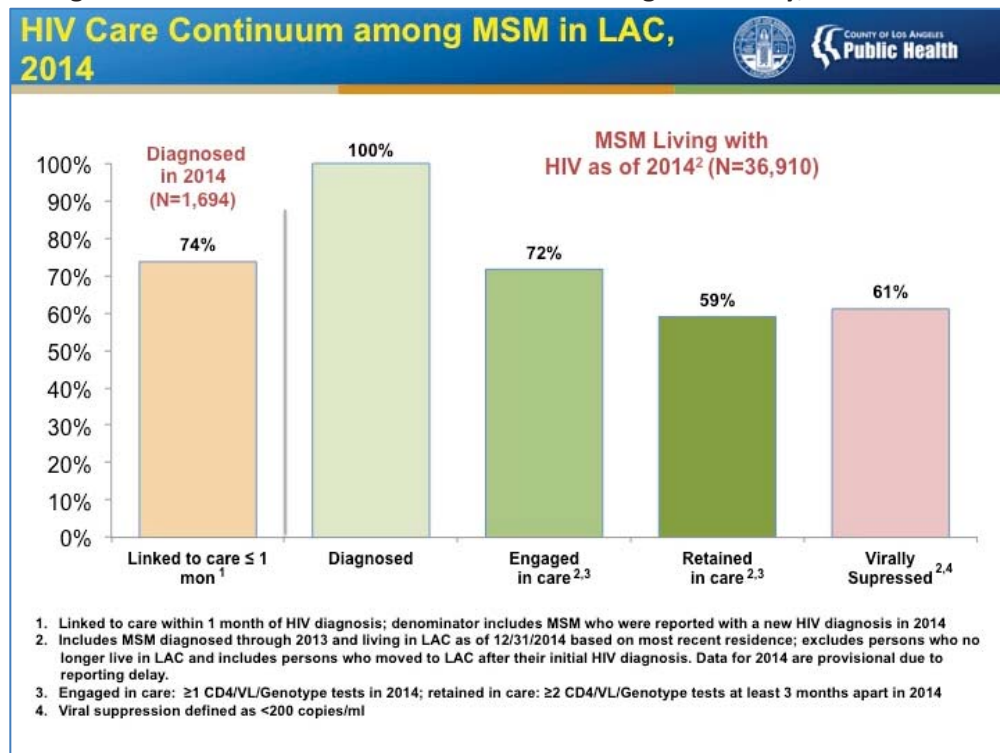
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 32. Diagnosed HIV Care Continuum for 18-29 Year Olds by Race/Ethnicity in Los Angeles County, 2014



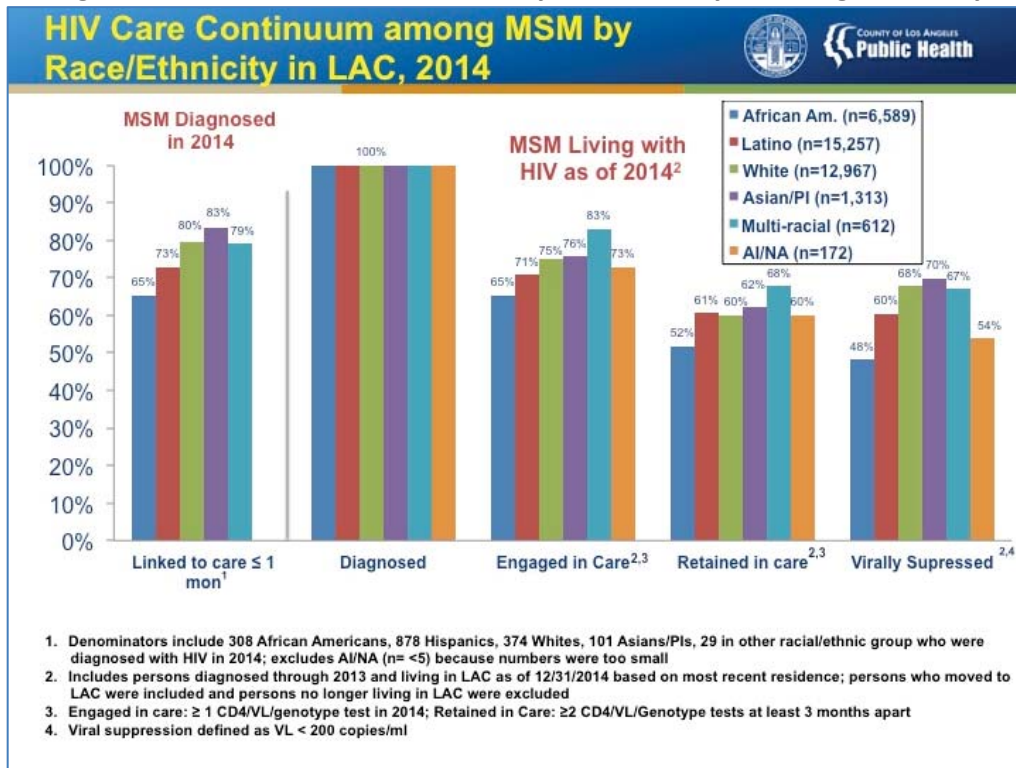
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 33. Diagnosed HIV Care Continuum for MSM in Los Angeles County, 2014



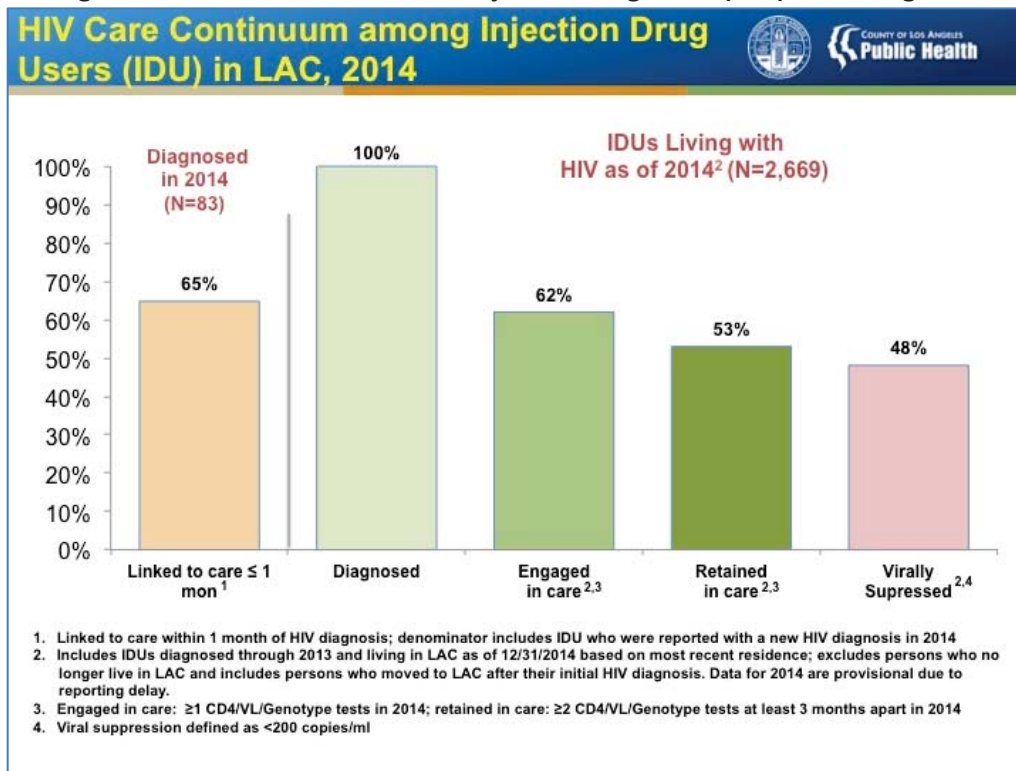
Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 34. Diagnosed HIV Care Continuum for MSM by Race/Ethnicity in Los Angeles County, 2014



Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Figure 35. Diagnosed HIV Care Continuum for Injection Drug Users (IDU) in Los Angeles County, 2014



Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, April 2016

Table 19 summarizes much of the data presented above, with the exception of Figure 32 (Youth 18-29 years old by race/ethnicity) and Figure 34 (MSM by race/ethnicity). Also included in Table 19 is the *National HIV/AIDS Strategy Updated to 2020*, which presents aggressive national targets.

For the purposes of identifying populations with the most severe disparities, a population whose health outcomes are greater than or equal to five percentage points less than the county average is considered to have a severe disparity. Using Los Angeles County’s average as the standard from which to compare various subpopulations, Table 19 reveals significant disparities in HIV-related outcomes across populations. These are highlighted in bold.

Table 19. Diagnosed HIV Care Continuum Indicators for Selected Populations of Persons Living with HIV, Los Angeles County 2014

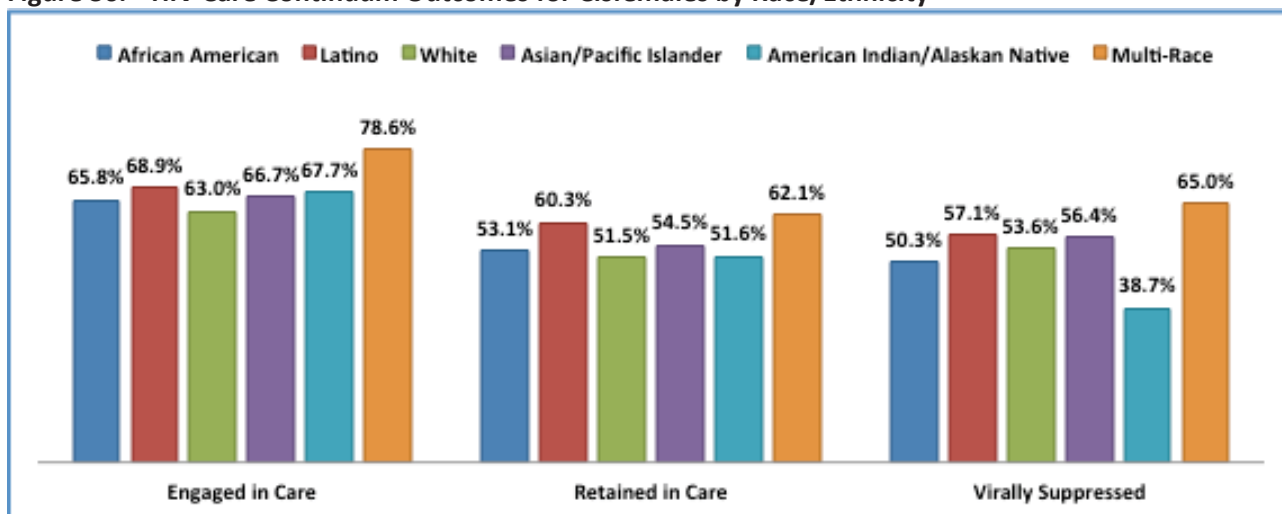
Population Group	Linked to Care (30 days)	Engaged in Care	Retained in Care	Virally Suppressed
<i>NHAS Updated to 2020 Target</i>	85%	N/A	90%	80%
Total Los Angeles County	71%	71%	59%	59%
Gender Identity				
Cismale	74%	71%	59%	60%
Cisfemale	55%	67%	56%	54%
Transgender	64%	73%	63%	49%
Age Group				
18-29 years	72%	68%	51%	50%
30-49 years	72%	70%	57%	57%
≥ 50 years	70%	73%	62%	64%
Race				
Black/African American	61%	65%	53%	48%
Latino/Hispanic	71%	70%	60%	59%
White	79%	74%	60%	66%
Asian/Pacific Islander	82%	74%	61%	68%
Multiple Races	71%	82%	67%	64%
American Indian/Alaska Native ¹	-	72%	56%	50%
Transmission				
MSM	74%	72%	59%	61%
IDU	65%	62%	53%	48%

¹ Number of AI/AN were too small for linkage to care measure.

Bold indicates percentages lower than the overall county average.

Due to the smaller impact of HIV on cisfemales in Los Angeles County, specific data that shows the disparities within this population is often not depicted in routine data reporting. However, there are significant differences by race/ethnicity among cisfemales, including differences in HIV-related health outcomes. Figure 37 depicts three of Los Angeles County’s HIV Care Continuum measures for cisfemales by race/ethnicity. As seen in Table 19, ciswomen have poorer outcomes in every HIV Care Continuum measure. African American and White cisfemales have even poorer engagement in care; African American, White, and American Indian/Alaska Native cisfemales have poorer retention in care; and African American and American Indian/Alaska Native cisfemales have the poorest viral suppression.

Figure 36. HIV Care Continuum Outcomes for Cisfemales by Race/Ethnicity



Source: Los Angeles County Department of Public Health Division of HIV and STD Programs, June 2016

From the HIV Continuum of Care data presented above, Table 20 presents a summary list of populations by step in the HIV Care Continuum that show evidence of having the most significant HIV-related disparities in Los Angeles County in one or more HIV Care Continuum categories. By definition, PLWH who are undiagnosed or who know their HIV status but are not in care are considered to have a disparity in every category and therefore are also included in this list.

As seen, Black/African Americans are the sole population, which experiences a severe disparity at every step along the HIV Care Continuum.

Table 20. HIV Care Continuum Disparity Populations by HIV Care Continuum Category

Linked to Care	Engaged in Care	Retained in Care	Virally Suppressed
<ul style="list-style-type: none"> • Undiagnosed PLWH • Out of Care PLWH 	<ul style="list-style-type: none"> • Undiagnosed PLWH • Out of Care PLWH 	<ul style="list-style-type: none"> • Undiagnosed PLWH • Out of Care PLWH 	<ul style="list-style-type: none"> • Undiagnosed PLWH • Out of Care PLWH
<ul style="list-style-type: none"> • Black/African Americans 	<ul style="list-style-type: none"> • Black/African Americans 	<ul style="list-style-type: none"> • Black/African Americans • American Indians/Alaska Natives (AI/AN) 	<ul style="list-style-type: none"> • Black/African Americans • AI/AN
<ul style="list-style-type: none"> • Cisfemales • Transgender persons 			<ul style="list-style-type: none"> • Cisfemales • Transgender persons
<ul style="list-style-type: none"> • Black/African American MSM • People Who Inject Drugs (PWIDs)/IDUs 	<ul style="list-style-type: none"> • Black/African American MSM 	<ul style="list-style-type: none"> • Black/African American MSM • People Who Inject Drugs (PWIDs)/IDUs 	<ul style="list-style-type: none"> • Black/African American MSM • AI/AN MSM • People Who Inject Drugs (PWIDs)/IDUs
	<ul style="list-style-type: none"> • Black/African American Youth (18-29 yrs) • AI/AN Youth (18-29 yrs) 	<ul style="list-style-type: none"> • Youth (18-29 yrs) • Black/African American Youth (18-29 yrs) • AI/AN Youth (18-29 yrs) • White Youth (18-29 yrs) 	<ul style="list-style-type: none"> • Youth (18-29 yrs) • Black/African American Youth (18-29 yrs) • AI/AN Youth (18-29 yrs)

[Note: Disparity is defined as \geq five percentage points less than Los Angeles County average for each measure.]

c. Los Angeles County's HIV Care Continuum and Planning

The Los Angeles County Department of Public Health Division of HIV and STD Programs (DHSP) and the Commission on HIV (Commission) have used the HIV Care Continuum model to improve its planning and related processes. In 2012, the Commission revised its own HIV Continuum of Care framework as part of its integrated prevention and care planning process that resulted in the development of the *Los Angeles County Five-Year Comprehensive Plan* (published March 2013). The planning process focused on the different populations along the continuum of prevention and care (i.e., HIV negative low-risk, HIV negative high-risk, HIV positive unaware of status, HIV positive aware but not accessing services, HIV positive accessing services, and HIV positive adherent to care plan). Interventions targeting these populations were designed to improve health outcomes and interrupt HIV transmission using Los Angeles County's TLC+ (i.e., testing, linkage to care, plus treatment) framework. This framework outlined the stages of the Gardner, et al. (2011) treatment cascade with a few modifications [49].

As part of its 2013 annual HIV surveillance report, Division of HIV and STD Programs (DHSP) incorporated diagnosed HIV Care Continuum data for the county as a whole, as well as for specific subpopulations to identify disparities. In its 2014 annual HIV/STD surveillance report, this expanded to include a prevalence-based care continuum for multiple subpopulations. Both efforts were designed to support the use of evidence-based planning. DHSP has provided HIV care continuum data in its annual Part A application to HRSA since 2015. In January 2016, DHSP has expanded the use of the HIV Care Continuum in planning through the development of its Outcomes Project. Key goals of this project include 1) outcomes-based program management, 2) systematic data collection and program evaluation, 3) evidence-based program planning, 4) collaborative quality improvement, and 5) innovative program development [49]. This project is specifically focused on improving measures along the HIV Care Continuum and will inform planning, prioritizing, targeting, and monitoring at all levels of service delivery.

As part of this current planning process, DHSP surveillance staff updated the HIV care continuum for the county overall, and numerous subpopulations already described, to include the one-month linkage to care measure set forth in the NHAS Updated to 2020. The Comprehensive HIV Plan Task Force and its Goals, Objectives, and Monitoring Work Group used this data in the development of the integrated plan, which is included in Section II of this document and detailed in full in Attachment C. The energy and conversation centered on the question: What strategies and activities are needed to improve outcomes along the HIV Care Continuum? This stimulated creative brainstorming to identify strategies and activities that would address the needs of populations with the greatest disparities. The Work Group also recognized the need to impact the whole population of PLWH in Los Angeles County, regardless of whether they received HIV medical care through the public or private sector.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

a. Los Angeles County HIV Resources Inventory

Appendix A presents Los Angeles County's financial resources inventory. This inventory is organized by funder. Most of the data gathered is publicly available online through various websites (e.g., CDC, HRSA, SAMHSA, etc.). Additional follow-up with individual grantees was conducted to obtain information regarding funding amount, contract period, services delivered, and/or impact along the HIV continuum to complete missing data. Additional information was also obtained from the Cities of Los Angeles, West

Hollywood, Pasadena, and Long Beach to reflect the specific work going on in these communities. The State of California Medi-Cal data for HIV positive individuals was also obtained online. A specific data request was sent to the State of California Office of AIDS to obtain financial data regarding Los Angeles County PLWH receiving AIDS Drug Assistance Program (ADAP) funding. The Division of HIV and STD Programs (DHSP) provided more detailed data on their funding for contracted services. Gilead Sciences, Inc. was also contacted to obtain financial data for their Pre-exposure Prophylaxis (PrEP) patient assistance program but they stated that it is not public information. They also stated that the number of persons served through the program for the county is not public information. Although financial information was not available from the Greater Los Angeles Veterans Affairs Healthcare System, they did share the number of veterans living with HIV who they are serving through their program. Lastly, data was gathered online through the Universal Data System (UDS) for PLWH being served through any of the 48 Federally Qualified Health Centers (FQHCs) and FQHC-Look Alike organizations in the county, and a financial estimate of these funds were estimated for this population.

This inventory represents one of the most exhaustive compilations of financial data to date. It is a point-in-time estimate. However, it is still incomplete. Financial data for Medicare is not available, nor is HIV-related financial data from private insurance. As local private fundraising can vary dramatically from year to year, this information was not collected and is excluded from this report. There is a column included on the table for the funding period. The purpose is to provide an idea when the funding would expire. For example, most federal grants are now on a five-year funding cycle. At the end of that period, many (e.g., HRSA Ryan White Part C and Part D grants and CDC directly-funded community based initiatives) grant terms end, and the federal funder will put those funds out for a new competitive solicitation. However, the online information is incomplete and does not always have the full funding period available. Where the data was incomplete, telephone calls were made to the specific organization in an attempt to update the information. This improved the data but there are still places where it is incomplete.

Through this process, Los Angeles County has identified \$487,745,766 in HIV-related funding. The vast majority (75.5%) is attributed to Medi-Cal (\$154,633,985) and AIDS Drug Assistance Program (\$192,105,486) expenditures. Most of these funds are for HIV-related medication, including anti-retroviral therapy (ART). Table 21 presents an aggregated summary of Appendix A by funding stream.

Table 21. Summary of Estimated Financial Resources by Funding Source

Funding Source	Grantee	Amount
Ryan White Part A	Division of HIV and STD Programs	\$38,389,840
Ryan White Part A – MAI	Division of HIV and STD Programs	\$3,320,033
Ryan White Part B	Division of HIV and STD Programs	\$2,000,000
Ryan White Part B – AIDS Drug Assistance Program (ADAP)	People Living with HIV	\$154,633,935
Ryan White Part C – Early Intervention Services	12 directly funded organizations	\$5,624,264
Ryan White Part D – Women, Infants, Children, and Youth	UCLA, USC, and Altamed	\$1,750,275
Ryan White Part F – Dental Reimbursement Program	UCLA and USC	\$1,112,617
Ryan White Part F – Special Projects of National Significance	6 directly funded organizations	\$1,883,377

Funding Source	Grantee	Amount
Ryan White Part F – AIDS Education and Training Center	Pacific AIDS Education and Training Center, Los Angeles Region	\$740,000
CDC PS15-1502 – Community Based Organizations	8 directly funded organizations	\$3,968,087
CDC PS14-1403 – Capacity Building Assistance	AIDS Project Los Angeles (Health Departments) and Public Health Foundation Enterprises	\$2,100,000
CDC PS13-1308	Los Angeles Unified School District	\$600,000
CDC PS09-007	Division of HIV and STD Programs	\$400,000
CDC PS15-1503	Division of HIV and STD Programs (MMP)	\$730,741
CDC PS12-1201	Division of HIV and STD Programs (Flagship grant)	\$14,259,272
CDC PS13-1302	Division of HIV and STD Programs (surveillance)	\$2,431,361
CDC 15-1506	Division of HIV and STD Programs (PrEP)	\$4,500,000
Denti-Cal (Medi-Cal program)	People living with HIV	unknown
Office of AIDS	Division of HIV and STD Programs (HIV AIDS Surveillance)	\$1,860,734
HOPWA (Formula Award)	City of Los Angeles	\$13,700,201
HOPWA (Permanent Supportive Housing)	City of Los Angeles	\$1,501,500
Medi-Cal (Fee for Service only)	People Living with HIV	\$192,105,486
Office of Minority Health	Children’s Hospital Los Angeles	\$375,000
SAMHSA – Center for Mental Health Services	Southern California Health & Rehabilitative Program	\$400,000
SAMHSA – Center for Substance Abuse Prevention	7 directly funded organizations	\$2,019,370
SAMHSA – Center for Substance Abuse Treatment	15 directly funded organizations	\$8,266,038
State of California	City of Long Beach	\$2,464,530
Tobacco Master Settlement Funds	Substance Abuse Prevention and Control (Needle Exchange Program)	\$500,000
Los Angeles County	Substance Abuse Prevention and Control (Early Intervention Services)	\$5,000,000
Los Angeles County Net County Cost	Division of HIV and STD Programs	\$17,800,000
City of Los Angeles	Various subcontracted organizations	\$935,000
City of Pasadena	City of Pasadena	\$408,000
City of West Hollywood	Various subcontracted organizations	\$1,672,729
HRSA Bureau of Primary Care	38 Section 330 Grantees	\$293,376
Gilead Sciences	PrEP Patient Assistance Program	Unavailable
U.S. Department of Veterans Affairs	Greater Los Angeles VA Health System	Unavailable

b. Continuity of HIV Prevention, Care, and Treatment Services in Los Angeles County

Resource Environment

The Commission on HIV and DHSP are responsible for planning the continuum of HIV prevention and care services in Los Angeles County. As part of this responsibility, they conduct various needs assessment activities to understand the extent of need for services, as well as barriers to accessing those services. They also gather as much financial data that is available regarding HIV-related resources to

identify gaps in current resources. They also are responsible for prioritizing and allocating Ryan White Part A and CDC funding to address service gaps, of which DHSP is the grantee.

Los Angeles County has the second largest number of people living with HIV (PLWH) in the United States (U.S.) of any metropolitan area. When compared to all states, the 48,908 PLWH as of December 31, 2014, Los Angeles County ranks fifth in the nation, with an HIV prevalence larger than that of 46 states [8]. Thus, identifying available financial and other resources to meet the service needs of this population is no small task. The complexity of this task has been confounded by numerous legislative changes at the federal level, most prominent of which are: (1) 75%/25% expenditure requirements for core medical and support services respectively resulting from the Ryan White HIV/AIDS Treatment Extension Act of 2009; (2) 75%/25% expenditure requirements for required and recommended HIV prevention services in 2012 as part of the CDC's High Impact Prevention (HIP) strategy; and (3) passage and implementation of the Patient Protection and Affordable Care Act (ACA), which was fully implemented in 2014 nationwide and began in Los Angeles County in 2012.

These legislative changes and their fiscal requirements have had a huge impact on the continuum of HIV services in Los Angeles County over the past six years. In many cases the impact has been positive but in other ways they have been less than positive as PLWH and persons at risk for HIV continue to fall through the deepening cracks of this system. For example, because behavioral health services are usually covered to some degree through public and private insurance, a person with insurance has to first seek treatment through a participating provider. That visit may have a co-payment that is considerable (e.g., \$70 per visit) and becomes in reality unaffordable to someone who may be among the working poor who is working and has insurance but is still low income. Thus, although that person needs mental health treatment, they do not seek it because they cannot afford it in the long term. Accessing mental health treatment through Healthy Way LA, Los Angeles' no cost health care program, or Medi-Cal may be just as difficult. If a person loses their health insurance and becomes Medi-Cal eligible, continuity of care is lost as their private insurance provider does not accept Medi-Cal.

This is the new resource environment that the Commission on HIV and DHSP are grappling with to ensure that there is a safety net for low-income PLWH but also that there are resources available to privately-insured PLWH, whether they have a subsidy or not, for services that are just simply not available in their private system of care (e.g., support groups, non-medical case management to help access medical and social services, benefits specialty that helps someone choose the health plan that will serve him/her best, emergency financial services to help pay for rent when crisis occurs, etc.). The Commission on HIV and DHSP recognize that the system of care needs to employ strategies to diagnose the undiagnosed and engage in care diagnosed PLWH who are out of care.

In an ideal world, the Commission on HIV and DHSP would like to create a continuum of HIV prevention and care services that are available to all PLWH in need of these services. In this ideal scenario, the funding mechanism is invisible to the individual and all structural/organizational barriers have been addressed. Unfortunately, numerous changes at the federal level have made achieving this ideal extremely difficult.

The most current reauthorization of the Ryan White Program in 2009 clearly demonstrates this shift in its title: the Ryan White HIV/AIDS Treatment Extension Act of 2009. The emphasis here on "treatment extension." As one of the requirements of this new legislation, jurisdictions are required, unless a waiver is in place, to spend 75% of Ryan White funds on core medical services and 25% of funds on support services. While at the time, this was not challenging, now that the U.S. has implemented the Patient

Protection and Affordable Care Act, commonly called the Affordable Care Act, this funding requirement for Ryan White services is now out of step with the ACA. Many of the Ryan White core medical services are billable under many public and private insurance programs, including but not limited to ambulatory/outpatient medical care, medical specialty services, oral health services, mental health services, substance abuse treatment, home health care, and medical nutrition therapy. Thus, in this new resource environment, creating a seamless, invisible system for the PLWH accessing these services is challenging.

Coordination of Resources

The following narrative describes some of the ways that the major funding streams interact to ensure a continuum of HIV prevention and care services that are designed to end HIV transmission in Los Angeles County and improve health outcomes of PLWH. This is not an exhaustive list but serves as an example.

Ryan White Resources (All Parts):

- **Part A:** Ryan White Part A funds are an integral part of Los Angeles County's safety net of services targeting PLWH at all stages of the HIV Care Continuum. All Ryan White funds are used as 'payer of last resort' and are designed to fill the gaps where other resources are insufficient or do not exist at all. The Commission on HIV conducts an annual priority setting and resource allocation process in which they review existing and anticipated funding from all other public and private sources, including other Ryan White funds (Parts B, C, D, and F). DHSP manages funds from local, state, and federal sources to avoid duplication. Client eligibility screening for Ryan White services is entered into Los Angeles County's current Ryan White client database (i.e., Casewatch). This client-level data system enables service providers to ensure that Part A funds are used as a last resort. Using non-medical case management funding, Los Angeles County funds "Benefits Specialty" services, which help PLWH identify the non-Ryan White resources for which they are eligible.
- **Part B:** Part B base grant funds, managed by the California Office of AIDS (OA), have historically supported four programs. Base funds also supplement ADAP funding, another Part B program. Los Angeles County receives a small amount of Part B funding and the Commission on HIV allocates Part A and Part B funds together through its annual priority and allocation process.

Part B-AIDS Drug Assistance Program: Part B ADAP funds, administered by the California OA, are a critical source of funding to help pay for HIV-related medications.

Part B-Health Insurance Premium Payment (OA-HIPP) program: The OA-HIPP program pays health insurance premiums, deductibles, share of cost, and co-payments for eligible PLWH. If fully leveraged, OA-HIPP has the potential to provide health insurance to all PLWH who live below 500% FPL who are enrolled in ADAP, including undocumented persons. The OA-HIPP program requires that all PLWH who apply for health insurance through Covered California apply for the federal subsidy under the Applied Premium Tax Credit. This is not a requirement for PLWH who apply for health insurance outside of Covered California. Dental care and vision care can also be paid for by OA-HIPP if they are part of the health plan selected by the individual. The program will pay up to \$1,700 per month for enrolled PLWH. Thus, an uninsured PLWH has access to comprehensive health insurance coverage. If fully leveraged, the OA-HIPP program has the potential of dramatically reducing the number of uninsured PLWH in Los Angeles County. However, due to the complexity of the program requirements, benefits

specialists are needed to help PLWH fully understand all their options in order to make the best choices.

- Part C-Early Intervention Services (EIS): HRSA provides Part C-EIS funds to 12 organizations throughout Los Angeles County (Appendix A). As many of these organizations also receive Part A funds, DHSP requires that they allocate Part C and Part A resources individually for services supported by both funding streams, and they are required to provide detailed budgets for each to prevent overlap. Part C EIS funds provide comprehensive outpatient primary health care to PLWH. Appropriate use of Part C funds includes: HIV counseling and testing; monitoring of disease progression; treatment of HIV; diagnosis and treatment of related infections; and case management and assistance accessing other Federal, State, and local programs that could provide needed health and support services to people living with HIV/AIDS.
- Part D: Women, Infants, Children, and Youth: HRSA directly-funds three organizations in Los Angeles County to provide Part D services targeting women, infants, children, and youth (Attachment A). Part D funds can be used similarly to Part A and C funds with the difference being the intended target population of women, infants, children, and youth. Similar to Part C, the three organizations funded for Part D also receive Ryan White Part A funding. DHSP requires that funding allocations and services delivered are tracked separately to ensure there is no duplication.
- Part F – Dental Reimbursement Program: HRSA directly funds two major dental schools in Los Angeles County: (1) USC School of Dentistry and (2) University of California, Los Angeles School of Dentistry. Both schools also receive Part A funding for oral health services. Similar to Part C and Part D-funded organizations, DHSP requires that Part A and Part F funds do not duplicate services.
- Part F – AIDS Education and Training Center (AETC): The Los Angeles office of the Pacific AETC provides a wide variety of training and education to healthcare providers (Attachment A). DHSP and the Commission on HIV collaborate with the AETC in training sessions, conferences, and consultations on various topics, including but not limited to viral resistance testing, mental health, and ACA-related consumer education. DHSP and the Commission on HIV plan on working closely with the AETC to educate providers about PrEP, National HIV AIDS Strategy Update to 2020 (NHAS), and the HIV Care Continuum initiative as part of its work over the next five years (Attachment A).

Centers for Disease Control and Prevention (CDC):

- DHSP CDC Funds: Los Angeles County is one of 12 metropolitan areas in the country to be directly-funded by CDC for HIV and STI prevention services. CDC-funded services include targeted and routine rapid HIV testing, health education and risk reduction (risk reduction activities), condom distribution, partner services, social marketing, outreach, HIV and STI surveillance, and biomedical interventions including non-occupational post-exposure prophylaxis (nPEP) and PrEP. DHSP implements CDC-funded partner services and social network testing at Ryan White-funded medical outpatient sites to identify undiagnosed infections. Routine testing supported by CDC funds is in place at primary care sites to promote direct linkage into affiliated Ryan White care clinics. These efforts help identify undiagnosed PLWH and increase awareness of services available in their communities. The Commission on HIV serves as

the planning body for both Ryan White and CDC funding. They coordinate services with the common goals described in the NHAS Update to 2020.

- Directly-Funded Community-Based Organizations: The CDC directly-funds 8 Community Based Organizations (CBOs) to conduct outreach, HIV prevention, HIV counseling and testing, linkage to care and other services (Attachment B). When DHSP contracts its CDC funds, it ensures that the services provided do not duplicate a CBO's CDC-funded program. Organizations are required to identify other funds during the application process and describe how funds are used differently (e.g., may be different target populations, different service areas, different services provided, etc.).

Housing Opportunities for Persons with AIDS (HOPWA):

- The City of Los Angeles is the grantee for the U.S. Department of Housing and Urban Development (HUD) HOPWA program. Funding for this program is predominantly formula based and is coordinated through the Los Angeles Housing + Community Investment Department (LAHCID). The City of Los Angeles subcontracts HOPWA funds to 28 organizations countywide. Locally, HOPWA funds are used for housing placement, housing assistance, housing specialists, informational services, and housing supportive services. Rental assistance for PLWH is coordinated through four housing authorities (County of Los Angeles, City of Los Angeles, City of Long Beach, and City of Pasadena). The lack of affordable housing in Los Angeles County is a significant challenge for PLWH, especially those who are low-income. DHSP and the Commission on HIV coordinate with the City of Los Angeles' HOPWA administrator to reduce duplication of services. The City of Los Angeles HOPWA program has a representative on the Commission on HIV who provides updates on HOPWA activities to assist planning council members in their coordination and allocation decisions. In Fiscal Year 2015-2016, the HOPWA program reported serving 867 total households through its four major programs: (1) short-term rent, mortgage, and utility assistance payments; (2) tenant-based rental assistance; (3) units provided in transitional housing; and (4) units provided in permanent housing.

Los Angeles County Net County Cost (NCC)

- Los Angeles County contributes significantly to HIV services annually. The contribution includes funding for the County clinics and DHSP. DHSP uses NCC funds across the HIV care continuum for HIV prevention, screening/diagnosis, care and treatment. Although the Commission on HIV does not plan or allocate NCC funds, information about how NCC funds are allocated and expended is shared with the Commission on HIV so they have a more complete picture about resources available to make their Ryan White Part A/B allocation decisions.

Health Insurance Marketplace under ACA

- According to the ACA provision, individuals with an income up to 400% federal poverty level (FPL) are eligible for subsidies to purchase insurance coverage through exchanges. The exchange marketplace in California is called *Covered California*. The insurance plans available under Covered California in Los Angeles County include: HealthNet, Anthem, Molina Healthcare, L.A. Care, Blue Shield, and Kaiser Permanente. Enrollment through the exchanges is available annually during the scheduled open enrollment period. It is available year-round for individuals who qualify under a significant life event (e.g., losing health coverage either from their job or

Medi-Cal, income changes, turning 26 years old, and changing residency, which also includes individuals released from jail or prison).

DHSP and the Commission on HIV have worked with various stakeholders to ensure Ryan White services appropriately support the primary health care services available through these exchanges for populations with different levels of income and coverage. This includes surveying RW providers to identify the marketplace insurance plans with which they have contracted, as well as discussions with the California OA regarding its health insurance premium program, OA-HIPP. Both the Commission and DHSP continue to monitor transition for coverage issues as part of the ongoing discussions on how best to use RW funding to close gaps in services as well as during the annual priority setting and resource allocation process.

The health plans available through Covered California continue to change. In some parts of the country, health insurance companies have withdrawn from some or even all marketplace plans. Although these changes have not yet hit Los Angeles County to such a dramatic degree, they need to be monitored closely in order to ensure that PLWH do not lose coverage. Careful coordination with the OA-HIPP program will help ensure that OA-HIPP eligible PLWH are able to purchase a more comprehensive plan (e.g., Platinum vs. Bronze), maximizing the quality of the benefit they receive.

Medi-Cal and Denti-Cal (California's Medicaid Program)

- California is a Medicaid Expansion state under the ACA. The federal Medicaid Program is administered by the State of California Medi-Cal Program. DHSP contracts require service providers to assess each client's eligibility for Medi-Cal. Since 2011, seniors and people with disabilities have enrolled in Medi-Cal managed care plans through California's early Medicaid expansion effort. Since January 2014, Medi-Cal patients have been transitioned to one of two insurance plans: L.A. Care or HealthNet.
- California reinstated basic adult dental benefits through the Denti-Cal program effective May 1, 2014. Basic benefits include the following services:
 - initial oral examinations, radiographs/photographic images, prophylaxis and fluoride treatments;
 - amalgam and composite restorations;
 - prefabricated stainless steel, resin and resin window crowns;
 - anterior root canal therapy;
 - complete dentures, including immediate dentures; and
 - complete denture adjustments, repairs, and relines.

Medicare and Medicare Part D

- Medicare provides limited health coverage to U.S. citizens or legal residents age 65 and older and people with disabilities who have received Social Security Disability Insurance for two years. Because of its limited coverage, Medicare alone does not provide sufficient health care, particularly for people living with HIV/AIDS. DHSP and the Commission monitor state demonstration projects to integrate care delivery and financing for individuals dually eligible for

Medicaid and Medicare services to assess the impact on the Ryan White population and the corresponding service delivery system.

Federally Qualified Health Centers and FQHC Look-Alike Centers

- There are 48 FQHCs in Los Angeles County serving low-income individuals and families. Although several of them were former HIV medical clinics that became FQHCs in recent years, the majority do not provide HIV specialty services. They provide HIV testing and referral for treatment. In 2014, FQHCs and Look-Alikes served 7,172 PLWH. The Section 330 legislation that governs these programs requires that they offer a comprehensive set of services to patients. Largely, FQHCs and Look-Alikes are an untapped resource for HIV specialty care and may be an important vehicle through which to expand HIV services. As the estimated 7,196 undiagnosed HIV positive individuals are diagnosed and brought into care and the estimated 13,745 diagnosed PLWH who are out of care are linked to care, there will be a critical need to expand the availability of HIV medical care. FQHCs also provide an untapped resource for increasing PrEP uptake among high-risk individuals. FQHCs by their nature are located in medically underserved regions, often in areas of high poverty, low educational attainment, and unemployment. As a result, they have accessibility to high risk populations and communities.

c. HIV Workforce Capacity in Los Angeles County

With the second largest metropolitan HIV epidemic in the nation, and fifth among all states, the magnitude of Los Angeles County's HIV prevention and care workforce is immense and includes a full array of job positions (e.g., physician, nurse practitioner, nurse, HIV test counselor, linkage to care coordinator, patient navigators, nurse case manager, PrEP navigator, dentist, mental health counselor, substance abuse counselor, benefits counselor, and so on). The question of workforce capacity can be examined through multiple lenses, including the enumeration of the workforce by job classification/position to identify where there are vacancies, challenges with turnover, anticipated retirement, etc. A dedicated study would need to be conducted to complete such an analysis. However, another critical lens relates to the skill level of the current workforce and whether or not they have the current and emerging skills needed to facilitate access to and engagement in the full continuum of HIV prevention and care services of the populations most impacted by HIV. This is especially important as biomedical interventions such as PrEP and nPEP have an increasing role in ending HIV transmission, as well as ensuring the PLWH are accessing the full array of services they need to support their retention in care and treatment adherence.

Black AIDS Institute Study

In 2013, the Black AIDS Institute (BAI), located in Los Angeles County, conducted the first national survey of knowledge, attitudes, and beliefs of the HIV workforce. The report begins:

The scientific evidence is clear. As a result of the extraordinary advances in biomedical research, we now have the tools we need to end the HIV epidemic in the United States. However, biomedical tools, even the most powerful ones, are only effective if they are used by those who need them [51].

The overall findings of the survey both nationally and in Los Angeles County found that the HIV workforce is not sufficiently knowledgeable about biomedical interventions and HIV treatments to end

HIV. Both Los Angeles County and the U.S. HIV workforce scored a “D” on their individual report cards. Knowledge increased among persons with higher education as well as longer time working in the field of HIV. Black/African American respondents overall had poorer knowledge.

Table 22 presents the overall score for Los Angeles County HIV workforce respondents by knowledge category. As seen, in all but one category, Los Angeles County has poorer scores than the U.S. overall. As noted, Blacks/African Americans and Latinos/Hispanics have the poorest scores.

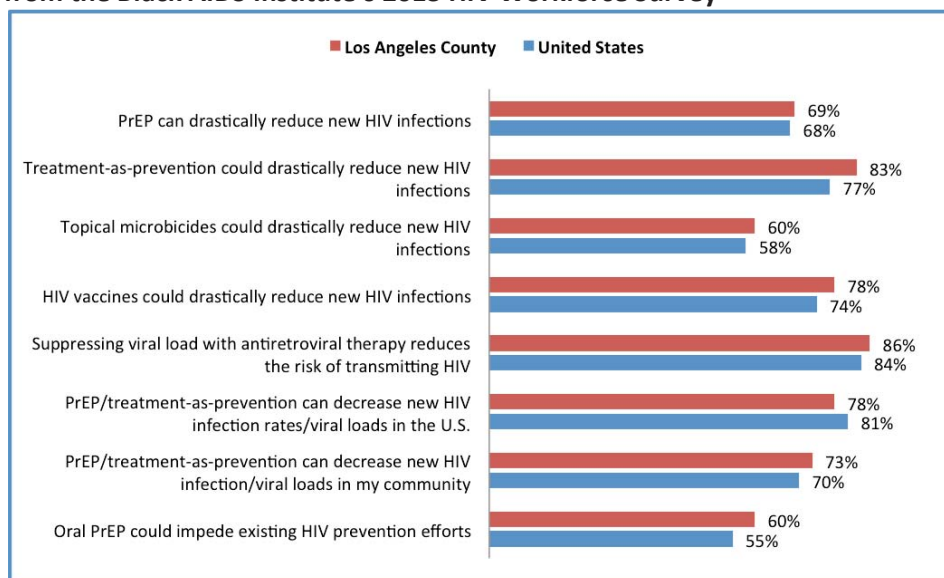
Table 22. Knowledge Scores, Los Angeles County, California by Race/Ethnicity Compared to United States and Los Angeles County Responses Overall

Race/Ethnicity and Total Number of Respondents	All Questions	Basic Knowledge & Terminology	Treatment	Clinical Knowledge (Biomedical Interventions)
United States	62%	71%	56%	49%
Los Angeles County Overall	61%	73%	54%	45%
Black/African American (n=54)	54%	63%	47%	47%
Latino/Hispanic (n=41)	62%	72%	59%	44%
White (n=50)	67%	75%	63%	52%

Source: Black AIDS Institute, 2015

The BAI also assessed the HIV workforce’s ‘familiarity’ with biomedical interventions. An extremely low proportion of Los Angeles County HIV workforce respondents stated that they were either “extremely familiar” or “very familiar” with a specific intervention: PrEP (37%); topical microbicides (23%); HIV vaccines (24%); and treatment as prevention (42%) [51]. In terms of their beliefs regarding the effectiveness of biomedical interventions, a larger proportion of the Los Angeles County HIV workforce respondents stated that they either “strongly agree” or “somewhat agree” with their effectiveness. Figure 37 presents the results of these questions for Los Angeles County respondents compared to the U.S.

Figure 37. Belief in Bio-Medical Interventions, “Strongly Agree” and “Somewhat Agree”, Responses from the Black AIDS Institute’s 2013 HIV Workforce Survey



Source: Black AIDS Institute, 2015

As seen, in comparison to their level of familiarity, Los Angeles County respondents have a stronger level of belief about bio-medical interventions. However, their beliefs were not always aligned with each other, suggesting the influence of a lack of information. For example, 69% of Los Angeles County respondents stated that they believed that PrEP can drastically reduce new HIV infections. Yet, 60% of Los Angeles County respondents stated that they believed that oral PrEP could impede existing HIV prevention efforts.

The need for educating Los Angeles County's HIV workforce is urgent, and vital to the success of the implementation of this plan. The expansion of PrEP and thorough understanding of 'treatment as prevention' underpin many of the activities outlined in the implementation plan (Attachment C). Only 54% of Los Angeles County respondents stated that they believed that they had the "proper knowledge/training to advocate for my community about PrEP" and 66% believed that they had the "proper knowledge/training to advocate for my community about treatment as prevention" [51]. These results, however, are countered by the fact that an overwhelming 92% of Los Angeles County respondents stated that they were "interested in learning about new biomedical prevention methods" [51].

Building this HIV workforce capacity around biomedical and treatment as prevention is the most immediate workforce capacity issue faced by Los Angeles County over the next five years.

d. Additional Resources or Services Needed in Los Angeles County

Pre-Exposure Prophylaxis

The potential of PrEP to curb HIV transmission dramatically is clearly recognized. DHSP estimates there may be as many as 2,000-4,000 high-risk persons accessing PrEP. However, estimates of PrEP need and use in Los Angeles County are built around men who have sex with men (MSM). They are limited in that they exclude other high-risk populations. They also do not estimate PrEP need among MSM by race/ethnicity.

Increasing PrEP uptake is a major element of Los Angeles County's implementation plan (Attachment C) under Goal 1 to reduce new infections and under Goal 3 to reduce disparities. The specific steps needed to increase PrEP are outlined in detail in Attachment C.

Data-to-Care

One of the key resources that Los Angeles County needs to improve the quality of its HIV care continuum data is a robust HIV-surveillance based "data-to-care" program that helps identify diagnosed PLWH who are not in HIV care. Other jurisdictions in the nation, including Seattle, Washington and the States of Colorado and Virginia have found that more than 50% of persons who are considered out of care are actually in care. But for a variety of reasons, they show up in the HIV surveillance system as being out of care. Data-to-care programs help clean up the available data regarding individual persons. This improves the accuracy of the HIV Care Continuum measures, which are being used to inform planning. For PLWH who are truly out of care, the program strives to engage them in care, sometimes for the first time if they have never been in care before. DHSP successfully received funds for this program from the CDC but due to chronic, internal challenges within the Los Angeles County system, DHSP has been unable to hire the additional staff it needs to implement the program.

Los Angeles County is currently reorganizing its operations and will merge DPH and the Department of Mental Health under the Department of Health Services umbrella. DHSP and Commission on HIV members are an active part of this process currently and will continue to be so throughout. It is hoped that as this integration is completed and new organizational charts are

developed, DHSP will be able to hire new staff positions to operate not only a data-to-care program but fill other future programs and/or vacancies.

Support and Wrap-Around Services, including Housing

With the medicalization of HIV under Ryan White Treatment Extension Act of 2009, there was a significant realignment of funded services to address the legislative funding requirements of 75% of Ryan White funds to be used for core services and only 25% for support services. Especially with the ACA and California's expanded Medi-Cal program, Los Angeles County's unmet service needs are more aligned with support service needs that help support long-term retention in care and treatment adherence, which lead to more virally suppressed persons. These needs are clearly articulated in the 2011 Los Angeles Coordinated HIV Needs Assessment (LACHNA-CARE), which represents a subset of PLWH who are receiving Ryan White services.

Los Angeles County is currently in the process of completing and compiling the results of the 2016 LACHNA, which is a population-based sample of all PLWH in Los Angeles County. The results from the 2016 LACHNA will help clarify and understand the specific areas where there are gaps in the current system of care for PLWH.

However, with the implementation of the ACA, medical needs are being met to a much larger degree than ever before. Thus, even though the 2016 LACHNA will update the extent of need for support services in the county, it is expected that the most significant service gaps will continue to be for support services. To address this, Los Angeles County has requested a waiver to the 75% core medical services/25% support services requirement from HRSA that allows the Commission on HIV to allocate a larger proportion of Ryan White Part A resources for support services as needed. In addition to Ryan White funding, DHSP receives funding through Los Angeles County Net County Cost (NCC) funds that are unrestricted. This funding can be used in a fluid manner to address gaps in services, including support services as needed.

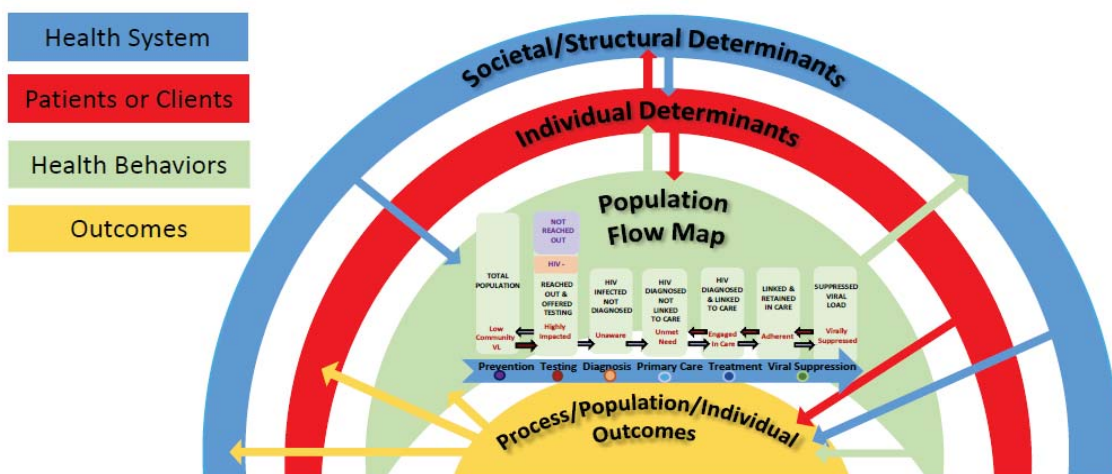
Housing continues to be a challenge for PLWH in Los Angeles County as the cost of housing continues to rise. The HUD 2016 Fair Market Rent in Los Angeles County for a studio/efficiency apartment is \$947 and a one-bedroom is \$1,154 [52]. For the many PLWH who receive supplemental security income (SSI) benefits in Los Angeles County as their sole income source, this means unstable housing or homelessness. The 2016 monthly SSI payment for a person 65 years and older or a disabled person living independently in California is \$889.40. People on Social Security in California are not eligible for the federal Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps. This is key as SSI has to be used to meet basic living needs.

The NHAS Update to 2020 calls for reducing homelessness among PLWH. However, to reduce homelessness effectively, Los Angeles County needs to increase overall housing stability among PLWH. This is also a key strategy outlined in Los Angeles County's implementation plan in Attachment C. Los Angeles County's plan also includes specific activities to coordinate with the four housing continua of care in Los Angeles County as well as the City of Los Angeles' HUD-funded Housing Opportunities for People with AIDS (HOPWA) program to identify gaps. Some of this work has already begun. As part of the FY 2017 priority setting process, the Commission on HIV's Priority, Planning, and Allocations (PP&A) committee discussed the need to expand the scope and/or create new housing-related standards of care to address new ways that Ryan White funds may need to be allocated to address housing gaps (e.g., short-term rent and utility assistance, tenant-based rental assistance), especially for PLWH who do not qualify for HOPWA or HUD's Housing Choice voucher program.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

The Los Angeles County Commission on HIV revised Los Angeles County’s HIV Continuum of Care in 2015 (Figure 38). It is a framework for the delivery of HIV services across the entire continuum of prevention and care. The “population flow map” in the center depicts the specific populations who are at risk for acquiring or transmitting HIV as well as those PLWH who are in need of HIV care services (Figure 39). The arrow beneath the *population flow map* (Figure 40) represents the possible points of intervention where there are opportunities to interrupt HIV transmission, reduce morbidity and mortality, and end stigma and discrimination, in order to improve the health and well being of all PLWH in the county.

Figure 38. Los Angeles County HIV Continuum of Care, Revised 2015



The Revised LAC HIV Continuum of Care is a framework for the delivery of HIV care services. It is built upon a biobehavioral model of healthcare utilization and depicts the interrelationship between the Los Angeles County health care system, the social and individual level determinants of health and the County HIV intervention programs on patient/client health behaviors and the process, population and system level outcomes.

Figure 39. Population Flow Map

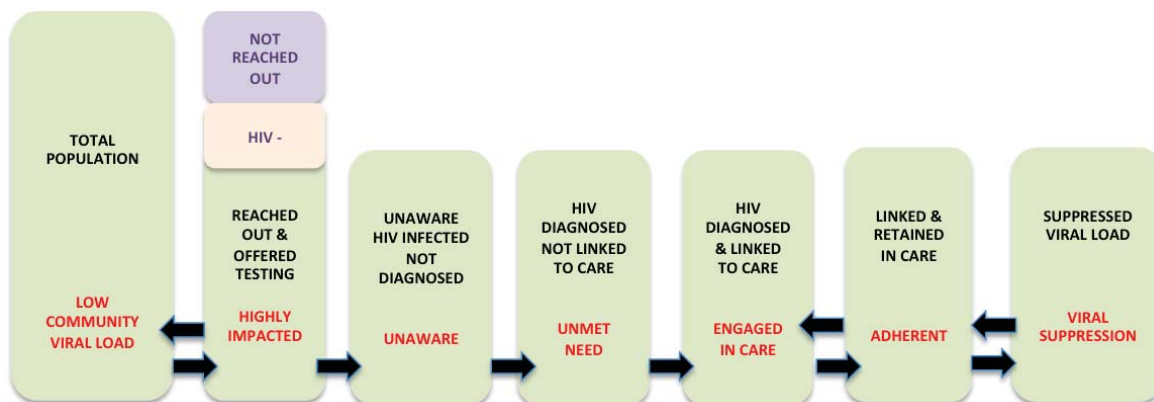


Figure 40. Points of Intervention along the Los Angeles County HIV Continuum of Care



Examining the need for services, as well as gaps and barriers to accessing them, is essential. The following narrative describes service needs, barriers, and gaps through the lens of the populations that comprise the *population flow map* at the possible points of intervention along Los Angeles County’s HIV continuum of care, which is aligned with the national HIV Care Continuum.

a. Process for Identifying HIV Prevention and Care Service Needs of People at Higher Risk for HIV and PLWH

Los Angeles County used multiple methods to assess the needs of persons at higher risk for HIV as well as PLWH. These methods included but are not limited to: review and analysis of numerous data sources, qualitative data for targeted populations through facilitated listening sessions, and:

- (1) Local and national HIV surveillance data, including various reports presenting data from Los Angeles County’s HIV incidence surveillance project and Medical Monitoring Project;
- (2) HIV Care Continuum measures for Los Angeles County by subpopulation;
- (3) Sexually transmitted infection surveillance data;
- (4) Los Angeles County estimated PrEP cascade;
- (5) United States Census Bureau, including the 2014 American Community Survey;
- (6) Behavioral surveillance reports, including the National Behavioral Health Survey and the Youth Behavioral Health Survey;
- (7) HIV testing data for DHSP publicly-funded testing data;
- (8) 2015 Unmet Need report;
- (9) 2013 Ryan White Client Utilization Report;
- (10) An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft; and
- (11) Research studies and reports, particularly related to social determinants of health.

Listening Sessions

To augment the abundant quantitative data available, the Needs, Barriers, Gaps, and Community Engagement workgroup (hereafter ‘Community Engagement Workgroup’) wanted to conduct qualitative ‘listening sessions’ with communities impacted by HIV. They conducted a first listening session with the Commission on HIV members, including the public, who attended the annual meeting of the Commission on HIV in November 2015. After engaging more than 20 providers, PLWH, and community members in a conversation about service needs, barriers, and gaps, the Community Engagement workgroup decided to conduct four formally facilitated listening sessions with four impacted populations. They conducted a brainstorming process to identify populations of interest and prioritize which populations should be assessed first, given time and resource limitations. The first populations selected were those where the group felt they had the least available information. They included: undocumented persons, women of color, aging population 50 years and older, and SPA 1. SPA 1 was selected due to their isolated geographic location from the rest of Los Angeles County and the fact that the Commission on HIV’s Operations Committee was targeting that region to facilitate recruitment of a Commissioner to fill a vacancy. Two additional tiers of listening sessions were planned for subsequent years.

The Community Engagement workgroup worked in concert with Commission on HIV staff to plan and implement the four listening sessions. They engaged the services of California State University Long Beach's (CSULB) Center for Latino Community Health and Leadership Training to facilitate the four sessions. The Commission on HIV and Community Engagement Co-Chairs developed the consent forms, demographic survey, facilitation guide, and listening session questions. The Commission on HIV and Community Engagement Workgroup were responsible for all participant recruitment. Interested individuals registered for the session with the Commission on HIV. A target of 15 participants was established for each session and the Commission on HIV allowed over-registration beyond the 15 in anticipation of no-shows. Although the original intention of the Community Engagement workgroup was to target both PLWH and persons at high risk, the overwhelming majority of participants (92.7%) were living with HIV. A total of 55 participants attended the sessions. Four surveys were excluded from the demographic analysis (3 were HIV negative individuals and one person refused to respond). Trained members of the CSULB team in small group facilitation who were bilingual in Spanish and English conducted and recorded the four sessions. The transcription was completed by a company already contracted with the Commission on HIV for transcription services. CSULB conducted the data cleaning, demographic analysis of respondents, and qualitative analysis of the transcriptions.

The demographic characteristics of 51 listening session participants were predominantly 50 years and older (66.7%); male (47%), female (37%), and transwomen (8%). Their race/ethnicity were Latino/Hispanic (43.1%), Black/African American (27.5%), and White (17.6%).

2011 Los Angeles Coordinated HIV Needs Assessment-Care Services (LACHNA-CARE)

The 2011 LACHNA-CARE is the most current completed needs assessment that Los Angeles County has available for the writing of this plan. Data collection for the 2016 LACHNA is in the final stages of completion. Once complete, DHSP will clean the data and begin the data analysis. Results from the 2016 LACHNA will be included in the first update of this plan in 2017.

The 2011 LACHNA-CARE collected interview data from 450 PLWH, which was a representative sample of the 18,545 Ryan White Part A clients at that time [22]. This data informed planning around the needs of low-income persons. A key limitation is that it is not a population-based sample and cannot be used to describe the needs of all PLWH in Los Angeles County. The highly anticipated 2016 LACHNA is however a population based sample and will be able to be used to describe the needs of all PLWH in the county.

The 2011 LACHNA-CARE final report presents detailed information on self-reported service needs, barriers, and gaps of PLWH receiving Ryan White Part A services. Although this data is limited, it provides the most comprehensive estimate of service needs as reported by PLWH that is currently available. Attachment B: HIV Service Needs by Part A Service Category has been developed to quantify service needs and gaps to aid planning, including the Commission on HIV's annual priority setting and resource allocation process. Limitations of the data are noted in Attachment C as well as potential resources available to address the service needs. The 2011 LACHNA-CARE defines a service gap as the difference between the number/percent of PLWH reporting a need for a service and the number/percent of PLWH reporting that they received the service [22]. Self-reported service needs that were not received are considered to be a gap. The 2011 LACHNA-CARE also presents information on barriers to accessing services. These are categorized into three types of barriers: (1) structural, (2) organizational, and (3) individual. They are defined as follows [22]:

- (1) Structural barriers: included too much paperwork or red tape, or too many rules and regulations;

- (2) Organizational barriers: included service provider was insensitive to my concerns, amount of wait time for an appointment or in the waiting room too long; or the organization provided me with the wrong referrals; and
- (3) Individual barriers: Included I was not aware that a service or treatment was available to me; I was not aware of the location of the service(s); or I did not know who to ask for help.

b. HIV Prevention and Care Service Needs and Gaps of Persons at Risk for HIV and PLWH

Much of the HIV surveillance, socio-economic, and HIV Care Continuum data presented earlier in this section clearly show the populations who are most impacted by HIV and in need of HIV prevention and care services. However, understanding the extent of the need for a specific service is necessary in order to then understand gaps in services and/or barriers to accessing those services. The following discussion is an attempt to measure the extent of need for a service within Los Angeles County. As there are limitations with every estimate, this approach provides a starting point from which planners can build upon and refine.

System Level Needs

Table 23 presents the broad Systemwide needs along the continuum of HIV prevention and care and the rationale supporting the need.

Table 23. System Level Needs, Rationale, and Potential Resources

SYSTEM NEED	RATIONALE	POTENTIAL RESOURCES
1. Stigma reduction	<p>Los Angeles County has long acknowledged the impact of HIV and other stigma (e.g., mental illness, alcohol/substance abuse, homophobia and transphobia) on access to the full spectrum of HIV prevention and care services. It was an objective in the <i>Los Angeles County Five-Year Comprehensive HIV Plan (2013-2017)</i>.</p> <p>Results from the four <i>Listening Sessions</i> held in April/May 2016 clearly show that stigma and fear of discrimination continues to impact the lives of PLWH and those at risk for HIV.</p> <p>MSM, the major population affected by HIV in Los Angeles County, is disproportionately impacted by stigma and discrimination [53]. Transgender individuals also are negatively impacted by stigma and discrimination [54].</p>	<ul style="list-style-type: none"> • Specific funding opportunities • CDC funding • HRSA Ryan White funding • Net County Cost
2. Addressing social determinants of health (SDH)	<p>The CDC has clearly demonstrated a strong association between specific SDH and new HIV infections, specifically poverty, low educational attainment, and unemployment among others [17].</p>	<ul style="list-style-type: none"> • Department of Labor funded workforce centers • Educational institutions • Specific funding opportunities • Net County Cost

SYSTEM NEED	RATIONALE	POTENTIAL RESOURCES
3. Having a medical home	<p>With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, the U.S. acknowledged access to health care as a right of all people versus a privilege.</p> <p>PLWH who are virally suppressed are 94% less likely to transmit HIV to non-infected persons [55].</p> <p>In December 2015, the CDC released a research based RFP (PS16-004) to create interventions to increase access to care among Black MSM both HIV positive and HIV negative [56]. There is growing evidence that the medical home model reduces health disparities [57, 58].</p>	<ul style="list-style-type: none"> • HRSA Ryan White Part A/B/C/D funds for eligible uninsured • Covered California • Private health insurance • Public health insurance

HIV Prevention Needs

The need for HIV prevention services is grounded in the NHAS Updated to 2020 Goal 1: Reduce New HIV Infections [4]. With the U.S. Food and Drug Administration’s approval of the use of the antiretroviral therapy drug Truvada® for PrEP in July 2012, the HIV prevention landscape has changed dramatically. As noted in the Black AIDS Institute’s report, we now have the tools to end HIV [51].

Persons who are in need of HIV prevention services are those who are at higher risk. These populations are described in the Epidemiology Overview and HIV Care Continuum sections of this report. Table 1 presents the demographic characteristics of recently diagnosed persons as a percentage and Table 5 presents Los Angeles County’s estimate of new HIV infections, including the rate per 100,000 population. There populations who are either severely impacted by HIV due to large numbers or disproportionate impact include but are not limited to: Blacks/African Americans (especially MSM and women), American Indians/Alaska Natives, Latinos (especially Latino MSM), transgender persons (especially transwomen), Youth 18-29 years old (especially YMSM). These populations are also those most severely impacted by poverty, low educational attainment, unemployment, and housing instability/homelessness. Halting the transmission of HIV in these populations requires bold actions and new strategies to ensure that high-risk individuals get tested to know their HIV status; have the knowledge, skills, and personal resiliency to protect themselves and others; and have access to PrEP and non-occupational exposure prophylaxis (nPEP) and the necessary education and treatment adherence support to increase the efficacy of these biomedical interventions.

As part of the CDC’s High-Impact Prevention strategy, they have compiled a recommended toolbox of 14 “required” and 10 “recommended” interventions (Table 24). Apart from the first four required interventions, the remaining 10 are built around a “treatment as prevention” strategy and target PLWH. A current requirement of DHSP’s CDC funding is that 75% of funds need to support HIV testing and required interventions and 25% of funds can be used to support recommended interventions. A key intervention missing in this “toolbox” is PrEP, which was approved by the FDA in 2012 and is now a recommended part of the HIV prevention toolbox in accordance with the CDC’s 2015 STD Treatment Guidelines [59]. Another important intervention that has been included in the HIV prevention toolbox for services within the county is needle exchange targeting high-risk PWID. The City of Los Angeles has provided funding for syringe services since 1994 and the County of Los Angeles since 2006. Until January

2016, there has been a ban on using federal funds for syringe exchange. The ban has been lifted in large part as a reaction to the 2015 HIV outbreak among PWID in Scott County, Indiana [60].

Table 24. CDC Required and Recommended Interventions and Los Angeles County’s Intervention Plan

<i>Required Interventions</i>
1. Routine, opt-out HIV screening in clinical settings
2. HIV testing in non-clinical settings
3. Condom distribution prioritized to target HIV positive (HIV+) persons and persons at high risk
4. Provision of [non-occupational] Post-Exposure Prophylaxis (nPEP)
5. Efforts to change existing structures, policies, and regulations that are barriers to optimal care and treatment
6. Linkage to HIV care, treatment and prevention services for those testing HIV+ and not in care
7. Interventions/strategies for promoting retention in or re- engagement in HIV care for HIV+ persons
8. Enforce policies and procedures for ensuring ART provision according to clinical practice guidelines
9. Interventions promoting ART treatment adherence for HIV+ persons
10. STD screening for HIV+ persons
11. Prevention of perinatal transmission
12. Partner services for HIV+ persons
13. Behavioral risk screening and risk reduction for HIV+ persons at risk for HIV transmission
14. Linkage to other medical and social services for HIV+ persons
<i>Recommended Interventions</i>
15. Condom distribution to the general population
16. Targeted HIV and sexual health social marketing
17. Evidence-based clinic-wide prevention interventions
18. Community interventions that reduce HIV risk
19. Behavioral risk screening followed by individual and group-level evidence-based interventions for HIV negative persons at high risk, particularly those in serodiscordant couples
20. Integration of hepatitis, TB, STD testing, partner services, vaccination and treatment for HIV negative persons at high risk
21. Targeted use of HIV and STD surveillance data to prioritize risk reduction and partner services
22. Broadening linkages and provision of services for social factors influencing HIV incidence for HIV negative persons at high risk
23. Brief alcohol screening and interventions for HIV+ persons and high-risk HIV negative persons
24. Community mobilization

Quantifying the need for HIV prevention services is challenging. For some services, such as HIV testing, numbers can be quantified. In 2014, DHSP-funded HIV testing had an overall 1.11% new HIV positive rate (self reported) among the total 151,535 tests conducted in that year [61]. However, this rate ranged by type of testing. Routine testing achieved a 1.28% overall new seropositive rate; targeted testing achieved a 1.07% new positive rate; and Partner Services testing achieved a 2.36% new positive rate [61]. Within targeted testing, social network testing programs had the greatest success, achieving a 2.66% new HIV positive rate, followed by community STD clinics that achieved a 2.34% new HIV positive rate [61]. Estimating a 1% new seropositive rate overall for the county, it will require 720,000 HIV tests countywide to diagnose the estimated 7,196 undiagnosed persons.

However, even this estimate assumes that the existing testing programs are reaching undiagnosed individuals and that all undiagnosed individuals have equitable access to HIV testing. However, there are innumerable barriers that can prevent someone from accessing HIV testing, including but not limited to:

system barriers (stigma), individual barriers (e.g., active substance use, mental illness), and organizational barriers (lack of convenient operating hours/days) among others.

Quantifying the need for PrEP is a current challenge facing Los Angeles County. Kelly et al. developed and applied a PrEP continuum of care for MSM that consists of four categories quantifying the number of persons who are: (1) at risk; (2) aware of PrEP; (3) willing to take PrEP; (4) have access to healthcare; and (5) ensuring adherence to PrEP [62]. Davey et al. (2016) applied this same continuum to a cohort in Los Angeles County and Atlanta, Georgia and found that PrEP awareness was much higher in Black/African American men (89%) compared to Latino/Hispanic men (54%) [63]. Interestingly, they also found that men who reported heavy drinking were more likely to be aware of PrEP (68%) compared to moderate or nondrinkers (42%) [63]. They also found that men who had been tested for HIV within the previous year had a significantly higher perceived access to PrEP (86%) compared to men who had not tested recently (22%) [63].

DHSP has also developed a preliminary PrEP Continuum of Care for MSM in Los Angeles County. The categories along the continuum are nearly the same with an additional category identifying MSM at “very high risk” for HIV. DHSP estimates there are 56,052 MSM at risk for HIV, 9,409 MSM at very high risk, 5,928 MSM aware of PrEP, 5,457 willing to take PrEP, 7,057 with access to healthcare, and 2,000 MSM with a PrEP prescription [64]. In May 2016, DHSP verbally reported a higher estimate of approximately 4,000 MSM accessing PrEP in Los Angeles County [65].

As discussed earlier, 92.7% of HIV transmission is attributed to PLWH who are undiagnosed or diagnosed and not in care [37]. Thus, Los Angeles County needs concerted efforts to diagnose PLWH who are undiagnosed and engage/re-engage into care PLWH who are diagnosed and not in care. As Los Angeles County examines its diagnosed HIV Care Continuum data, they will be able to identify what part of each measure, including viral suppression, can be attributed to PLWH who are not in care. New strategies, including the use of surveillance data, to identify PLWH who are not in care and re-engage them into care need to be implemented. As the majority of PLWH who are not in care are from communities of color (70.3%), it is imperative that programs designed are culturally and linguistically responsive to these communities.

HIV-Related Care Needs

The *Los Angeles Coordinated HIV Needs Assessment* (LACHNA) is an instrumental tool for understanding HIV care-related needs among PLWH. This survey targets PLWH to obtain self-reported information on their service needs that support engagement and retention in care services, as well as viral suppression. It augments other available need data. The most current LACHNA is from 2011 and targets Care services only (2011 LACHNA-CARE).

Since the inception of the Ryan White Program, HRSA has funded a comprehensive set of medical and related services targeting low-income PLWH. The most recent list of services allowed under the Ryan White Program for Part A and B funding was clarified by HRSA in February 2016 [66]. Tables 25 and 26 present the list of Ryan White Core Medical Services and Support Services and their corresponding Los Angeles County service category(ies).

Although these services are not an exhaustive list of potential areas of need, they serve as a starting point for examining need. The 2011 LACHNA-CARE assessed the needs of PLWH for most of these services. Attachment B presents a quantified baseline assessment of service need and service gaps for PLWH in Los Angeles County. In most categories, the percentage of PLWH who reported a need for that

service, as well as PLWH who identified a gap in the service (i.e., defined as a person who needed a service but did not receive it) is applied to the total number of PLWH receiving Ryan White Part A/B services as reported in the *County of Los Angeles HIV Care and Treatment Service Utilization 2013 Year-End Report* [21] to determine an actual number of PLWH needing and not receiving each service. This method represents a new approach for quantifying needs and gaps to support evidence-based planning.

Table 25. Ryan White and Los Angeles County Core Medical Service Categories

HRSA Ryan White Core Medical Services	Los Angeles County Service Category
Outpatient/Ambulatory Health Services	Medical Outpatient; Medical Specialty
AIDS Drug Assistance Program Treatments	No current equivalent (funded through State OA)
AIDS Pharmaceutical Assistance	Medication Assistance and Access
Oral Health Services	Oral Health Care
Early Intervention Services (EIS)	Early Intervention Program Services
Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals	No current equivalent (funded through State OA)
Home Health Care	Home-Based Care
Home and Community-Based Health Services	Home-Based Care
Hospice Services	Long-Term and Palliative Care
Mental Health Services	Mental Health Services
Medical Nutritional Therapy	Medical Nutrition Therapy
Medical Case Management, including Treatment Adherence Services	Medical Care Coordination
Substance Abuse Outpatient Care	Substance Abuse Services

Table 26. Ryan White and Los Angeles County Support Service Categories

HRSA Ryan White Support Services	Los Angeles County Service Category or Standard of Care
Case Management (non-medical)	Linkage Services Benefits Specialty Transitional Case Management
Child Care Services	Child Care Services
Emergency Financial Assistance	Direct Emergency Financial Assistance
Food Bank/Home Delivered Meals	Nutrition Support
Health Education/Risk Reduction	Treatment Education
Housing Services	Housing Case Management Services Residential Care and Housing
Legal Services	Legal Services Permanency Planning
Linguistic Services	Language Interpretation Services
Medical Transportation Services	Transportation
Outreach Services	Linkage and Re-engagement
Psychosocial Support Services	Peer Support
Referral for Health Care and Supportive Services	Referral Services
Rehabilitation Services	No current equivalent
Respite Care	Respite Care
Substance Abuse Services (residential)	Residential Substance Abuse Services

When results of the 2016 LACHNA are complete, this section will be updated using that data, which by design will be generalizable to all PLWH in Los Angeles County. Table 27 presents a summary of the needs and gaps that are detailed extensively in Attachment B, including limitations of the data and potential resources that can be used to address the gaps identified.

It is important to note that there have been important changes in the healthcare delivery system since the 2011 LACHNA-CARE was completed. Most notable is the full implementation of the ACA. Many more PLWH have been able to enroll in California’s expanded Medi-Cal program, and others, including those eligible for subsidies, enrolled in marketplace health insurance programs offered through Covered California. The estimate of gap is based on the service delivery system in 2011 and not the current service delivery system. The 2016 LACHNA data will provide a critical update to these estimates.

The core medical services listed below are the most likely to be covered through public and/or health insurance with a few exceptions. The exceptions are: Early Intervention Program, Health Insurance Premium Payment, Home & Community Based Health Services, and Medical Care Coordination (aka Medical Case Management).

Table 27. Estimate of Core Medical Service Needs and Gaps (Summary of Attachment B)

Core Medical Services	Estimate of Need (number of PLWH)	Estimate of Gap (number of PLWH)
Medical Outpatient Services	48,908	13,745
Medical Specialty Services	7,054	2,249
AIDS Pharmaceutical Assistance	48,908	16,286
Oral Health Care	48,908	6,202
Early Intervention Program	7,196	7,196
Health Insurance Premium Payment	4,515	2,140
Home Health Care	1,414	725
Home & Community Based Health Services	762	326
Hospice	526	363
Mental Health – Psychotherapy	5,567	2,049
Mental Health – Psychiatry	8,178	1,632
Medical Nutrition Therapy	9,865	3,427
Medical Care Coordination	1,777	562
Substance Abuse Services, Outpatient	2,049	762
Substance Abuse Services, Methadone	399	73

Note: Estimates are largely derived using the 2011 LACHNA-CARE estimate of need, which is not reflective of all PLWH and must be interpreted with caution.

Table 28 presents the estimate of service need and gaps for HIV-related support services. Support services play a critical role in helping PLWH initially link to HIV medical care, engage and be retained in care, which leads to viral suppression. For the most part, these services are unique to the Ryan White Program and not covered by health insurance with a few exceptions (i.e., rehabilitation services, which include physical/occupational/speech therapy and substance abuse residential services). As discussed earlier, the HIV Care Continuum outcomes of PLWH accessing Ryan White services are significantly higher than the county averages. Support services play a critical role in mitigating barriers to accessing care and treatment. This is especially important in communities of color and other populations that experience significant disparities in HIV-related health outcomes. These populations are those that are also most severely impacted by social determinants of health, including but not limited to poverty, low

educational attainment, unemployment, and lack of health insurance. These populations experience inequities in all aspects of their lives, including health.

Table 28. Estimate of Support Service Needs and Gaps (Summary of Attachment B)

Core Medical Services	Estimate of Need (number of PLWH)	Estimate of Gap (number of PLWH)
Psychosocial Case Management	14,471	1,886
Transitional Case Management – Criminal Justice	1,088	363
Transitional Case Management – Youth	798	326
Child Care Services	326	127
Direct Emergency Financial Assistance	4,552	3,627
Nutrition Support – Food Bank	10,717	3,591
Nutrition Support – Home delivered meals	2,212	1,161
Health Education/Risk Reduction	3,500	1,414
Treatment Education	2,539	1,578
Housing Services – Rental Assistance	8,831	5,077
Housing Services – Housing Case Management	5,767	2,738
Housing Services – Transitional Housing	2,865	1,324
Housing Services – Permanent Supportive Housing	2,412	1,741
Housing Services – Emergency Shelter	2,013	1,088
Housing Services – Residential Care Facility	762	490
Housing Services – Transitional Residential Care Facility	725	326
Housing Services – Skilled Nursing	562	363
Legal Services	1,886	1,450
Language Interpretation Services	725	363
Transportation Services – Bus Pass	12,404	3,192
Transportation Services – Bus Voucher	4,751	1,813
Transportation Services – Taxi Voucher	4,189	2,539
Outreach	20,941	20,941
Peer Support	5,767	1,777
HIV LA Directory	5,005	2,013
Referral Services	1,977	889
Rehabilitation Services (e.g., physical/speech therapy)	1,451	762
Respite Care	490	236
Substance Abuse Services, Residential	1,650	526
Workforce Entry / Re-Entry (not a HRSA category)	2,013	1,578

Note: Estimates are largely derived using the 2011 LACHNA-CARE estimate of need, which is not reflective of all PLWH and must be interpreted with caution.

As reported in the 2011 LACHNA-CARE, the need for services varies across different population groups. Tables 29 and 30 present the top ranked needed services for all PLWH, by race/ethnicity, and by selected sub-populations: Youth, Transgender Persons, Currently Homeless, and PWID (i.e., IDU).

What is interesting in both groups, the top five needed services are shared by all but two populations (i.e., Whites and Transgender Persons have slightly different prioritized service needs), albeit in varying order of priority. Two of the top five needed services are support services: psychosocial case management, which is intended to help PLWH access other medical and social services, and medical transportation services. The other top three services are core medical services: medical outpatient care, oral health care, and ADAP.

Table 29. Top Ranked Service Needs Reported by PLWH in the Ryan White System of Care for All Respondents and By Racial/Ethnic Group (2011 LACHNA-CARE)

Need(s)	Ranking by Population Group				
	All (n=450)	White (n=93)	Latino/Hispanic (n=213)	Black/African American (n=107)	Other ¹ (n=30)
Medical outpatient care	1	1	1	1	1
Oral health care	2	7	5	2	2
Psychosocial case management	3	4	2	3	4
AIDS Drug Assistance Program	4	2	3	5	3
Medical Transportation-bus passes	5	--	4	4	5
Nutrition Support-Food Bank	6	6	8	6	6
Medical Nutrition Therapy	7	10	7	8	9
Rental Assistance	8	8	10	7	--
Mental Health, Psychiatry	9	5	6	9	8
Medical Specialty	10	--	9	--	7
Counseling and testing in care settings	--	3	--	--	--
Health education/risk reduction		9	--	--	--
Housing Case Management	--	--	--	10	--
Local pharmacy program/drug reimbursement		--	--	--	10

¹ Respondents identified as Asian and Pacific Islander, American Indian/Alaska Native, or Mixed Race. Numbers for each group are too small for analysis by themselves.

-- indicates service was not in top 10 services with a gap and gaps not identified in the final LACHNA-CARE report.

Bold indicates a Ryan White Core service

Table 30. Top Ranked Service Needs Reported by PLWH in the Ryan White System of Care for All Respondents and Selected Subpopulations (2011 LACHNA-CARE)

Need(s)	Ranking by Population Group				
	All (n=450)	Youth (n=31)	Transgender Persons (n=32)	Homeless (n=54)	PWID (n=32)
Medical outpatient care	1	3	1	1	1
Oral health care	2	1	2	3	2
Psychosocial case management	3	2	3	2	3
AIDS Drug Assistance Program	4	4	8	5	5
Medical Transportation-bus passes	5	5	4	4	4
Nutrition Support-Food Bank	6	--	5	6	6
Medical Nutrition Therapy	7	7	6	8	7
Rental Assistance	8	6	7	--	9
Mental Health, Psychiatry	9	--	9	7	10
Medical Specialty	10	--	--	--	--
Housing Case Management	--	8	--	10	8
Medical Transportation-bus tokens	--	9	--	--	--
Peer Support	--	--	10	--	--
Transitional Housing	--	--	--	9	--

-- indicates service was not in top 10 services with a gap and gaps not identified in the final LACHNA-CARE report.

Bold indicates a Ryan White Core service.

Table 31 presents an overall summary of service needs among persons represented on the Population Flow Map (Figure 39).

Table 31. Service Needs of Populations Represented on the Population Flow Map

Service Need	Total Population	Highly Impacted	Unaware	Unmet Need	Engaged in Care	Adherent (Retained)	Virally Suppressed
System Level							
• Stigma reduction	x	x	x	x	x	x	x
• Addressing social determinants of health	x	x	x	x	x	x	x
• Having a medical home	x	x	x	x	x	x	x
Prevention							
• Outreach		x	x	x	x	x	x
• Behavioral interventions (i.e., successful approaches)		x	x	x	x	x	x
• PrEP/nPEP – education and treatment		x					
• HIV/STI Partner Services		x	x	x	x	x	x
• Condom distribution	x	x	x	x	x	x	x
• Syringe exchange/disposal	x	x	x	x	x	x	x
• Social marketing (e.g., traditional, social media)	x	x	x	x	x	x	x
Testing							
• Routine	x	x	x				
• Targeted (e.g., social network testing)		x	x				
• Co-morbidity (e.g., other STIs, viral hepatitis)		x	x				
• Referrals as needed (both HIV negative and positive)		x	x				
Diagnosis							
• Linkage to care (including peer based)			x				
• Mental/emotional support			x				
Primary Care							
• Engagement/Re-engagement			x	x			
• Benefits counseling and enrollment					x	x	x
• Referrals for other medical and social services					x	x	x
• Services and/or care coordination					x	x	x
• Oral health care					x	x	x
• Ciswomen/Cismen/Transgender health services					x	x	x
• Primary care related to other chronic conditions					x	x	x
• Medical Care Coordination (MCC) for high acuity patients					x	x	x
Treatment							
• Antiretroviral therapy (ART) prescription					x	x	x
• Treatment for STIs, other health conditions					x	x	x
• Treatment adherence support					x	x	x
Retention and Viral Suppression							
• Housing stability (e.g., rental assistance, emergency financial assistance, housing case management, etc.)					x	x	x
• Mental/emotional health services					x	x	x
• Alcohol/substance disorder services					x	x	x
• Wrap-around supportive services (e.g., nutrition support, medical transportation, peer support, etc.)					x	x	x
• Services coordination (e.g., case management)					x	x	x

c. Barriers to HIV Prevention and Care Services

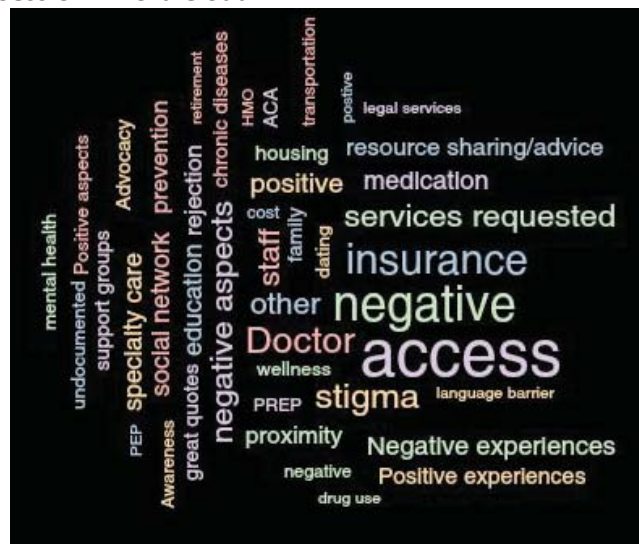
i. Social and structural barriers (e.g., poverty, cultural barriers, stigma, etc.)

As Buchbinder and Loi (2016) note, “stigma contributes to risk behaviors and HIV acquisition across populations,” [67] Thus, it is imperative that Los Angeles County take radical action to understand stigma better from those populations most affected by it, including but not limited to communities of color (especially Black/African Americans, Latinos/Hispanics, and American Indians/Alaska Natives), transgender persons, and PWID. Only then will Los Angeles County be able to design and implement programs that address stigma directly. Lastly, as youth and young adults, especially 18-29 years old, are disproportionately represented among new HIV diagnoses, it is vital that all prevention programming be developmentally tailored to address the needs of this population [11]. Members of the target population(s) need to be involved in the planning and design of services that target them to mitigate the barriers that prevent these populations from accessing prevention and/or care services. DHSP and the Commission on HIV need to advocate for the use of federal funding to support innovative and creative responses to the epidemic. For example, the CDC has clearly identified that there are higher new HIV diagnoses in communities that are poor. As poverty level increases within a census tract, so do HIV diagnoses. Thus, a creative response to prevent HIV may involve the implementation of a multi-pronged approach that addresses poverty and its causes (e.g., low educational attainment, unemployment).

ii. Federal, state, or local legislative/policy barriers (e.g., the changing health care coverage landscape, policies on HIV testing or lab reporting, etc.)

Although the ACA, including California’s expanded Medi-Cal program, increased access to insurance for PLWH, it also has created difficulties in accessing services due to the increased complexity of the insurance system. PLWH who participated in one of four “listening sessions” targeting four different subpopulations (i.e., undocumented persons, women of color, aging PLWH 50 years and older, and SPA 1: Antelope Valley) all described the complexity of insurance and challenges in accessing services [67]. Figure 41 depicts the “word cloud” developed through the qualitative analysis of the listening sessions. A word cloud is a visual representation of words used during the listening sessions, and the size of the word depicts its relative frequency. As noted in the final report, “the two topics most central to the discussions were access to services and insurance issues, with stigma being the third theme raised most often” [68].

Figure 41. Listening Session “Word Cloud”



One participant in the Aging Listening Session described his experience and frustration with the insurance system. He states:

“... the paperwork is astoundingly uninformative, this piece of paper, and once... it says it’s talking about A, but it’s really talking about Z, and then wanting to do D, and you call to find out what’s going on, and then you get someone who’s an answering service to forward the call and no one has anything and I’m one of the most persistent people in... my therapist says I’m at the top of the list, and if I’m frustrated and having an issue, I can’t even imagine how difficult it could be with someone dealing with this who, does not have the time, or gets tired and fed up”(Aging Participant) [68].

Continuity of care may also be challenging in this environment, especially for PLWH who lose an employer’s insurance and enroll in a Medi-Cal plan or vice versa. If his/her medical provider does not accept Medi-Cal, then the PLWH is required to change providers, potentially disrupting a valued, long-term relationship. PLWH participants in the Goals, Objectives, and Monitoring Work Group noted the challenges of PLWH trying to access mental health and substance disorder services. Ryan White can only pay for services that are not billable. The Work Group identified the need to develop a more coordinated system around mental health and substance disorder services to ensure that PLWH are able to get the treatment they need.

Given that 92.7% of new HIV infections are attributed to PLWH who are undiagnosed or out of care, priority needs to be given at a federal level to finding these individuals, linking them to, and engaging them in care and then providing the necessary support services to increase retention and viral suppression. Support services such as outreach, non-medical case management, psychosocial support, housing, etc. are critical for improving retention.

iii. Health department barriers (e.g., political landscape, staff capacity, etc.)

DHSP currently is unable to add new positions to its department to facilitate implementation of key activities, including but not limited to a robust linkage and reengagement program, including Data-to-Care that utilizes HIV surveillance data to identify PLWH who are not in care to link or re-engage them into care. In addition, Los Angeles County is currently in the process of merging the Department of Health Services with the Department of Public Health’s programs (i.e., DHSP and the Department of Mental Health). It is uncertain what the impact will be of this re-organization on HIV services in the county.

iv. Program barriers (e.g., infrastructure capacity, access to data, data sharing, inadequate health information systems, availability of funding, etc.)

The Commission on HIV hosted a listening session during its 2015 annual meeting. During this session, many HIV service providers talked about the challenges with Los Angeles County’s current client data system—Casewatch. They expressed frustration with the system and not being able to get the data and reports they needed from it. As part of the Goals, Objectives, and Monitoring Work Group, participants discussed the need for a new data system that is able to track prevention and care services seamlessly. They also wanted a system that would simply follow a PLWH from initial testing and diagnosis through HIV treatment and support services. They expressed the need for a system that would streamline the Ryan White re-certification process that is required every six months.

v. Service provider barriers.

A key element of Los Angeles County’s implementation plan is to engage the housing continua of care to

improve the housing situation among PLWH. Participants in all four “listening sessions” described the challenges with housing [68]. A common definition of housing instability is when housing costs exceed 30% of an individual’s/family’s household income [10]. With this definition, most all low-income PLWH, especially those living off of SSI as their sole income source, are considered as having unstable housing. Long-term solutions crossing multiple sectors are urgently needed.

Another challenge for Aging PLWH is the need for coordinated care, including specialty care. As noted in the Listening Session report,

“As those living with HIV age, they are faced with multiple chronic conditions. Coordinated care and treatment of all conditions becomes more critical. Therefore there is a need not only for specialty care but coordinated specialty care” [68].

During their “listening session,” PLWH in SPA 1: Antelope Valley consistently described their challenges in accessing medical specialty referrals and other services. Their remote location from the center of the county makes transportation extremely challenging when trying to access services outside of their geographic area. One SPA 1 participant stated:

“So my issue is transportation and they also have a whole bunch of people who live that way in my area, and the van don’t go that far. And if they don’t have transportation, no family support or no outside support that can give them a ride to take them halfway to meet that van, they won’t get into care” [68]. (SPA 1 Participant)

vi. Client barriers (e.g., transportation, homelessness/housing instability, inability to navigate the system, poverty, stigma, comorbid conditions, etc.)

When examining the specific barriers to services, the 2011 LACHNA-CARE grouped barriers into three types—structural, organizational, and individual. Structural barriers included: “too much paperwork or red tape or too many rules and regulations.” Organizational barriers included: “service provider was insensitive to my concerns; amount of ‘wait time’ for an appointment or in the waiting room too long; or the organization provided me with the wrong referrals.” Individual barriers included: “I was not aware that a service or treatment was available to me; I was not aware of the location of service(s); or I did not know whom to ask for help.”

The overwhelming barrier to accessing services was identified as an “individual” or client-level barrier. Individual barriers referred to a person’s personal knowledge of whether or not a service existed, where it was located, or whom to ask for help. In a county the size of Los Angeles, it is not surprising that there is a lack of information among PLWH about the availability of services, eligibility requirements, how to access the services, and where to go for help. Although Los Angeles County has a number of systems in place to help PLWH learn about and navigate the myriad systems of care (e.g., Medical Care Coordination service category, HIV LA Resource Directory), this lack of information about services points to a persistent, system-level problem and need. Respondents from the four Listening Sessions also had similar problems in know how and where to access services. This suggests that the system of care that is designed to help PLWH access needed services has not improved over the past three years. Table 32 presents the top 10 needed services and identified type of barrier as reported in the 2011 LACHNA-CARE.

Table 32. Top 10 Service Needs Reported by PLWH in the Ryan White System of Care, Including Barriers and Gaps, Findings from the 2011 LACHNA-CARE (n=450)

Need(s)	Percent Need	Gap(s) ¹	Type of Barrier(s)		
			Structural	Organizational	Individual
1. Medical outpatient care	93.8%	--	--	--	--
2. Oral health care	82.9%	34.2%	22.0%	18.9%	53.8%
3. Psychosocial case management	79.8%	--	--	--	--
4. AIDS Drug Assistance Program	74.4%	--	--	--	--
5. Medical Transportation-bus passes	68.4%	17.6%	13.9%	11.1%	68.1%
6. Nutrition Support-Food Bank	59.1%	19.8%	NR	22.4%	69.7%
7. Medical Nutrition Therapy	54.4%	18.9%	10.0%	15.7%	68.6%
8. Rental Assistance	48.7%	28.0%	20.5%	30.8%	42.7%
9. Mental Health, Psychiatry	45.1%	--	--	--	--
10. Medical Specialty	38.9%	23.1%	33.3%	23.1%	35.9%

¹Gaps are defined as someone reporting a “need” for a service but who did not “receive” the service.

-- indicates service was not in top 10 services with a gap and gaps not identified in the final LACHNA-CARE report; NR= <5 respondents, too few to report.

A participant in the Women of Color Listening Session describes her experience:

“People are getting lost in care because of the fact it’s strictly medical, so then who connects you to housing, I’ll say [U/A],⁺⁺⁺ mental health, who? Social security, who tells you exactly where to go? [68]. (Women of Color Participant)

When designing programs, DHSP, the Commission on HIV, and community-based organizations need to integrate issues related to intimate partner violence and trauma informed care into their programs. This is especially important for partner services programs [69], as well as programs targeting vulnerable populations, including but not limited to ciswomen and sexual minority populations, including lesbian, gay, bisexual, and transgender persons [69, 70].

E. Data: Access, Sources, and Systems

a. Primary Sources of Data and Data Systems

Los Angeles County uses multiple data sources to estimate the extent of the county’s HIV epidemic, describe the need for services, as well as assess progress in achieving health outcomes along the HIV Care Continuum. The main data sources include HIV surveillance systems used by Los Angeles County: (1) enhanced HIV/AIDS Surveillance System (eHARS), (2) HIV incidence surveillance, and (3) molecular surveillance. Together, these surveillance systems give Los Angeles County the ability to track the extent of the county’s HIV epidemic including persons who are diagnosed and receiving care as well as those who are diagnosed and not in care. They also provide Los Angeles County the data needed to develop the HIV Care Continuum measures, including the number of PLWH who are: diagnosed, linked to care, engaged in care, retained in care, and virally suppressed.

⁺⁺⁺ U/A signifies “unintelligible answer.”

Other datasets that Los Angeles County uses are (1) United States Census Bureau data, including data from the annual American Community Survey; (2) National HIV Behavioral Surveillance, most recently MSM and IDU; (3) Youth Risk Behavior Surveillance; (3) the Medical Monitoring Project (MMP); (4) Ryan White client data through Casewatch (Los Angeles County’s Ryan White client data system); (5) HIV testing data for testing conducted through DHSP’s contracted providers; (6) STD Casewatch data; and (7) Los Angeles Coordinated HIV Needs Assessment-Care data among others. These datasets each contribute to the assessment of need and HIV-related health outcomes within Los Angeles County.

b. Data Policies

Los Angeles County utilizes an evidence-based approach to planning. To accomplish this, a thorough understanding of data, including the terminology used, the datasets available with their strengths and limitations, and how to apply that data in planning is needed by everyone involved in the planning process. Thus, the Los Angeles County Commission on HIV (Commission) and DHSP take responsibility for ensuring that planning participants, including Commission members as well as members of the community are well trained. During this past year, DHSP surveillance staff presented an HIV epidemiology training during the annual meeting of the Commission in November 2015. This training presented key epidemiology terms as well as their application in examining the current Los Angeles County HIV epidemiology profile of PLWH. Trends in the epidemic were also presented. To augment this initial training, the Commission hosted a full day training in April 2016 to dive deeper into understanding data, its sources, uses, and limitations. This all day training included multiple presentations and culminated in a practical exercise to apply participants’ new or strengthened knowledge. DHSP and the Commission have partnered to host these “Data Summits” to build the skill level of its community planners in order to increase and improve the quality of their participation in the planning process.

c. Additional Data and Information Needed for Planning

There are three areas where Los Angeles County and the planning group would benefit from in order to improve services in the county. They include: (1) completion of the 2016 Los Angeles Coordinated HIV/Needs Assessment (LACHNA); (2) access to PrEP prescription information; and (3) access to population-based antiretroviral therapy (ART) prescription of all PLWH in the county.

1. LACHNA Update

DHSP and the Commission on HIV are currently completing the 2016 Los Angeles Coordinated HIV Needs Assessment (LACHNA) data collection process. It was hoped that the process would have been completed in time to be incorporated into this current planning process. LACHNA-CARE only targeted PLWH who received Ryan White-funded HIV care services and did not contain information on HIV risk behaviors prior to diagnosis.

Even though the newest LACHNA was not ready for this planning process, it will be worth the wait and will be available to inform future updates of this plan. Due to an innovative sampling methodology using HIV surveillance data, the 2016-2017 LACHNA will be generalizable to all PLWH in Los Angeles County. This will be the first time ever that a local HIV needs assessment survey will reflect all diagnosed PLWH (excludes undiagnosed persons). In this post ACA environment, understanding needs of PLWH across the spectrum of medical providers is crucial in order to design programs that address these gaps and leverage resources from multiple funding sources. *Getting to Zero* new HIV infections will require a collaborative approach across all public and private payers. Thus, having needs assessment reflective of all PLWH will lay a strong foundation for system-wide planning.

2. PrEP Prescription

Currently, there is no way for Los Angeles County to assess how many people are prescribed PrEP. DHSP uses a variety of methods to estimate this number. As part of this planning process, Gilead Sciences, the pharmaceutical company for Truvada®, was contacted to ask if they were willing to share information on the number of persons in Los Angeles County accessing their Truvada® for PrEP Medication Assistance Program. They were unwilling to share this information as it was not public information. They did share that participation in the program has increased 280%. However, without a baseline number, this percentage is meaningless. Through another contact with the Veterans Affairs Greater Los Angeles Healthcare System, they did share the estimated number of Los Angeles County veterans accessing PrEP through their healthcare system.

With the Federal Drug Administration (FDA) approval of Truvada® for PrEP use in July 2012, the use of PrEP has been gradually increasing across the country. In the CDC's 2015 HIV Prevention Conference, many successes of PrEP were presented. Los Angeles County's use of PrEP as a major HIV prevention method is outlined in the objectives of this plan under Goal 1: Reduce New HIV Infections. However, having access to good data on not only the total number of people accessing PrEP but also demographic data on PrEP users will be essential to ending new HIV infections in Los Angeles County.

3. ART prescription

Los Angeles County does not currently have a method for tracking antiretroviral therapy (ART) prescription across all PLWH in the county. As a result, the county does not include "prescribed ART" as a regular part of its local HIV Care Continuum and consider "virally suppressed" as a surrogate for ART prescription. As needed, they are able to examine ART prescription through its Casewatch database for Ryan White clients as well as through MMP data, which is a subset of all PLWH in the county. However, if ART prescription was included as a field in eHARS, Los Angeles County would be able to monitor this HIV Care Continuum measure on a regular basis and identify if there are any disparities in ART prescription. For example, viral suppression is extremely low in some populations, e.g., African Americans and PWIDs. To better understand this disparity, understanding the possible causes of the disparity is essential. Thus, understanding if there is also a disparity in ART prescription in these populations, then specific activities can be developed to address this. However, if ART prescription is at the same level as other virally suppressed populations, then this may point to problems with adherence, which might include missing doses and not taking the prescription as prescribed or even that individuals are selling their medications to meet survival or other needs. Different interventions are needed for different underlying problems.

As seen in Section I, the extensive data and analysis of available resources, needs, barriers, and gaps in services provides a strong foundation for Los Angeles County's integrated plan that follows in Section II. This integrated plan is the centerpiece of the *Los Angeles County Comprehensive HIV Plan 2017-2021* and provides a blueprint for action over the next five years. During that time, the plan will be monitored on an ongoing basis (Section III) and updated to address new data, as well as emerging needs.

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Section II: Integrated HIV Prevention and Care Plan

A. INTEGRATED HIV PREVENTION AND CARE PLAN

Attachment C presents the complete implementation plan for integrated HIV prevention and care services in Los Angeles County. The goals, objectives, and strategies are summarized below.

1. *REDUCE NEW HIV INFECTIONS.*

Objective 1.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV infections by at least 25%.

Strategy 1.1.1 Increase viral suppression among persons living with HIV (PLWH).

Strategy 1.1.2 Increase engagement in quality medical care among high-risk HIV negative individuals.

Strategy 1.1.3 Reduce the percent of persons with undiagnosed HIV infection and percent of diagnosed persons who are not in care.

Strategy 1.1.4 Increase access to a “toolbox” of interventions designed to reduce the risk for acquiring and/or transmitting HIV.

Objective 1.2 By December 31, 2021, Los Angeles County will increase to 25,000 the number of high-risk HIV negative individuals accessing pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) as needed.

Strategy 1.2.1 Eliminate structural and provider barriers to accessing PrEP and nPEP.

Strategy 1.2.2 Educate high-risk individuals about PrEP and nPEP.

Strategy 1.2.3 Decrease stigma related to accessing PrEP and nPEP.

2. *INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.*

Objective 2.1 By December 31, 2021, Los Angeles County will increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%.

Strategy 2.1.1 Remove system barriers to linkage to care.

Strategy 2.1.2 Educate medical and other providers.

Strategy 2.1.3 Reduce stigma and address other social determinants of health that are barriers to linkage to care.

Objective 2.2 By December 31, 2021, Los Angeles County will increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 85%.

Strategy 2.2.1 Increase housing stability among PLWH.

Strategy 2.2.2 Increase access to high quality behavioral health services.

Strategy 2.2.3 Minimize administrative barriers to retention in care.

Strategy 2.3.4 Expand access to Ryan White-funded services.

3. REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES.

Objective 3.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV diagnoses by at least 30% in the following groups: YMSM, Blacks/African Americans, Latino MSM, and Transgender Persons.

Strategy 3.1.1 Have developmental and cultural specificity in HIV prevention efforts.

Strategy 3.1.2 Increase PrEP and nPEP uptake in each population proportionate to their percent of recent diagnoses (2009-2013).

Strategy 3.1.3 Reduce stigma and address other social determinants of health that are barriers to accessing the full continuum of services.

Objective 3.2 By December 31, 2021, Los Angeles County will increase to 80% viral suppression among the following groups: persons who inject drugs (PWID), youth (18-29 years), Ciswomen, transgender persons, Blacks/African Americans, and American Indians/Alaska Natives.

Strategy 3.2.1 Decrease the percentage of PLWH who are out of care.

Strategy 3.2.2 Tailor services to address specific barriers to viral suppression for each group.

Strategy 3.2.3 Ensure equitable access to high quality HIV care.

4. CREATE A COLLABORATIVE SYSTEM, INCLUSIVE OF PUBLIC AND PRIVATE SECTORS THAT BEST RESPONDS TO HIV, STIs, AND SOCIAL DETERMINANTS OF HEALTH.

Objective 4.1 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) internal efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.

Strategy 4.1.1 Leverage the internal re-organization of the Los Angeles County Department of Health Services as an opportunity for strengthening internal relationships.

Strategy 4.1.2 Improve communication and coordination among HIV service providers.

Strategy 4.1.3 Actively participate in other strategic planning processes within the county.

Objective 4.2 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) external efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.

Strategy 4.2.1 Strengthen collaboration with the State Office of AIDS.

Strategy 4.2.2 Strengthen collaboration with public (other than DHS) and private healthcare systems.

Strategy 4.2.3 Strengthen collaboration with the Housing Continua of Care in Los Angeles County, including HOPWA.

a. Activities/Interventions, Targeted Populations, Responsible Parties, and Time-phased, Resources

The activities are outlined in Attachment C. Bolded activities represent those that are addressing gaps along the HIV Care Continuum.

A comprehensive list of available HIV resources are outlined in Attachment A. The funding period is included in the table to demonstrate, which programs are due to end or be renewed. Many of the activities identified in Attachment C are new (i.e., those that fill a gap in the continuum of HIV services) and others are part of on-going initiatives. All activities will require commitment of staff resources as well as financial resources. However, due to the complexity of the funding mechanisms (e.g., annual Ryan White Part A application, anticipated CDC funding opportunity announcement to replace PS 12-1201, current housing resource analysis being conducted in Los Angeles County, coordination of public and private insurance), Los Angeles County plans to examine resource needs on an annual basis prior to the start of each year of the plan. Thus, for 2017, this work will be completed by December 31, 2017 and included as an Addendum to this plan.

b. Metrics for Monitoring Progress

Los Angeles County’s goals closely align with the NHAS Updated to 2020 goals and many of the objectives chosen were selected from the NHAS indicators. Table 33 presents the four goals and the indicators that will be used to measure progress.

Table 33. Los Angeles County Goals and Corresponding Metrics

Goal	Metric
1. Reduce new HIV infections.	<ul style="list-style-type: none"> • Annual HIV incidence estimate • Estimate of high-risk persons accessing PrEP
2. Increase access to care and improve health outcomes for people living with HIV.	<ul style="list-style-type: none"> • One month linkage to care • Retention in care (at least 2 medical visits 3 months apart)
3. Reduce HIV-related disparities and health inequities.	<ul style="list-style-type: none"> • Number of new diagnoses by population • Viral suppression (<200 copies/ml) by population
4. Create a collaborative system, inclusive of public and private sectors that best responds to HIV, STIs, and social determinants of health.	<ul style="list-style-type: none"> • Percentage of PLWH reporting service gaps in LACHNA by service category

c. Anticipated Challenges or Barriers in Implementing the Plan

The activities outlined in Attachment C are comprehensive in scope. They present numerous changes to the current system of care with active efforts designed to engage the non-Ryan White public health care system, as well as the private health care system. They outline the need for changing the Ryan White funding paradigm to place increased emphasis on support services designed to link and re-engage PLWH into care and to provide the services needed to support retention and treatment adherence. There are many changes and enhancements included in this plan, too many to be completed in a single year. Thus, there is a need to prioritize and resist the urge to want everything done immediately. Thus, although the

actual timeline may need to be adjusted from time to time, the plan itself presents a roadmap for achieving the goals of NHAS and laying the foundation for *Getting to Zero New Infections, Zero discrimination, and Zero AIDS-related deaths*.

Anticipated challenges and/or barriers include but are not limited to the following:

1. Standards of care will need to be created and/or updated to reflect prioritized services (e.g., housing will need to add a standard for short-term and/or tenant-based rental assistance; Health Education/Risk Reduction will need a new standard developed that is current with HRSA's definition of the service category to include treatment adherence counseling).
2. Due to Los Angeles County's lengthy RFP process (approximately 18 months), new services will not be able to be contracted until the second year of this plan, delaying desired system changes.
3. DHSP's inability to hire new staff may continue to impact implementation of the plan if it continues. It is hoped that this will be resolved under the new restructuring of Public Health and the Department of Health Services. If not, concerted effort needs to be made to ensure that DHSP can hire the staff it needs to assist in plan implementation, including but not limited to developing a robust linkage and re-engagement program, which may include data-to-care.
4. The proposed coordination with other systems of care takes this to a new level. The plan recommends that the Commission on HIV also hire a dedicated strategic planner to engage with these other systems. It will be essential that the Commission on HIV have the resources necessary to achieve this.
5. The theme of addressing stigma and social determinants of health is woven throughout the plan. It includes the development of a specific stigma reduction plan in the first year to guide activities in subsequent years. Any potential delays in completing this plan and/or lack of resolve in implementing recommended actions will have a deleterious effect on Los Angeles County's ability to reach the proposed objectives.

B. COLLABORATIONS, PARTNERSHIPS, AND STAKEHOLDER INVOLVEMENT

There were numerous stakeholders and community partners involved in the development of this comprehensive HIV plan for integrated prevention and care services. The primary involvement was through the very active participation of Commissioners who have seats on the Commission on HIV on the Comprehensive HIV Plan Task Force and/or one of its work groups (i.e., Goals, Objectives, and Monitoring; Needs, Barriers, and Gaps and Community Engagement; and Epidemiology). Commissioners participated that represented various agencies in the community including in alphabetical order:

- AIDS Project Los Angeles Health and Wellness (FQHC)
- Alliance for Housing and Healing
- Behavior Health Services
- Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), University of California, Los Angeles
- Children's Hospital Los Angeles
- City of Los Angeles, AIDS Coordinator's Office

- JWCH Institute (Ryan White Part C provider)
- Los Angeles LGBT Center (Ryan White Part C provider, FQHC)
- Thrive Tribe
- Reach LA
- University of California, Los Angeles

In addition to Commissioners, other organizations participated in this planning process, including organizations specifically invited to attend to ensure their representation:

- California Family Health Council
- City of Long Beach Health Department
- Commission on HIV staff
- Los Angeles County Department of Public Health's Division of HIV and STD Programs
- Los Angeles County Substance Abuse Prevention and Control
- Maternal Child Adolescent/Adult Center, Keck School of Medicine, University of Southern California (Ryan White Part D provider)
- North Valley Health Corporation
- The Wall Las Memorias
- USC School of Dentistry (Ryan White Part F provider)

As part of the financial resources inventory data gathering process, a number of other key stakeholders were talked to in order to understand the nature of some of their projects as well as to learn how they contribute currently to the continuum of services in Los Angeles County. These organizations included:

- Bartz-Altadonna Community Health Center (SPA 1) (Ryan White Part C provider)
- Bienestar Human Services
- City of Pasadena
- City of Long Beach, HOPWA program
- City of Los Angeles, HOPWA program
- Friends Research Center
- Gilead Sciences, PrEP Patient Assistance Program
- Greater Los Angeles VA Health System
- Pacific AIDS Education and Training Center, Los Angeles Region (Ryan White Part F provider)
- Special Services for Groups/APAIT

Together, these organizations represent a well-rounded sample of the full array of HIV services that currently exist in Los Angeles County.

A Letter of Concurrence from the Los Angeles Commission on HIV co-chairs is provided at the front of this document after the Table of Contents.

The key stakeholders that were not a part of this current planning process that are essential to improving health outcomes were representatives from the private healthcare system, including Kaiser Permanente, as well as the non-Ryan White public health care system, including LA Care Health Plan. In addition to these, during the planning process participants identified the need for coordination with mental health services in the county, including the Los Angeles County Department of Mental Health.

As part of the annual updates to this plan, there need to be concerted efforts to engage these and other stakeholders that were not part of this plan.

C. PEOPLE LIVING WITH HIV (PLWH) AND COMMUNITY ENGAGEMENT

There were 54 individuals who participated actively in the development of Los Angeles County's plan. They reflected well the populations impacted by HIV in the county, including but not limited to: MSM, transgender persons, Blacks/African Americans, Latinos, American Indians/Alaska Natives, Asians, youth/young adults (18-29 years), aging persons (50 years and older), and so on. Of the 54 participants, 24 (44.4%) were also Commissioners on the Los Angeles Commission on HIV. This planning body is itself reflective of the HIV epidemic in the county. Geographically, participants from all five supervisorial districts were included and all SPAs. Where specific voices were missing, e.g., SPA 1, the Community Engagement Work Group (discussed below) organized Listening Sessions to obtain their voice. Four sessions were conducted during this initial planning process.

PLWH were involved in every aspect of development of Los Angeles County's integrated plan. They represented 28% (n=16) of the 54 individuals that actively participated as members of the Comprehensive HIV Plan (CHP) Task Force and/or one of its work groups: (1) Epidemiology, (2) Needs, Barriers, Gaps, and Community Engagement, and (3) Goals, Objectives, and Monitoring. The CHP Task Force, under the authority of the Los Angeles Commission on HIV's Priority, Planning and Allocations (PP&A) Committee, began meeting in August 2015 through July 2016.

In addition to participation on the CHP Task Force and/or one or more of its work groups, 51 PLWH participated in one of four Listening Sessions that were conducted as a project of the Needs, Barriers, Gaps, and Community Engagement Work Group (Note: This work group became the Community Engagement Work Group in March 2016, giving the CHP Task Force the responsibility of the Needs, Barriers, and Gaps component.) The Listening Sessions were specifically designed to solicit information from populations where the county had less needs-related data available. The four populations included in the first tier of Listening Sessions were: (1) undocumented persons, (2) women of color, (3) aging population, 50 years and older, and (4) persons from SPA 1. There are two additional tiers that are planned over the next year, which will target yet other populations where there is less data available to describe and understand the needs of these populations.

The 2011 LACHNA-CARE and the anticipated 2016 LACHNA are a primary vehicle through which PLWH are engaged in needs assessment activities. A total of 450 PLWH participated in the 2011 LACHNA-CARE needs assessment survey. That survey recruited participants from Ryan White clinics and although the sample was reflective of the Ryan White population, it was not reflective of all PLWH in the county. To address this, DHSP epidemiology staff developed a sampling methodology using HIV surveillance data. Although the data collection was slow and the overall sample size was reduced to 300 participants from 400 participants, the survey results will be generalizable to all PLWH in the county. This will improve planning and service delivery for all PLWH regardless of whether or not they receive public or privately-funded medical care.

Ending HIV in Los Angeles County will require a new set of services targeting PLWH who access medical care through the privately funded health care system. Yet, up to now, there has been no information on what the service needs are of this population. Although someone may have employer paid health insurance, they may still benefit from case management or navigation services to help them access

other needed social services or support groups or peer-led treatment adherence counseling. The 2016 LACHNA will give local planners insight into these needs for the very first time.

The very active participation of PLWH discussed above and others from or representing highly impacted communities, especially on the Goals, Objectives, and Monitoring Work Group, resulted in a very lively discussion about the barriers PLWH and at-risk persons face when accessing services. Several participants on the Work Group also participated on the Commission on HIV's Consumer Caucus and they were able to enhance the discussion by highlighting issues discussed during those meetings. For example, there was extensive discussion about the need for housing, substance use disorder, and mental health services. In the discussion about housing, the work group was able to hone in on issues to identify where PLWH were falling through the cracks of an existing system. Not all PLWH qualify for HOPWA services, including persons with a felony, undocumented individuals, as well as persons who live in low-income housing units that were federally subsidized when constructed. However, when a person loses their source of income, even low-income housing is too expensive. Thus, the Work Group talked about the need for programs that improve housing stability versus just programs that address homelessness. Another example discussed the challenges some PLWH face in trying to access substance use disorder services through the publicly-funded system. One person stated that they knew of a situation where a PLWH had to relapse in order to get expedited access to treatment. The inclusion and participation of PLWH provided a real world understanding of how the current continuum of services works. This discussion led to a more well-rounded discussion of how to address numerous challenges they experience on a daily basis.

The Commission on HIV annually conducts a priority-setting and resource allocation process as part of its legislative responsibilities as the stewards of Ryan White Part A funding the county receives. As this process typically occurs in the early summer months, examination of data from the epidemiologic overview and HIV Care Continuum as well as the proposed draft implementation plan (Attachment C) were presented and discussed during the annual priority setting process in June 2016. The lively discussion led to a very different ranking of service priorities than in previous years, with an emphasis on service categories that are needed to help identify and engage PLWH in medical care and providing the support services need to help him/her remain in care. At this writing decisions on allocations are yet to be made but it is expected that services outlined in the Implementation Plan will be allocated the necessary Ryan White resources to implement recommended actions.

Section III: Monitoring and Improvement

a. Process for regularly updating planning bodies and stakeholders.

The Los Angeles County's HIV planning body, the Commission on HIV, meets monthly, which includes an annual meeting in the fall/winter. As all meetings are open to the public, they will be one of the primary vehicles through which Commissioners and community stakeholders are updated on the progress of this plan. Formal updates will be scheduled quarterly. These updates will include progress on achieving the goals and SMART objectives outlined in Los Angeles County's implementation plan. Annually, the Commission on HIV and DHSP also convene a data summit for Commissioners, key stakeholders, and members of the community. The data summit may also be used as one of the quarterly update opportunities.

As part of the regular Commission on HIV meetings, there is time on the agenda for colloquia, which are opportunities for additional education for Commissioners. The Commission on HIV will use a minimum of two colloquia presentations to drill down and focus on one aspect of the plan's implementation (e.g., PrEP uptake, coordination with the housing continua of care in Los Angeles County). Individuals attending the colloquia will be asked to complete a presentation evaluation form, which will include at least one question on the information presented regarding the plan. Commission on HIV staff will collate the responses from these evaluations and present to the Priorities, Planning, and Allocations (PP&A) and Executive committees for review. This feedback will inform the annual update of the plan.

In addition to these meetings, the Commission on HIV has a website, which is currently being redesigned, which will be used for updates on the plan. The Commission on HIV will post any presentation materials from the quarterly updates. They will also maintain a link to the plan dashboard, which will be comprised of the SMART objectives outlined in the plan. This dashboard will be updated as progress is reported, at least quarterly.

b. Plan to monitor and evaluate implementation of the goals and SMART objectives.

DHSP and the Commission on HIV will work together to monitor and evaluate implementation of the goals and SMART objectives outlined in the implementation plan. The quarterly updates described above on progress being made will be used to update the dashboard that will be on the Commission on HIV website. This progress will be presented and discussed at Commission on HIV meetings quarterly. The Commission on HIV and DHSP will monitor progress yearly using the targets outlined in Table 34. This progress will be used to inform the annual update of the plan.

Los Angeles County chose to use several of the same targets outlined in the *NHAS Updated to 2020*. Based on the county's past experience, some of the indicators (e.g., linkage to care and retention in care) have changed minimally in the past five years. Thus, these targets represent "stretch" targets for the county. If the implementation plan outlined in Attachment C is successful, DHSP and the Commission on HIV expect to see greater change.

Table 34. Yearly Targets for SMART Objectives

NHAS Goal and SMART Objective		2017	2018	2019	2020	2021	
1. Reduce New HIV Infections.							
1.1	By December 31, 2021, Los Angeles County will decrease the number of new HIV infections by at least 25%. 2010 Baseline: 2,117	2,011	1,905	1,799	1,694	1,588	
1.2	By December 31, 2021, Los Angeles County will increase to 25,000 the number of high-risk HIV negative individuals accessing pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) as needed. 2016 Baseline: 4,000	8,000	12,000	16,000	20,000	25,000	
2. Increase Access To Care And Improve Health Outcomes For People Living With HIV.							
2.1	By December 31, 2021, Los Angeles County will increase the percentage of newly diagnosed persons <i>linked</i> to HIV medical care within one month of their HIV diagnosis to at least 85%. 2014 Baseline: 71%	73%	76%	79%	82%	85%	
2.2	By December 31, 2021, Los Angeles County will increase the percentage of persons with diagnosed HIV infection who are <i>retained</i> in HIV medical care to at least 85%. 2014 Baseline: 59%	64%	69%	74%	79%	85%	
3. Reduce HIV-Related Disparities and Health Inequities.							
3.1	By December 31, 2021, Los Angeles County will decrease the number of new HIV diagnoses by at least 30%.	YMSM 2014 Baseline: 640	640*	592	544	496	448
		Blacks/African Americans 445	445*	412	379	346	312
		Latino MSM 702	702*	649	596	543	491
		Transgender Persons 25	25*	24	22	20	18
3.2	By December 31, 2021, Los Angeles County will increase to 80% viral suppression.	PWID 2014 Baseline: 48%	54%	61%	67%	73%	80%
		Youth (18-29 years) 50%	56%	62%	68%	73%	80%
		Cisgender females 54%	59%	64%	70%	75%	80%
		Transgender persons 49%	55%	61%	67%	73%	80%
		Blacks/African Americans 48%	54%	61%	67%	73%	80%
		American Indians/ Alaska Natives 50%	56%	62%	68%	73%	80%
4. Create a Collaborative System, Inclusive of Public and Private Sectors That Best Responds to HIV, STIs, and Social Determinants of Health.							
4.1	By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>internal efforts</i> to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.	1 effort		1 effort	1 effort	Plan for next 5 years	
4.2	By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>external</i> efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.	1 effort		1 effort	1 effort	Plan for next 5 years	

*In Year 1 of the implementation plan, there are no anticipated decreases in new diagnoses as DHSP and the

Commission on HIV are striving to diagnose the estimated 7,196 PLWH who are undiagnosed.

c. Strategy to utilize surveillance and program data to assess and improve health outcomes along the HIV Care Continuum, which will be used to impact the quality of the HIV.

DHSP and the Commission on HIV have used the surveillance-based HIV Care Continuum measures to assess and improve health outcomes for the past three years. The sophistication of the data available has improved over time and the county is beginning to trace the HIV Care Continuum outcomes for numerous subpopulations, especially by race/ethnicity to identify disparities. The most current HIV Care Continuum measures for multiple populations are presented in *Section I. A. b. HIV Care Continuum in Los Angeles County* of this plan. Available HIV Care Continuum data from Los Angeles County's Medical Monitoring Project (MMP) and its Ryan White Program clients through Casewatch has also been used. The HIV Care Continuum data from these datasets has been used extensively in the development of the implementation plan outlined in Attachment C. These data will continue to be used to monitor the plan based on Table 34.

The HIV Care Continuum data is only as good as the data that is entered into the surveillance system. Other jurisdictions across the nation have implemented robust data-to-care programs, which uses HIV surveillance data for identifying PLWH who are not in care and linking or re-engaging them into care. Seattle, Colorado, and Virginia have all learned that more than 50% of PLWH who are supposedly "not in care" are actually "in care." These programs have allowed jurisdictions to clean their data, thereby improving the quality of information that it describes. As part of this plan, Los Angeles County is proposing to develop a robust data-to-care program that will increase the accuracy of the HIV Care Continuum measures across all populations.

ATTACHMENTS

- A. HIV Funding in Los Angeles County by Funding Source
- B. HIV Service Needs by HRSA Part A Service Category
- C. Comprehensive HIV Plan 2017-2021 Implementation Plan
- D. Population Profiles
 - HIV and Older Adults
 - HIV and Youth/Young Adults
 - HIV and Transgender Persons

Attachment A. HIV Funding in Los Angeles County by Funding Source

SOURCE	GRANTEE	AMOUNT	PERIOD	SERVICES PROVIDED	HIV CONTINUUM OF CARE STEPS IMPACTED								
					Prevention	PrEP	DX	Linked	Retained	ARI	Suppressed		
Ryan White Part A	LAC DHSP	\$38,389,840	3/1/2016-2/28/2017	Outpatient/Ambulatory Medical Care Non-medical Case Management (Benefits Specialty) Non-medical Case Management (Linkage Case Management) Non-medical Case Management (Transitional Case Management) Oral Health Care Mental Health-Psychiatry Mental Health-Pschotherapy Medical Case Management Substance Abuse Treatment, Residential Housing Services (RCFCI, TRCF) Medical Transportation Services Food bank/home delivered meals (Nutrition Support) Referral for Health Care/Support Services Medical Nutrition Therapy (SPA 1 only) Legal Services Language Services Home Based Case Management Health Education Risk Reduction PrEP Social Marketing			X	X	X	X	X	X	
Part A-Minority AIDS Initiative	LAC DHSP	\$3,320,033	3/1/2015-2/29/2016										
Ryan White Part B	California Office of AIDS -LAC DHSP subcontract	\$2,000,000	4/1/2016-3/31/2017										
Los Angeles County - Net County Cost	LAC DHSP	\$17,800,000	7/1/2016-6/30/2017						X	X	X	X	X
Ryan White Part B - ADAP	California Office of AIDS	\$154,633,985	4/1/2014-3/31/2015	AIDS Drug Assistance Program								X	X
Ryan White Part C - EIS	Bartz-Altadonna Community Health Center	\$305,633	FY 2015	HIV testing, outreach, behavioral health counseling, health and wellness with a focus on chronic illness			X	X				X	X
Ryan White Part C - EIS	Dignity Health, DBA Saint Mary Medical Center	\$936,178	FY 2015	Outpatient ambulatory medical care			X	X				X	X

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
Ryan White Part C - EIS	AIDS Healthcare Foundation	\$285,000	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	Charles Drew University of Medicine and Science	\$408,500	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	JWCH Institute, Inc.	\$285,000	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	University of Southern California	\$315,875	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	Watts Healthcare Corporation	\$301,913	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	T.H.E. Clinic, Inc.	\$333,430	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	Tarzana Treatment Center, Inc.	\$343,663	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	Venice Family Clinic	\$343,972	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	Altamed Health Services Corporation	\$988,861	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part C - EIS	Los Angeles Gay and Lesbian Community Services Center	\$776,239	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part D	University of California, Los Angeles	\$808,934	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part D	University of Southern California	\$826,677	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part D	Altamed Health Services Corporation	\$114,664	FY 2015	Outpatient ambulatory medical care			X	X	X	X	X	X
Ryan White Part F - Dental Reimbursement Program	University of California, Los Angeles	\$372,331	FY 2015	Oral health services					X			X
Ryan White Part F - Dental Reimbursement Program	University of Southern California	\$740,286	FY 2015	Oral health services					X			X

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>													
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>							
Ryan White - Part F SPNS - Use of Social Media to Improve Engagement, Retention, and Health Outcomes along the HIV Continuum of Care	Friends Research Center, Inc.	\$384,279	2015-2019	This project will utilize a text-messaging intervention to improve health outcomes along the HIV Care Continuum, with the desired outcome of viral suppression among HIV-positive young trans women, aged 18-34, who are not linked to care, or not retained in care, or not prescribed ART, or non-adherent to ART, or not virologically suppressed. Over the course of the 90-day intervention, participants will receive 270 theory-based text messages that are targeted, tailored, and personalized specifically for HIV-positive young trans women.		x		x	x		x						x	
Ryan White - Part F SPNS - Use of Social Media to Improve Engagement, Retention, and Health Outcomes along the HIV Continuum of Care (Evaluation and Technical Assistance Center)	University of California, Los Angeles	Not Available	2015-2019	Evaluation and Training N/A														
Ryan White - Part F SPNS (Culturally appropriate interventions of outreach, access, and retention among Latino Populations)	Bienestar Human Services	\$300,000	2013-2018	Proyecto Vida includes: Social Network Testing and Social Network Engagement (SNE), strengthening of relationships with community partners who refer clients to Bienestar, and activities to facilitate engagement and retention in care through Motivational Interviewing coupled with a linkage to care/peer navigation intervention as its primary strategy.				x	x		x						x	

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
Ryan White - Part F SPNS (Culturally appropriate interventions of outreach, access, and retention among Latino Populations)	AIDS Project Los Angeles	\$300,000	2013-2018	APLA's Fuerza Positiva will focus on HIV-infected men (especially MSM) and women of Mexican origin living in Los Angeles County, California. Using culturally appropriate models, the project will implement an intervention strategy comprised of: 1) identification and recruitment; 2) strength-based case management/patient navigation; and 3) social support. Operation Link, a community-based demonstration program, will provide care navigation to approximately 100 HIV positive homeless individuals annually who are multiply diagnosed with mental illness and substance use addiction living in the San Gabriel Valley. Operation Link has two simple components: 1) utilize a Mobile Care Unit that takes project services into the community, and 2) utilize care navigators who will conduct a customized Client-level needs assessment and work across a system of coordinated Network Providers to connect the client to appropriate services.				X	X	X		
Ryan White - Part F SPNS (Building a medical home for multiply diagnosed HIV positive homeless populations; navigation services for 100 HIV positive homeless)	City of Pasadena	\$299,098	2012-2017	The Alexis Project will employ a multi-tiered, comprehensive approach, which includes network, individual and structural components to identify, recruit, test, link, treat and retain transwomen of color into quality HIV care. The Alexis Project will incorporate three proven models, Social Network Recruitment	X		X	X	X	X		X
Ryan White - Part F SPNS (Enhancing engagement and retention in quality HIV care for transgender women of color)	Friends Research Center, Inc. (Friends Community Center)	\$300,000	2012-2017									

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
Ryan White - Part F SPNS (Enhancing engagement and retention in quality HIV care for transgender women of color)	Bienestar Human Services	\$300,000	2012-2017	(network); Peer Health Navigation (individual); and Contingency Management (structural) into one multi-leveled project to optimize HIV health outcomes for transwomen of color. Working in partnership with JWCH Institute, the Los Angeles Gay and Lesbian Center and Children's Hospital Los Angeles, Bienestar has designed and will implement TransActivate, a comprehensive program to improve the timely entry, engagement and retention in quality HIV care for Latina transgender women in Los Angeles County. TransActivate, seeks to encourage transgender Latinas to activate themselves to get tested for HIV, get engaged in care and to stay in care. TransActivate strategies include Social Network Testing, Social Network Engagement, a Motivational Interviewing-based linkage and peer navigation intervention, and an innovative training component designed to increase provider competency in working with Latina transgender clients.		x		x	x	x			x
Ryan White Part F-AETC	Pacific AIDS Education and Training Center-Los Angeles Region	\$740,000	7/1/15-6/30/16	Trainings can include didactics, skills building workshops, but a heavy emphasis is place on adult learning principles, interaction and clinical training experiences. Current funding includes earmarks for working with 2 FOHCs that do not receive Part	x	x	x	x	x	x			x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
				<p>C funding to help them with "Practice Transformation" activities to improve outcomes. The LA PAETC is the site for the IPE program. It also receives MAI funding to train providers at the Jail (USC) and Spanish speaking MDs (UCLA). There are trainings for high-volume HIV specialist providers and for HIV care coordination teams. Finally, it receives a small amount of funding (\$40k) to coordinate a US/Mexico border project, called UMBAST the US/Mexico Border AETC Steering Team which includes trainings of US Immigration and Customs Enforcement clinicians, webinars, and HIV trainings for Promotores. The LA PAETC also trains on continuity of care for HIV patients who may return to Mexico or Central America. Other components include: routine HIV screening in the emergency department, FQHCs, trainings on PrEP implementation, ACA, etc.</p>								
CDC - PS15-1502 (CBOs)	Altamed Health Services Corporation	\$350,000	7/1/15-6/30/20	Description not provided	x	x	x	x	x			x
CDC - PS15-1502 (CBOs)	APLA Health & Wellness	\$350,000	7/1/15-6/30/20	HIV primary care and treatment, prevention services, oral health, behavioral health, home health. Target populations: MSM and MSM of Color, Young Black MSM, transgender persons	x	x	x	x	x			x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
CDC - PS15-1502 (CBOs)	Bienestar Human Services	\$350,000	7/1/15-6/30/20	Outreach; HIV testing; linkage to medical care for newly diagnosed and PLWH not in care; referrals for integrated STD/TB/viral hepatitis screening and partner services; ARTAS; Peer Support; referral to PrEP; condom distribution. Target population: Latino MSM and other high-risk Latinos in SPAs 2, 4, 7, and 8	x	x	x	x	x			x
CDC - PS15-1502 (CBOs)	Black AIDS Institute	\$757,793	7/1/15-6/30/20	Description not provided	x	x	x	x	x			x
CDC - PS15-1502 (CBOs)	JWCH Institute, Inc.	\$702,501	7/1/15-6/30/20	HIV testing and treatment; health alternative risk reduction program; health relations program age 21 and older. Target population: YMSM of Color (18-29 years)	x	x	x	x	x			x
CDC - PS15-1502 (CBOs)	Los Angeles LGBT Center	\$350,000	7/1/15-6/30/20	HIV and STD testing and treatment; linkage to HIV and social support services. Target population YMSM of Color (18-29 years)	x	x	x	x	x			x
CDC - PS15-1502 (CBOs)	REACH LA	\$350,000	7/1/15-6/30/20	HIV testing and counseling patient navigation, support services; peer health education. Target population YMSM of Color (18-29 years)	x	x	x	x	x			x
CDC - PS15-1502 (CBOs)	Special Service for Groups/APAIT	\$757,793	7/1/15-6/30/20	HIV testing, linkage to care, patient navigation. Partners with Central City Community Health Clinic (FOHC) for HIV specialty care. Target population: High risk individuals in SPA 4 ages 30-64 years, including MSM and transgender persons of color, Asian/Pacific Islander and Latino	x	x	x	x	x			x
CDC - PS14-1403 (CBA program)	AIDS Project Los Angeles	\$1,000,000	4/1/14-3/31/19	Capacity Building Assistance for Health Departments	x	x	x	x	x			x
CDC - PS14-1403 (CBA program)	Public Health Foundation Enterprises	\$1,100,000	4/1/14-3/31/19	Capacity Building Assistance for CBOs	x	x	x	x	x			x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
CDC - PS13-1308	L.A. Unified School District	\$600,000	8/1/13-7/31/18	Promoting Adolescent Health through School-Based HIV/STD Prevention	X								
CDC - PS09-007	LAC DHSP	\$400,000	2014	Evaluating locally-developed (homegrown) HIV prevention interventions for African American and Hispanic/Latino MSM (MLMS)	X								
CDC - PS15-1503	LAC DHSP	\$730,741	2016	Medical Monitoring Project (MMP)			X	X	X	X			X
CDC - PS12-1201 (HIV Prevention Project for Health Departments)	LAC DHSP	\$14,259,272	1/1/12-12/31/17 (Five Year grant period extended one more Year to 12/31/17)	Category A: This grant supports targeted HIV Testing Services Programs in non-clinical settings, Risk Reduction Activities for HIV positive individuals, Social Marketing (PrEP and Condom Distribution), Policy Initiatives, and community level intervention for HIV negative individuals. Category B supports HIV testing in healthcare settings. Category C: supported Project Engage & Navigation Program, syndemic spatial analysis, and matching of surveillance data, Category C grant ended 12/31/15	X		X	X	X	X			X
CDC - PS13-1302 (National HIV Surveillance System (NHSS))	LAC DHSP	\$2,431,361	1/1/13-12/31/17	HIV case and HIV incidence surveillance activities			X	X	X	X			X
CDC - PS16-1601 (National HIV Behavioral Surveillance (NHBS))	LAC DHSP	\$703,149	1/1/16 - 12/31/16	Study of HIV risk and prevention behaviors among at-risk populations	X		X	X	X	X			X
CDC-15-1506 (Health Department Demonstration Projects to Reduce HIV Infection &	LAC DHSP	\$4,500,000	9/30/15-9/29/16	CDC Demonstration Project Category 1 (Sept 30, 2015- September 29, 2016) \$1,904,384. This is the Implementation of PrEP Linkage							X		

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
Improve Engagement in HIV Medical Care)				and re-engagement to HIV Medical Services project.									
				CDC Demonstration Project Category 2 (Sept 30, 2015-September 29, 2016) \$2,595,616. This grant was originally intended to support the Data to Care or Linkage Re-engagement Program. Beginning in 2016 the Linkage Re-engagement Program will be supported through Part A, MAI, or NCC funds. CDC approved use of Cat 2 funds for PrEP as of September 2016.		x							
Office of AIDS (State Block Grant)	LAC DHSP	\$1,860,734	CY 2016	HIV AIDS surveillance program	x	x	x	x	x	x			x
HOPWA (Formula Award)	City of Los Angeles	\$13,700,201	FY 2016	In FY 2015-2016, the HOPWA program provided the following services: Short-term rent, mortgage, and utility assistance payments (105 households served); tenant-based rental assistance (237 served); transitional housing units (406 served); permanent housing units (199 served).					x				x
HOPWA (Permanent Supportive Housing)	City of Los Angeles	\$1,501,500	FY 2015	Medicaid waiver, inpatient, outpatient, long-term care, and pharmacy (does not include Denti-Cal). Supported 12,464 unduplicated users from July to December 2014.					x				
Medi-Cal Expenditures	County of Los Angeles	\$192,105,486	7/1/14 - 6/30/15	The AIMM Initiative specifically addresses the unmet needs of young racial and ethnic minority men who have sex with men (MSM) who are between the									
Office of Minority Health (HIV/AIDS Initiative for Minority Men)	Children's Hospital Los Angeles	\$375,000	9/1/2014 - 8/31/2017		x								x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>									
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>			
				ages of 20-29 and young minority males living with HIV/AIDS or at high risk for HIV infections. The AIMM Initiative will establish a comprehensive Integrated Center for Care and Supportive Services (ICSS) that employs evidence-based disease management and preventive health program and supportive services										
SAMHSA – Primary and Behavioral Health Care Integration (Center for Mental Health Services)	Southern California Health & Rehabilitative Program	\$400,000	09/30/2015 - 09/29/2019	This program will improve health outcomes for adults with SMI and those with co-occurring substance use disorders, primarily minorities who are homeless, veterans recently incarcerated, with trauma history and/or HIV/AIDS in disproportionately affected Los Angeles County SPA 6.						x			x	
SAMHSA- Capacity Building Initiative (Center for Substance Abuse Prevention)	JWCH Institute, Inc.	\$283,875	09/30/2015 - 09/29/2020	YMC Project: YMSM of color (13-24 years) Develop a Youth Service Provider Network, HIV/viral hepatitis testing, viral hepatitis vaccination, and the implementation of two HIV/SA prevention focused evidence-based practices (Community PROMISE and Communities That Care (CTC)). The project will also include direct linkages to HIV primary care, mental health treatment, and other prevention and care services.										x
SAMHSA- Capacity Building Initiative (Center for Substance Abuse Prevention)	Center for Health Justice	\$283,875	09/30/2015 - 09/29/2020	KIR project will enhance and expand its existing efforts to comprehensively address needs related to SA, HIV/AIDS, and viral hepatitis education and prevention among African										x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
				American and Latino youth (18-24; transgender (M2F); men who have sex with men; female sex workers; and male injection drug users) transitioning out of LA County Jails and back into their communities.									
SAMHSA- Capacity Building Initiative (Center for Substance Abuse Prevention)	Bienvenidos Children's Center, Inc.	\$283,875	09/30/2015 - 09/29/2020	<u>Project SAFE-LA</u> : To develop the infrastructure and capacity necessary for a system of integrated HIV and substance abuse, HIV and Viral Hepatitis prevention services for the greater East Los Angeles community. Additionally, direct and indirect drug and HIV prevention services will be provided to Latino youth in 2 local high schools and on 2 local college campuses.	x								
SAMHSA- Capacity Building Initiative (Center for Substance Abuse Prevention)	Sunrise Community Counseling Center	\$283,875	09/30/2015 - 09/29/2020	<u>Dial/Project New Day (PND)</u> : Will offer a variety of substance abuse prevention services coupled with HIV and viral hepatitis prevention services to improve behavioral health and clinical outcomes for racial/ethnic minority individuals including Hispanic or Latinos, African Americans, gays, bisexuals, lesbians, and transgendered individuals. PND will expand prevention services for youth and young adults (13-24 years old) with substance use disorders that are at high risk for or living with HIV/AIDS.	x								

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
SAMHSA- Capacity Building Initiative (Center for Substance Abuse Prevention)	APLA Health & Wellness	\$283,875	09/30/2015 - 09/29/2020	D.I.C.E. Lives is an adapted version of the evidence-based intervention-Project TND (Towards No Drug Abuse). It provides services to 568 high-risk African American and Latino young men (18-24 years), including MSM living in Los Angeles County. The APLA anticipates the following activity: (1) through outreach, recruit high risk young men to participate in program activities; (2) provide HIV counseling and testing; (3) provide screening for viral hepatitis; (4) and develop and implement a media campaign in the metro system as a key environmental strategy.	x		x	x				
SAMHSA-Minority Serving Institution/CBO (Center for Substance Abuse Prevention)	California State University Long Beach	\$299,997	09/30/2014 - 09/29/2017	California State University Long Beach (CSULB) is partnering with Bienestar Human Services, Inc. to deliver-Salud a la Vida: Cheers to Life!-alcohol/substance abuse, HIV, HCV prevention program targeting Latino young adults, 18-24 years who are either CSULB students or City of Long Beach residents. A minimum of 300 Latino young adults will participate in a SAMHSA evidence-based intervention.	x		x	x				

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
SAMHSA-Minority Serving Institution/CBO (Center for Substance Abuse Prevention)	California State University Long Beach	\$299,998	09/30/2015 - 09/29/2018	California State University, Long Beach (CSULB) Center for Health Equity Research, in partnership with St. Mary Medical Center, the LGBTQ Center Long Beach, the Long Beach Department of Health and Human Services (LBDHHS) and Behavioral Health Services (BHS), will address an unmet need on campus and in the Long Beach community to serve young Black men who have sex with men (MSM) ages 18 to 24 at risk for substance use and HIV and hepatitis C (HCV) infection.	x							
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Tarzana Treatment Center, Inc.	\$500,000	09/30/2012 - 09/29/2017	Substance use disorder and co-occurring substance use and mental health outpatient services to young, minority men who have sex with men (YMMSM). Getting Off at TTC, located in, and primarily serving clients from northwestern Los Angeles County in SPA 2, will use Getting Off with Friends, an evidence-based program built on the success of Cognitive Behavioral Therapy and Contingency Management. Getting Off will serve 80 participants per year and 380 over the project period.	x				x	x		x
SAMHSA-ATTC Regional Center (Center for Substance Abuse Treatment)	University Of California Los Angeles	\$1,341,875	09/30/2012 - 09/29/2017	This program will create a Center of Excellence (CoE) for racial/ethnic minority YMSM and other LGBT populations to provide training and technical assistance on culturally responsive prevention and treatment services to decrease rates of substance use and HIV	x	x	x	x	x	x		x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Volunteers Of America Of Los Angeles	\$500,000	09/30/2012 - 09/29/2017	<p>infections among racial/ethnic minority YMSM (ages 18-29), and other LGBT communities. Outpatient substance abuse treatment program which includes trauma-based interventions and is linked to integrated mental health and primary health care (including HIV and hepatitis interventions), case management, wraparound recovery support and aftercare for the targeted population. Services will target a minimum of 75% racial/ethnic minority populations who have substance use and/or co-occurring substance use and mental health disorders and are at highest risk for or living with HIV and includes offenders leaving the LA County Sheriff's Department, particularly its K6G unit for gay men and transgender women, including young (age 18-29) and older (30 and older) MSM, and a small percentage of heterosexual men and women. It is anticipated that the project will serve 120 unduplicated persons annually and a total of 600 over the five-year project period.</p>					X	X	X	

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Special Service For Groups, Inc.	\$520,000	09/01/2014 - 08/31/2016	<p>Healing, Empowering, and Living (HEAL): This is a trauma-informed outpatient substance abuse treatment program for racial/ethnic minority women (including transgender women) over the age of 18 in Los Angeles (LA), with a focus on Asian/Pacific Islander (API) and Hispanic/ Latina women. HEAL implements two evidence-based practices: (1) RESPECT, an HIV risk reduction intervention provided in conjunction with HIV and hepatitis B/C testing; and (2) Seeking Safety, a structured, integrated treatment intervention for substance abuse and trauma.</p>	x	x	x	x	x	x	x	x
SAMHSA-MAI-COC Pilot 2014 (Center for Substance Abuse Treatment)	Volunteers Of America Of Los Angeles	\$500,000	09/30/2014 - 09/29/2018	<p>Volunteers of America of LA (VOALA), in partnership with HHCLA, LA Christian Health Centers, and AIDS Healthcare Foundation will integrate HIV/hepatitis prevention and medical care as well as primary health care through co-located sites with VOALA's and HHCLA's behavioral health care, case management, wraparound and peer support services, and aftercare for the benefit of eligible racial/ethnic minority populations in Service Planning Area 4. The project will serve a total of 450 participants over the four-year period.</p>	x	x	x	x	x	x	x	x
SAMHSA-MAI-COC Pilot 2014 (Center for Substance Abuse Treatment)	Sunrise Community Counseling Center	\$483,226	09/30/2014 - 09/29/2018	<p>Proyecto Buena Vida/Project Good Life (PBV/PGL): Will offer a variety of integrated behavioral health services coupled with HIV prevention and medical care to</p>	x		x	x	x	x	x	xx

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
				<p>improve behavioral health and clinical outcomes for racial/ethnic minority individuals including Hispanic or Latinos, African Americans, and gays, bisexuals, lesbian, and transgendered individuals. PBV/PGL will expand behavioral health services for over 235 participants with mental health and substance abuse disorders that are at high risk for or living with HIV.</p>									
SAMHSA-MAI-COC Pilot 2014 (Center for Substance Abuse Treatment)	Special Service For Groups, Inc.	\$500,000	09/30/2014 - 09/29/2018	<p>Special Service for Groups (SSG) will implement the Health Integration for At-risk Racial/Ethnic Communities (HI-ARC) program. The program seeks to provide substance abuse and co-occurring mental health treatment services in conjunction with HIV/AIDS services for MSM, ages 18 and over who are most at-risk for or are living with HIV/AIDS. The program will serve 70 clients per year, 280 over the four-year award, through a culturally and linguistically competent program based on RESPECT and Seeking Safety; all eligible participants will receive rapid HIV testing with RESPECT counseling; all eligible clients will receive hepatitis B/C testing and counseling; all clients will receive case management; all clients accepted and enrolled in the program will participate in Seeking Safety; and all eligible clients will be enrolled in HIV Medical services and necessary primary care services.</p>	x	x	x	x	x	x	x	x	

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
SAMHSA-TCE-HIV 2015 (Center for Substance Abuse Treatment)	Sunrise Community Counseling Center	\$496,365	09/30/2015 - 09/29/2018	<p>Proyecto Progresando Juntos (PPJ) will offer substance abuse and mental health treatment services coupled with HIV and viral hepatitis (VH) prevention and treatment services to improve behavioral health and clinical outcomes for Hispanic/Latinos including LGBT individuals. PPJ will expand treatment services for 240 adults (18 years old and over) with substance abuse, mental health, or co-occurring disorder issues that are at high risk for or living with HIV/AIDS or viral hepatitis.</p>	x	x	x	x	x	x	x	x
SAMHSA-TCE-HIV 2015 (Center for Substance Abuse Treatment)	Southern California Alcohol/Drug Progs	\$500,000	09/30/2015 - 09/29/2018	<p>Southern California Alcohol and Drug Programs, in partnership with Homeless Health Care Los Angeles, will expand substance abuse disorder treatment, behavioral health and HIV services for Hispanic/Latino and African American/Black adult men and women over the age of 18 who have substance abuse and/or co-occurring disorders with or at high risk of HIV. In addition to substance abuse treatment, clients will receive integrated mental health and trauma-informed care, HIV prevention and medical care, primary health care, case management, linkage to public benefits and health care enrollment, wraparound supports and aftercare to promote stability and improved outcomes. The project will serve 330 participants over the three-year period.</p>	x	x	x	x	x	x	x	x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Bienestar Human Services, Inc.	\$500,000	09/30/2012 - 09/29/2017	With Cri-Help, Inc., Bienestar Human Services, Inc. will implement Nuevo Amanecer (New Dawn) to expand and enhance culturally competent treatment and recovery services for substance use or co-occurring substance abuse and mental disorders for young Latino men who have sex with men (YLSM) in the San Fernando Valley. Over the project's five years, Nuevo Amanecer will deliver treatment/ recovery services to YLSM (18-29 years old). A total of 570 individuals will be served. The program will incorporate a 20-week intensive outpatient treatment curriculum consisting of the evidence-based Matrix Model of treatment with recovery reinforcement enhancement.	x		x	x	x	x		x
SAMHSA-MAI-COC Pilot 2014 (Center for Substance Abuse Treatment)	Bienestar Human Services, Inc.	\$500,000	09/30/2014 - 09/29/2018	Bienestar is partnering with the AIDS Healthcare Foundation, Inc. to deliver Clinica Bienestar-a co-located and integrated culturally responsive substance abuse, mental health, and co-occurring disorder treatment and HIV medical care program. The program will target Latino adults and other persons of color, 18-64 years of age living in East Los Angeles, serving at minimum 400 participants. Bienestar will deliver a 20-week enhanced version of the Matrix Model evidence-based practice for substance use and co-occurring disorder treatment to 160 participants, and 12	x		x	x	x	x		x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>						
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>
SAMHSA-TCE-HIV 2015 (Center for Substance Abuse Treatment)	Bienvenidos Community Health Center	\$500,000	09/30/2015 - 09/29/2018	<p>weeks of cognitive behavioral therapy for persons presenting with mental illness only. Lastly, Bienestar will provide integrated behavioral health/HIV medical care to 160 HIV positive Latinos and other persons of color.</p> <p>A substance use disorder treatment project for ethnic minorities at high-risk for HIV/AIDS, which will serve Latinos and other ethnic minorities who are low-income and/or uninsured and will have a subpopulation focus on YMSM ages 18-29. The goals of this project are to: (1) reduce the number of people who become infected with HIV; (2) increase access to care and optimize health outcomes for people living with HIV; (3) reduce HIV-related health disparities; (4) provide behavioral health services to patients in need of these services.</p>	x	x	x	x	x	x	x
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Behavioral Health Services, Inc.	\$500,000	09/30/2012 - 09/29/2017	<p>Behavioral Health Services, Inc. in partnership with the Gay and Lesbian Community Center of Long Beach will provide substance abuse counseling and prevention case management services to 18-29 year old MSM of color in the Greater Long Beach area. This will be accomplished through targeted street and internet outreach to the population. The proposed evidence-based intervention is Motivational Enhancement Therapy (MET). The program will</p>	x						

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
				serve 500 clients during five years.									
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Watts Healthcare Corporation	\$500,000	09/30/2012 - 09/29/2017	Outreach provided at three large public housing projects in the Watts community of Los Angeles for high-risk individuals. HIV treatment services are also provided. The population of focus is African American and Latino adults that primarily reside in three large public housing complexes managed by the Housing Authority of the City of Los Angeles. WHCC will serve 130 unduplicated clients each year totaling 650 throughout the lifetime of the project.	x	x	x	x	x	x	x	x	
SAMHSA-Targeted Capacity - HIV/AIDS (Center for Substance Abuse Treatment)	Safe Refuge	\$424,572	9/01/15 - 8/31/16	The Integrated Services To Avert Risk (iSTAR) Project is a culturally appropriate, women and family centered, trauma-informed substance abuse/co-occurring mental health treatment and HIV/viral hepatitis services program that targets the needs of highly vulnerable, economically disadvantaged minority women (ages 18 years and older), including heterosexual, lesbian, bisexual, previously incarcerated women, and their significant others, who have substance use or co-occurring substance use and mental disorders and are living with or at risk for HIV/AIDS. The iSTAR project will be enhanced through the implementation of the HTS screening tools and the establishment of a coordinated approach to address intimate	x	x	x	x	x	x	x	x	

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>								
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>		
				Partner Violence (IPV) among participants.									
State of CA (1204)	City of Long Beach	\$602,972	1/16-12/16	HIV Testing & Outreach (funds are also used for 1.0 FTE DIS)	x								
State of CA (1207)	City of Long Beach	\$263,052	7/15-6/16	HIV Surveillance		x		x	x	x			x
State of CA (1250)	City of Long Beach	\$155,764	4/16-3/17	Linkage and Outreach Services (Minority AIDS Initiative)				x	x				
State of CA (1265)	City of Long Beach	\$1,442,742	4/16-3/17	Medical care, case management, outreach, and linkage to care					x	x	x		x
Tobacco Master Settle Funds	LAC Substance Abuse Prevention & Control	\$500,000	ongoing	Needle exchange program for areas outside the City of Los Angeles. The program currently serves about 1,500 unduplicated clients. SAPC estimates there are 151,000 IDUs in LAC.	x								
Los Angeles County	LAC Substance Abuse Prevention & Control	\$5,000,000	ongoing	Early Intervention Services that include: risk assessment, pre/posttest counseling, HIV/HCV/STD/TB testing; linkage to care; medical intervention; treatment adherence services; patient navigation; medical transportation; overdose education; risk reduction; encourage to enter substance abuse services	x		x	x	x	x			x
City of Los Angeles	City of Los Angeles contractor	\$40,000	7/1/15-6/30/16	Health Education/Risk Reduction (HE/RR) targeting AA/Latino Youth	x								
City of Los Angeles	City of Los Angeles contractor	\$50,000	7/1/15-6/30/16	HE/RR targeting API 18+	x								
City of Los Angeles	City of Los Angeles contractor	\$55,000	7/1/15-6/30/16	HE/RR targeting HIV+ Latinas	x								
City of Los Angeles	City of Los Angeles contractor	\$55,000	7/1/15-6/30/16	HE/RR targeting Homeless Youth	x								
City of Los Angeles	City of Los Angeles contractor	\$45,000	7/1/15-6/30/16	HE/RR targeting Incarcerated MSM	x								
City of Los Angeles	City of Los Angeles contractor	\$40,000	7/1/15-6/30/16	HE/RR targeting Transgender Women	x								

SOURCE	GRANTEE	AMOUNT	PERIOD	SERVICES PROVIDED	HIV CONTINUUM OF CARE STEPS IMPACTED								
					Prevention	PrEP	DX	Linked	Retained	ART	Suppressed		
City of Los Angeles	City of Los Angeles contractor	\$50,000	7/1/15-6/30/16	HE/RR targeting Transgender Youth	x								
City of Los Angeles	City of Los Angeles contractor	\$45,000	7/1/15-6/30/16	HE/RR targeting Young AA MSM	x								
City of Los Angeles	City of Los Angeles contractor	\$55,000	7/1/15-6/30/16	Routine HIV Testing	x		x						
City of Los Angeles	City of Los Angeles contractor	\$450,000	7/1/15-6/30/16	Syringe Collection and Disposal	x								
City of Los Angeles	City of Los Angeles contractor	\$50,000	7/1/15-6/30/16	Transgender Economic Empowerment	x								
City of Pasadena	City of Pasadena	\$109,000	1/1/16-12/31/16	HIV Counseling & Testing	x		x						
City of Pasadena	City of Pasadena	\$299,000	7/1/16-9/30/17	Operation Link- Serves homeless HIV positive individuals with mental illness, substance abuse issues and other comorbidities	x		x					x	
City of West Hollywood	City of West Hollywood	\$184,222	7/1/14 - 6/30/15	Oral Health Care						x			x
City of West Hollywood	City of West Hollywood	\$102,073	7/1/14 - 6/30/15	Mental Health Services	x			x				x	x
City of West Hollywood	City of West Hollywood	\$128,083	7/1/14 - 6/30/15	Early Intervention Services (including HIV testing)	x		x					x	x
City of West Hollywood	City of West Hollywood	\$112,231	7/1/14 - 6/30/15	Outpatient substance abuse services	x				x			x	x
City of West Hollywood	City of West Hollywood	\$207,627	7/1/14 - 6/30/15	Case management (non-medical)	x				x			x	x
City of West Hollywood	City of West Hollywood	\$209,001	7/1/14 - 6/30/15	Residential Substance Abuse services	x				x			x	x
City of West Hollywood	City of West Hollywood	\$84,611	7/1/14 - 6/30/15	Housing services	x				x			x	x
City of West Hollywood	City of West Hollywood	\$118,757	7/1/14 - 6/30/15	Outreach	x		x					x	x
City of West Hollywood	City of West Hollywood	\$70,414	7/1/14 - 6/30/15	Food bank/home delivered meals	x				x			x	x
City of West Hollywood	City of West Hollywood	\$25,000	7/1/14 - 6/30/15	Transportation	x				x			x	x
City of West Hollywood	City of West Hollywood	\$21,250	7/1/14 - 6/30/15	Legal Services	x				x			x	x
City of West Hollywood	City of West Hollywood	\$153,000	7/1/14 - 6/30/15	Referral for Health and Support Services	x				x			x	x

<u>SOURCE</u>	<u>GRANTEE</u>	<u>AMOUNT</u>	<u>PERIOD</u>	<u>SERVICES PROVIDED</u>	<u>HIV CONTINUUM OF CARE STEPS IMPACTED</u>							
					<u>Prevention</u>	<u>PrEP</u>	<u>DX</u>	<u>Linked</u>	<u>Retained</u>	<u>ART</u>	<u>Suppressed</u>	
City of West Hollywood	City of West Hollywood	\$153,960	7/1/14 - 6/30/15	HIV education, peer support, animal companion support	x			x	x	x		x
City of West Hollywood	City of West Hollywood	\$102,500	7/1/14 - 6/30/15	Administration and in-kind support	N/A							
Gilead Sciences	Individual Patients	not available	not available	Patient Assistance Program supports cost of Truvada for PrEP. Program increased 280% from previous year.		x						
HRSA Bureau of Primary Care	38 Section 330 FOHC Grantees	\$293,376	1/1/14-12/31/14	FOHC services - primary medical care, etc. Funds to serve an estimated 7,051 HIV positive patients. An additional 121 HIV positive patients being served through FOHC Look-Alike centers that do not receive Section 330 funding.			x	x	x	x		x
U.S. Department of Veterans Affairs	Greater Los Angeles VA System	not available	ongoing	Provides primary medical care and HIV specific services to approximately 600 HIV positive veterans.			x	x	x	x		x
U.S. Department of Veterans Affairs	Greater Los Angeles VA System	not available	ongoing	Provides PrEP to approximately 50 veterans		x						
U.S. Department of Veterans Affairs/ Housing and Urban Development	Greater Los Angeles VA System	not available	ongoing	VA Supported Housing (VASH) program provides Section 8 vouchers to homeless veterans coupled with intensive case management services.					x			x

Attachment B. HIV Service Needs by HRSA Part A Service Category

Service Category:	HRSA Core Service Category		Los Angeles County Category
	Outpatient/Ambulatory Health Services		Medical Outpatient
Rationale/Assumption	<p>Rationale: PLWH need access to culturally and linguistically responsive primary medical care to improve health outcomes and reduce HIV-related health disparities. This is based on current HIV treatment guidelines that recommends antiretroviral therapy prescription (ART) for all PLWH.¹ Also based on a “treatment as prevention” strategy to reduce new HIV infections.²</p> <p>Assumption: 100% of PLWH need access to medical outpatient services to improve their health and well-being and reduce risk of transmitting HIV to non-infected persons.</p>		
Estimate	Need	48,908	Gap 13,745
Measurement Source	2014 HIV/STD Surveillance Report		
Limitations	<ul style="list-style-type: none"> The need and gap estimates exclude 7,196 estimated undiagnosed persons and 1,820 estimated annual new infections who will need this service once they are diagnosed. Does not identify the total number of PLWH who are in need of Ryan White-funded care due to ineligibility in other programs. 		
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White funds for eligible uninsured Public and Private health insurance, inclusive of plans accessed through Covered California VA Greater Los Angeles Healthcare System Healthy Way LA Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) 		

Service Category:	HRSA Core Service Category		Los Angeles County Category
	Outpatient/Ambulatory Health Services		Medical Specialty
Rationale/Assumption	<p>Rationale: PLWH with chronic and other health conditions need access to medical specialty services. This need may continue to grow with an aging population of PLWH.</p> <p>Assumption: 38.9% of 2011 LACHNA-CARE respondents reported a need for Medical Specialty services; 12.4% did not receive it.</p>		
Estimate	Need	7,054	Gap 2,249
Measurement Source	2011 LACHNA		
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. These estimates exclude non-Ryan White PLWH. The 2011 LACHNA-CARE is pre-ACA and may now over-estimate the gap for medical specialty services as more PLWH are insured. 		
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White funds for eligible uninsured Public and Private health insurance, inclusive of plans accessed through Covered California VA Greater Los Angeles Healthcare System Healthy Way LA Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) 		

Service Category:	HRSA Core Service Category AIDS Pharmaceutical Assistance	Los Angeles County Category None
Rationale/Assumption	Rationale: Current HIV treatment guidelines recommend that all PLWH are prescribed antiretroviral therapy prescription (ART) regardless of CD4 count. ¹ As ART is known to improve viral suppression among PLWH, there is a 94% transmission reduction of HIV in PLWH who are virally suppressed. Thus, ART prescription supports a “treatment as prevention” strategy to reduce new HIV infections. ² Assumption: 100% of PLWH are recommended to be prescribed ART.	
Estimate	Need 1 48,908	Gap 16,286
Measurement Source	2014 HIV/STD Surveillance Report	MIMP data (33.3% not prescribed ART) as reported in FY 2016 Part A application
Limitations	<ul style="list-style-type: none"> The need and gap estimates exclude 7,196 estimated undiagnosed persons and 1,820 estimated annual new infections who will need this service once they are diagnosed. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part B: AIDS Drug Assistance Program Medi-Cal Medicare Part D Private health insurance Other public health insurance programs (e.g., Healthy Kids) VA Greater Los Angeles Healthcare System Pharmaceutical companies’ patient assistance programs 	

Service Category:	HRSA Core Service Category Oral Health Care	Los Angeles County Category Oral Health
Rationale/Assumption	Rationale: “PLWH experience a high incidence of common oral health problems (e.g., dental decay/cavities, gingivitis) as well as other oral health problems that are directly related to HIV infection. Between 32 and 46 percent of PLWHA will have at least one major HIV-related oral health problem—bacterial, viral, and fungal infections as well as cancer and ulcers—in the course of their disease.” ^{3,4} Assumption: 100% of PLWH need for oral health care services; 34.2% of 2011 LACHNA-CARE respondents did not receive it.	
Estimate	Need 48,908	Gap 6,202
Measurement Source	2014 HIV/STD Surveillance Report	2011 LACHNA-CARE
Limitations	<ul style="list-style-type: none"> The estimate of service gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. The gap estimate excludes non-Ryan White PLWH. The 2011 LACHNA-CARE was conducted prior to the Denti-Cal program expanding the availability basic services to adults beginning May 1, 2014. See: http://www.cda.org/news-events/basic-denti-cal-services-for-adults-to-be-re-established-may-1. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Parts A/B/C/D for eligible PLWH HRSA Ryan White Part F: Dental Reimbursement Programs at UCLA and USC California Denti-Cal Private dental insurance FQHCs are legislatively required to offer oral health preventive services 	

Service Category:	HRSA Core Service Category		Los Angeles County Category	
	Early Intervention Services		Early Intervention Program	
Rationale/Assumption	<p>Rationale: PLWH who are newly diagnosed need services that will newly link them to HIV care and supportive services in order to improve their health and reduce risk of transmitting HIV to others.</p> <p>Assumption: 100% of PLWH who are undiagnosed need the combination of services within EIS to be tested, provided referrals, and linked to HIV care and treatment services.</p>			
Estimate	Need	7,196	Gap	7,196
Measurement Source	April 2016 DHSP estimate of undiagnosed PLWH			
Limitations	<ul style="list-style-type: none"> The need estimate excludes 1,829 estimated annual new infections who will have a need for this service once they are diagnosed. Estimate of gap is unable to be determined based on available data. HRSA Ryan White Part A/B/C funds 			
Potential Resources				

Service Category:	HRSA Core Service Category		Los Angeles County Category	
	Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals		Refers PLWH to Office of AIDS Health Insurance Premium Payment Program (OA-HIPP)	
Rationale/Assumption	<p>Rationale: Maintaining continuity of health insurance improves PLWH's ability to access HIV medical treatment and other services. The Health Insurance Premium Payment Program is designed to assist PLWH who are unable to pay the full amount of their insurance premium.</p> <p>Assumption: 24.9% of PLWH responding to the 2011 LACHNA-CARE reported a need for this service; 11.8% reported a gap.</p>			
Estimate	Need	4,515	Gap	2,140
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. Participation in the OA-HIPP program requires ADAP enrollment. Ryan White Part B funds through the State of California Office of AIDS 			
Potential Resources				

Service Category:		HRSA Core Service Category Home Health Care	Los Angeles County Category Home Health Care
Rationale/Assumption	<p>Rationale: Home Health Care refers to a wide variety of services that are provided in the home generally due to an illness or injury.⁵ Need for this service is determined based on medical necessity.</p> <p>Assumption: 7.8% of 2011 LACHNA respondents reported a need for this service; 4% reported they did not receive this service.</p>		
Estimate	Need	1,414	Gap 725
Measurement Source	2011 LACHNA-CARE		
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. The 2011 LACHNA-CARE is pre-ACA and may now over-estimate the gap for Home Health Care as more PLWH are insured. 		
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A Public and private insurance VA Greater Los Angeles Health System 		

Service Category:		HRSA Core Service Category Home and Community Based Health Services	Los Angeles County Category Home Based Case Management
Rationale/Assumption	<p>Rationale: Home and Community Based Health Services is a HRSA Ryan White service category that provides similar services as Home Health Care. Need for this service is determined based on medical necessity.</p> <p>Assumption: 4.2% of 2011 LACHNA-CARE respondents reported a need for this service; 1.8% of respondents did not receive service.</p>		
Estimate	Need	762	Gap 326
Measurement Source	2011 LACHNA-CARE		
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 		
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A 		

Service Category:	HRSA Core Service Category Hospice Services	Los Angeles County Category Hospice Services
Rationale/Assumption	Rationale: Hospice is a palliative approach to end-of-life care that is provided in a person's home. PLWH must meet the medical criteria for hospice services with a life expectancy of six months. Assumption: 2.9% of 2011 LACHNA-CARE respondents reported need for Hospice Services; 2% of respondents did not receive service.	
Estimate	Need 526	Gap 363
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. The 2011 LACHNA-CARE is pre-ACA and may now over-estimate the gap for Hospice Services as more PLWH are insured. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A Public and private insurance 	

Service Category:	HRSA Core Service Category Mental Health Services	Los Angeles County Category Mental Health, Psychotherapy Mental Health, Psychiatry
Rationale/Assumption	Rationale: PLWH have a significantly higher rate of mental health disorders than the general population. PLWH with mental health disorders are less likely to be adherent to their HIV treatment regimen. ⁶ Assumption 1: 30.7% of 2011 LACHNA-CARE respondents reported need for <u>Mental Health, Psychotherapy</u> services; 11.3% reported they did not receive it. Assumption 2: 45.1% of 2011 LACHNA-CARE respondents reported need for <u>Mental Health, Psychiatry</u> services; 9.3% reported they did not receive it.	
Estimate	Need 1 5,567	Gap 1 2,049
Measurement Source	Need 2 8,178	Gap 2 1,632
Limitations	2011 LACHNA-CARE	
Potential Resources	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. These estimates exclude non-Ryan White PLWH. The 2011 LACHNA-CARE is pre-ACA and the gap for Mental Health Services is unclear as PLWH anecdotally report difficulty in accessing insurer-paid Mental Health Services, especially bilingual services. HRSA Ryan White Part A Public and private insurance VA Greater Los Angeles Healthcare System FQHCs are legislatively required to provide referrals for mental health services 	

Service Category:	HRSA Core Service Category	Los Angeles County Category
	Medical Nutrition Therapy	Medical Nutrition Therapy
Rationale/Assumption	<p>Rationale: The American Dietetic Association supports the position that “medical nutrition therapy, assurance of food and nutrition security, and nutrition education are essential to the total system of health care available” to PLWH.”⁷</p> <p>Assumption: 54.4% of 2011 LACHNA-CARE respondents reported need for service; 18.9% reported that they did not receive it.</p>	
Estimate	Need 9,865	Gap 3,427
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. The 2011 LACHNA-CARE is pre-ACA and may now over-estimate the gap for medical nutrition therapy as more PLWH are insured. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A Public and private insurance VA Greater Los Angeles Healthcare System 	

Service Category:	HRSA Core Service Category	Los Angeles County Category
	Medical Case Management, including Treatment Adherence Services	Medical Care Coordination
Rationale/Assumption	<p>Rationale: MCC is intended to improve health outcomes for higher acuity PLWH who are not self-managed. It provides intensive, nursing case management services, including treatment adherence counseling to clients.</p> <p>Assumption 1: 9.8% of 2011 LACHNA-CARE respondents reported a need for this service; 3.1% reported they did not receive it.</p>	
Estimate	Need 1,777	Gap 562
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A funds for eligible uninsured Public and Private health insurance VA Greater Los Angeles Healthcare System Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) 	

Service Category:	HRSA Core Service Category	Los Angeles County Category								
	Substance Abuse Outpatient Care	Substance Abuse Treatment, outpatient Substance Abuse Treatment, Methadone								
Rationale/Assumption	<p>Rationale: PLWH with substance use issues are less likely to be adherent to their HIV treatment regimen. People who inject drugs (PWID) have among the poorest viral suppression of various population groups in Los Angeles County.</p> <p>Assumption 1: 11.3% of 2011 LACHNA-CARE respondents reported a need for Substance Abuse Treatment, outpatient services; 4.2% did not receive it.</p> <p>Assumption 2: 2.2% of 2011 LACHNA-CARE respondents reported a need for Substance Abuse, Methadone services; 0.4% did not receive it.</p>									
Estimate	<table border="1"> <tr> <td>Need 1</td> <td>2,049</td> <td>Gap 1</td> <td>762</td> </tr> <tr> <td>Need 2</td> <td>399</td> <td>Gap 2</td> <td>73</td> </tr> </table>	Need 1	2,049	Gap 1	762	Need 2	399	Gap 2	73	
Need 1	2,049	Gap 1	762							
Need 2	399	Gap 2	73							
Measurement Source	2011 LACHNA-CARE	2011 LACHNA-CARE								
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA, which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. 									
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White funds for eligible uninsured Public and Private health insurance VA Greater Los Angeles Healthcare System Los Angeles County Department of Public Health Substance Abuse Prevention and Control <p>[Note: In Fiscal Year 2014-15, SAPC had 23,790 outpatient treatment admissions serving 20,798 total clients; 2,803 Intensive outpatient treatment admissions and 2,674 total clients; and 20,717 Opioid Treatment admissions and 16,309 total clients.</p> <ul style="list-style-type: none"> SAMHSA directly funded treatment programs to community based organizations 									

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	Non-Medical Case Management Services		Psychosocial Case Management	
Rationale/Assumption	<p>Rationale: Non-medical case management services can assist PLWH with identifying and accessing medical, social, community, legal, financial, and other services to address their needs. Addressing needs are intended to improve retention and care, treatment adherence, and viral suppression.</p> <p>Assumption 1: 79.8% of 2011 LACHNA-CARE respondents reported a need for Psychosocial Case Management Services; 10.4% did not receive it.</p> <p>Assumption 2: 6% of 2011 LACHNA-CARE respondents reported a need for Transitional Case Management Services (Criminal Justice); 2% did not receive it.</p> <p>Assumption 3: 4.4% of 2011 LACHNA-CARE respondents reported a need for Transitional Case Management Services (Youth); 1.8% did not receive it.</p>			
Estimate	Need 1	14,471	Gap 1	1,886
	Need 2	1,088	Gap 2	363
	Need 3	798	Gap 3	326
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. These case management categories in LACHNA may include duplicated PLWH respondents across categories. 			
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B/C/D VA Greater Los Angeles Healthcare System FQHCs are legislatively required to offer case management services to patients 			

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	Child Care Services		Child Care	
Rationale/Assumption	<p>Rationale:</p> <p>Assumption: 1.8% of 2011 LACHNA-CARE respondents reported a need for child care services; 0.7% did not receive it.</p>			
Estimate	Need	326	Gap	127
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. 			
Potential Resources	<ul style="list-style-type: none"> Head Start Early Childhood Services (birth to 2 years) Head Start Services (3-5 years) California State Pre-School Program (CSPP) for eligible 3 and 4 year old children offered through LAUSD and other school districts CalWorks Childcare Program Private daycare and early childhood education programs 			

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	Emergency Financial Assistance		Direct Emergency Financial	
Rationale/Assumption	<p>Rationale: This service is intended to provide one-time or short-term payments to assist with basic needs, including utilities, housing, food, transportation, and medication.</p> <p>Assumption: 25.1% of 2011 LACHNA-CARE respondents reported a need for short-term rent, mortgage, and/or utility assistance; 20% did not receive it.</p>			
Estimate	Need	4,552	Gap	3,627
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 			
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White funds Discounted rates available through local utility companies (e.g., SCE) for low income persons California Low Income Home Energy Assistance Program (LIHEAP) 			

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	Food Bank/Home Delivered Meals		Nutrition Support, food bank Nutrition Support, home delivered Meals	
Rationale/Assumption	<p>Rationale: This provides assistance to help PLWH meet basic need for food and nutrition.</p> <p>Assumption 1: 59.1% of 2011 LACHNA-CARE respondents reported need for Nutrition Support, food bank; 19.8% did not receive it.</p> <p>Assumption 2: 12.2% of 2011 LACHNA-CARE respondents reported a need for Nutrition Support, home delivered meals; 6.4% did not receive it.</p>			
Estimate	Need 1	10,717	Gap 1	3,591
	Need 2	2,212	Gap 2	1,161
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. 			
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B Local community/church food banks Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps Women, Infants, and Children (WIC) benefits Meals on Wheels 			

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	Health Education/Risk Reduction		Health Education/Risk Reduction Treatment Education	
Rationale/Assumption	<p>Rationale: HE/RR may include but is not limited to: educating PLWH about transmission risk and risk reduction strategies, including PrEP; education about health insurance options; health literacy education; and treatment adherence education.</p> <p>Assumption 1: 19.3% of 2011 LACHNA-CARE respondents reported a need for <u>Health Education/Risk Reduction</u>; 7.8% reported not receiving it.</p> <p>Assumption 2: 14% of 2011 LACHNA-CARE respondents reported a need for <u>Treatment Education</u>; 8.7% reported not receiving it.</p>			
Estimate	Need 1	3,500	Gap 1	1,414
	Need 2	2,539	Gap 2	1,578
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. 			
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B/C/D Covered California enrollment counselors Public and private healthcare providers VA Greater Los Angeles Healthcare System 			

Service Category:	HRSA Support Service Category	Los Angeles County Category
	Housing	Housing Case Management Rental Assistance Residential Care and Housing Skilled Nursing
Rationale/Assumption	<p>Rationale: PLWH who have stable housing have improved health outcomes, including viral suppression. The NHAS Updated to 2020 also calls for a reduction in homelessness, thereby increasing PLWH who are stably housed.</p> <p>Assumptions:</p> <ol style="list-style-type: none"> 48.7% of 2011 LACHNA-CARE respondents reported a need for rental assistance; 28% did not receive it. 31.8% of 2011 LACHNA-CARE respondents reported a need for Housing Case Management Services; 15.1% did not receive it. 15.8% of 2011 LACHNA-CARE respondents reported a need for Transitional Housing; 7.3% did not receive it. 13.3% of 2011 LACHNA-CARE respondents reported a need for Permanent Supportive Housing; 9.6% did not receive it. 11.1% of 2011 LACHNA-CARE respondents reported a need for Emergency Shelter; 6% did not receive it. 4% of 2011 LACHNA-CARE respondents reported a need for Residential Care Facility for the Chronically Ill; 1.8% did not receive it. 4.2% of 2011 LACHNA-CARE respondents reported a need for a Transitional Residential Care Facility; 2.7% did not receive it. 3.1% of 2011 LACHNA-CARE respondents reported a need for Skilled Nursing; 2% did not receive it. 	
Estimate		Gap 1 5,077 Gap 2 2,738 Gap 3 1,324 Gap 4 1,741 Gap 5 1,088 Gap 6 490 Gap 7 326 Gap 8 363
	Need 1 - Rental Assistance	8,831
	Need 2 - Housing Case Management	5,767
	Need 3 - Transitional Housing	2,865
	Need 4 - Permanent Supportive Housing	2,412
	Need 5 - Emergency Shelter	2,013
	Need 6 - Transitional Residential Care Facility	762
	Need 7 - Residential Care Facility for Chronically Ill	725
	Need 8 - Skilled Nursing	562
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. PLWH reporting needs may be duplicated across categories. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B HOPWA [Note: In Program Year 2015/2016, HOPWA served 867 PLWH across its various programs; 105 for short-term rental, mortgage, utility assistance; 237 tenant based rental assistance; 406 transitional housing; and 119 permanent housing] Housing Choice Voucher Program (HUD) Discounted rates available through local utility companies (e.g., SCE) for low income persons California Low Income Home Energy Assistance Program (LIHEAP) Public and private insurance (for skilled nursing) 	

Service Category:	HRSA Support Service Category	Los Angeles County Category/ies
	Other Professional Services	Legal Services
Rationale/Assumption	Rationale: Intended to be used for legal services, income tax preparation, and/or permanency planning. Assumption: 10.4% of 2011 LACHNA-CARE respondents reported a need for Legal Services; 8% did not receive it.	
Estimate	Need 1,886	Gap 1,450
Measurement Source	2011 LACHNA-CARE	2011 LACHNA-CARE
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A funds Legal Aid Programs in Los Angeles County 	

Service Category:	HRSA Support Service Category	Los Angeles County Category
	Linguistic Services	Language Interpretation
Rationale/Assumption	Rationale: Provides interpretation services for non-English speaking PLWH, including PLWH who are deaf. Assumption: 4% of 2011 LACHNA-CARE respondents reported a need for Language Interpretation services; 2% did not receive it.	
Estimate	Need 725	Gap 363
Measurement Source	2011 LACHNA-CARE	2011 LACHNA-CARE
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White funds for eligible uninsured Public and private healthcare systems (governed by the U.S. Department of Health and Human Services CLAS standards) VA Greater Los Angeles Healthcare System Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) 	

Service Category:	HRSA Support Service Category Medical Transportation	Los Angeles County Category Transportation
Rationale/Assumption	<p>Rationale: Provides access to transportation to ensure that PLWH are able to attend medical appointments, thereby supporting retention in care.</p> <p>Assumption 1: 68.4% of 2011 LACHNA-CARE respondents reported a need for Medical Transportation, Bus Passes; 17.6% did not receive it.</p> <p>Assumption 2: 26.2% of 2011 LACHNA-CARE respondents reported a need for Medical Transportation, Bus Tokens; 10% did not receive it.</p> <p>Assumption 3: 23.1% of 2011 LACHNA-CARE respondents reported a need for Medical Transportation, Taxi Vouchers; 14% did not receive it.</p>	
Estimate	<p>Need 1 - Bus Passes 12,404</p> <p>Need 2 - Bus Tokens 4,751</p> <p>Need 3 - Taxi Vouchers 4,189</p>	<p>Gap 1 3,192</p> <p>Gap 2 1,813</p> <p>Gap 3 2,539</p>
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services and not all PLWH. These estimates exclude non-Ryan White PLWH. PLWH may be duplicated across medical transportation categories. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B/C/D Discounted transportation for seniors and disabled in local communities Local medical transportation in some communities 	

Service Category:	HRSA Support Service Category Outreach Services	Los Angeles County Category Outreach
Rationale/Assumption	<p>Rationale: To improve health of PLWH who are out of care and undiagnosed, as well as to reduce risk of transmitting HIV to HIV negative individuals. Together, these populations account for two thirds of HIV transmission.</p> <p>Assumption: 26% (13,745) of diagnosed PLWH are estimated to not be out of care; 7,196 undiagnosed PLWH estimated</p>	
Estimate	Need 20,941	Gap 20,941
Measurement Sources	FY 2016 Part A application estimate of PLWH not in care. DHSP April 2016 estimate of undiagnosed PLWH.	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B/C/D Public and Private health insurance and healthcare systems VA Greater Los Angeles Healthcare System 	

Service Category:	HRSA Support Service Category	Los Angeles County Category
	Psychosocial Support Services	Peer Support Services
Rationale/Assumption	Intended to be used for support and counseling activities, support groups, caregiver support, etc. Assumption: 31.8% of 2011 LACHNA respondents reported a need for Peer Support; 9.8% did not receive it.	
Estimate	Need 5,767	Gap 1,777
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B/C/D Centers for Disease Control and Prevention 	

Service Category:	HRSA Support Service Category	Los Angeles County Category
	Referral for Healthcare and Support Services	HIV LA Directory Referral Services
Rationale/Assumption	Referrals assist PLWH in accessing needed core and support services available through other programs. Assumption 1: 27.6% of 2011 LACHNA-CARE respondents reported a need for HIV LA Directory; 11.1% did not receive this service.	
Estimate	Assumption 1: 10.9% of 2011 LACHNA-CARE respondents reported a need for Referrals; 4.9% did not receive them.	
	Need 1 - HIV LA Directory 5,005	Gap 2,013
	Need 2 - Referrals 1,977	889
Measurement Source	2011 LACHNA-CARE	
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B/C/D 	

Service Category:	HRSA Support Service Category	Los Angeles County Category
	Rehabilitation Services	None
Rationale/Assumption	Rationale: Provides support for rehabilitation services (e.g., occupational/physical/speech therapy). Assumption: 8% of 2011 LACHNA-CARE respondents reported a need for Rehabilitation Services; 4.2% did not receive this service.	
Estimate	Need 1,451	Gap 762
Measurement Source	2011 LACHNA-CARE	2011 LACHNA-CARE
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. The 2011 LACHNA-CARE is pre-ACA and may now over-estimate the need for Rehabilitation Services as more PLWH are insured. 	
Potential Resources	<ul style="list-style-type: none"> Ryan White Part A/B/C/D Public and Private health insurance VA Greater Los Angeles Healthcare System 	

Service Category:	HRSA Support Service Category	Los Angeles County Category
	Respite Care	None
Rationale/Assumption	Rationale: This service provides non-medical assistance to PLWH in order to provide relief to primary caregiver. Assumption: 2.7% of 2011 LACHNA-CARE respondents reported a need for Respite Care; 1.3% did not receive it.	
Estimate	Need 490	Gap 236
Measurement Source	2011 LACHNA-CARE	2011 LACHNA-CARE
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 	
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B Respite programs available for cancer patients through local hospice and other organizations 	

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	Substance Abuse Services (residential)		Substance Abuse Residential	
Rationale/Assumption	Rationale: Provides inpatient residential substance abuse treatment services. Assumption: 9.1% of 2011 LACHNA-CARE respondents reported a need for Substance Abuse Residential services; 2.9% did not receive it.			
Estimate	Need	1,650	Gap	526
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 			
Potential Resources	<ul style="list-style-type: none"> HRSA Ryan White Part A/B Los Angeles County Department of Public Health Substance Abuse Prevention and Control [Note: In Fiscal Year 2014-15, SAPC had 8,400 treatment admissions and 7,539 clients in residential programs] Substance Abuse and Mental Health Services Administration 			

Service Category:	HRSA Support Service Category		Los Angeles County Category	
	No Equivalent Category		Workforce Entry / Re-Entry	
Rationale/Assumption	Rationale: To reduce poverty, PLWH need to enter or return to the workforce. Assumption: 11.1% of 2011 LACHNA-CARE respondents reported a need for Workforce Entry/Re-Entry services; 8.7% did not receive it.			
Estimate	Need	2,013	Gap	1,578
Measurement Source	2011 LACHNA-CARE			
Limitations	<ul style="list-style-type: none"> The estimate of service need and gap is based on PLWH responses from the 2011 LACHNA-CARE, which is representative of PLWH receiving Ryan White Services. This estimate excludes non-Ryan White PLWH. 			
Potential Resources	<ul style="list-style-type: none"> Department of Labor funded Workforce Centers Local schools, community colleges, vocational training programs, universities 			

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Attachment C. Comprehensive HIV Plan 2017-2021 Implementation Plan

The following plan, developed by the Goals, Objectives, and Monitoring Workgroup, has been reviewed by DHSP and aligns with their strategy to eliminate new HIV infections in Los Angeles County. The Commission on HIV (COH) will continue to work collaboratively with DHSP in the ongoing monitoring and revision of this plan as needed throughout the five-year implementation period.

1. REDUCE NEW HIV INFECTIONS.

Objective 1.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV infections by at least 25%.				
Strategy 1.1.1 Increase viral suppression among persons living with HIV (PLWH).				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By the end of 2021	DHSP, COH	1. Increase accessibility to HIV treatment adherence counseling, including peer-based education. 2. Educate clinical providers on current HIV treatment guidelines regarding ART initiation.	All PLWH regardless of payer source Public/private clinical providers	<ul style="list-style-type: none"> Number of PLWH receiving RW-funded services Number of participants in educational session
By the end of 2021	AETC; COH			
Strategy 1.1.2 Increase engagement in quality medical care among high-risk HIV negative individuals.				
By the end of 2021	HIV Prevention and Testing Contractors	1. Screen HIV negative consumers to identify if they have seen a doctor in the past year. 2. Provide linkage/navigation/brief case management services to assist individuals in finding an appropriate medical home.	HIV negative program participants HIV negative persons; California Primary Care Assn; Community Clinic Assn LAC; FQHCs	<ul style="list-style-type: none"> Percent of total participants screened for medical home Percent of participants that do not have a medical home that are provided linkage/navigation/case management services
By the end of 2021	Linkage/navigation/non-medical case management staff			
Strategy 1.1.3 Reduce the percent of persons with undiagnosed HIV infection and percent of diagnosed persons who are not in care.				
By the end of 2021	DHSP	1. Design and implement an ongoing data-to-care program to identify PLWH who are not in care to re-engage in care. 2. Deliver expanded partner services, including HIV/STI testing for partners and presumptive STI treatment in accordance with CDC guidelines.	PLWH who are not engaged in HIV medical care Newly diagnosed/ re-engaged PLWH; sex and/or needle sharing partners of PLWH	<ul style="list-style-type: none"> Number/percent of PLWH identified as out-of-care with updated disposition Percent of diagnosed PLWH who are not in care Number of newly diagnosed and/or re-engaged PLWH who were referred to Partner Services Percent of partners identified that were successfully contacted
By the end of 2021	DHSP; DHSP contracted agencies			

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 1.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV infections by at least 25%. Strategy 1.1.3 Reduce the percent of persons with undiagnosed HIV infection and percent of diagnosed persons who are not in care.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
Beginning January 2017	DHSP; DHSP contracted agencies	3. Expand re-engagement services for PLWH who are not in care.	PLWH who are not in care	<ul style="list-style-type: none"> Number of PLWH who are considered not in care who are reengaged into care
By the end of 2021	DHSP; DHSP contracted agencies	4. Expand successful and identify innovative HIV testing strategies targeted to high-risk populations, and communities impacted by social determinants of health (e.g., multiple-morbidity testing, social network testing).	High risk populations in syndemic cluster areas; high poverty census tracts (e.g., ≥21% below FPL)	<ul style="list-style-type: none"> HIV positivity rate in targeted populations and/or areas
Strategy 1.1.4 Increase access to a “toolbox” of interventions designed to reduce the risk for acquiring and/or transmitting HIV.				
By the end of 2021	SAPC; City of LA; contracted CBOs DHSP; COH	1. Expand access to syringe exchange programs.	Estimated 70,990-151,000 people who inject drugs	<ul style="list-style-type: none"> Number of syringes disposed and/or exchanged Number of persons served
By the end of 2021	DHSP; DHSP contracted agencies	2. Expand targeted condom distribution.	PLWH; persons at risk for HIV/STIs (e.g., incarcerated, MSM, high risk heterosexuals)	<ul style="list-style-type: none"> Number of condoms distributed
By the end of 2021	DHSP; DHSP contracted agencies	3. Expand effective HIV prevention programming that addresses social determinants of health (SDH) including homelessness, targeting PLWH and highest risk HIV negative individuals or those of unknown HIV serostatus. May include behavioral interventions (e.g., CDC, SAMHSA, homegrown).	PLWH; high-risk HIV negative persons, especially YMSM and Blacks/African Americans	<ul style="list-style-type: none"> Number of persons completing interventions Retention/VL suppression data for PLWH PrEP uptake for HIV negative
By the end of 2021	COH; DHSP; DHSP contracted agencies	4. Develop and pilot “social-oriented” programming to re-energize the conversation among PLWH and high-risk individuals about HIV risk, PrEP, engagement/retention in care, treatment adherence, viral suppression.	PLWH; high-risk HIV negative persons, especially YMSM, and Blacks/African Americans, and Latinos	<ul style="list-style-type: none"> Uptake of PrEP among participants completing intervention Number of persons tested Number of PLWH virally suppressed

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 1.2 By December 31, 2021, Los Angeles County will increase to 25,000 the number of high-risk HIV negative individuals accessing pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) as needed.

Strategy 1.2.1 Eliminate structural and provider barriers to accessing PrEP and nPEP.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By the end of 2021	AETC; DHSP	1. Educate all clinical providers about PrEP and nPEP.	Clinical providers that prescribe	<ul style="list-style-type: none"> Number of clinicians trained
By the end of 2021	DSHP; DHSP contracted agencies; CDC CBA providers	2. Educate DHSP-funded workforce about PrEP and nPEP.	DHSP-funded workforce	<ul style="list-style-type: none"> Number of DHSP-funded workforce trained
By the end of 2021	DHSP; AETC	3. Increase the number of medical providers who have the capacity to and are willing to prescribe PrEP and nPEP, including those serving youth less than 18 years old.	Public and private medical providers	<ul style="list-style-type: none"> Number of new clinicians added to list of PrEP providers
By the end of 2021	DHSP; COH; DHSP contracted agencies	4. Expand availability of expedited access programs for PrEP (i.e., “Red Carpet”) that include use of trained PrEP/nPEP navigators who are knowledgeable of health insurance and other financial assistance programs as well as other referral resources that support adherence.	High risk HIV negative persons	<ul style="list-style-type: none"> Number of new Red Carpet service programs
Strategy 1.2.2 Educate high-risk individuals about PrEP and nPEP.				
By the end of 2021	DHSP; COH	1. Expand Get PrEP LA social marketing campaign to high prevalence, high poverty areas (e.g., Crenshaw corridor)	High risk HIV negative persons	<ul style="list-style-type: none"> Number of venues/social media outlets where campaign is visible
By the end of 2021	DHSP	2. Implement effective peer-based behavioral interventions to educate about PrEP.	High risk HIV negative persons	<ul style="list-style-type: none"> Number of peers trained Number of peers reached
By the end of 2021	DHSP	3. Expand use of targeted community outreach at gay pride and other related festivals/events.	High risk HIV negative persons	<ul style="list-style-type: none"> Number of outreach sites Number of outreach encounters

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Strategy 1.2.2 Educate high-risk individuals about PrEP and nPEP.			
By the end of 2021	DHSP	<p>4. Expand PrEP/nPEP education to the communities most at risk for HIV, especially South Los Angeles. For example:</p> <ul style="list-style-type: none"> • Develop and distribute PrEP/nPEP information cards (i.e., palm cards, business cards) • Integrate PrEP/nPEP information into HIV counseling and testing session • Develop a PrEP fact sheet and post on DHSP, COH, and agency websites 	<ul style="list-style-type: none"> • Number of peers trained • Number of peers reached <p>High risk HIV negative persons, including monolingual Spanish speaking MSM, in high prevalence communities (i.e., syndemic cluster areas, high poverty areas)</p>
Strategy 1.2.3 Decrease stigma related to accessing PrEP and nPEP.			
By the end of 2021	AETC; DHSP	<ol style="list-style-type: none"> 1. Educate all clinical providers about PrEP and nPEP to increase the number of providers prescribing and address provider concerns related to these interventions. 	<ul style="list-style-type: none"> • Number of clinicians trained <p>Clinical providers that prescribe</p>
By the end of 2017	DHSP; COH	<ol style="list-style-type: none"> 2. Develop and implement a stigma reduction plan for Los Angeles County to address stigma that high risk individuals may experience related to accessing PrEP. 	<ul style="list-style-type: none"> • Completed written plan • Other indicators TBD after completion of written plan <p>PLWH</p>
By the end of 2017	DHSP; COH	<ol style="list-style-type: none"> 3. Implement recommended actions of stigma reduction plan. 	<ul style="list-style-type: none"> • TBD upon completion of the plan <p>PLWH; clinical providers; community</p>

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

2. INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV.

Objective 2.1 By December 31, 2021, Los Angeles County will increase the percentage of newly diagnosed persons <u>linked</u> to HIV medical care within one month of their HIV diagnosis to at least 85%.				
Strategy 2.1.1 Remove system barriers to linkage to care.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By March 31, 2017 and ongoing as needed	DHSP, COH	1. Analyze LACHNA data and conduct additional population-specific needs assessment as needed to understand their barriers to care.	Newly diagnosed PLWH who do not link to care within one month	<ul style="list-style-type: none"> 2016 LACHNA findings on barriers to care Number of other needs assessment participants (e.g., listening sessions)
By the end of 2018	DHSP	2. Purchase or develop a data system that allows for seamless data reporting and a streamlined process between prevention and care (e.g., person who tests HIV positive can be tracked easily into care services).	DHSP; DHSP-funded contractors	<ul style="list-style-type: none"> New data collection system is in place
By the end of 2018	DHSP	3. Use HIV surveillance data to conduct HIV Care Continuum analyses by medical provider to identify providers/groups (e.g., FQHC, Kaiser Permanente) that are having greatest difficulty with linkage to care and other HIV Care Continuum measures.	HIV medical care providers	<ul style="list-style-type: none"> HIV Care Continuum by medical provider or provider group
By the end of 2017 and ongoing thereafter	DHSP; DHSP contracted agencies	4. Utilize countywide and population-specific navigators to both link and retain PLWH in care.	Newly diagnosed PLWH	<ul style="list-style-type: none"> Percent of PLWH linked to care through navigation program
By the end of 2017 and ongoing thereafter	DHSP; COH	5. Utilize Ryan White funds to guarantee payment of first medical visit to expedite linkage; insurance reimbursement collected later.	HIV medical care providers	<ul style="list-style-type: none"> Number of medical visits paid for Percent of participants linked to care within one month
By the end of 2019	DHSP; AETC	6. Expand access points for geographically accessible HIV medical care services (e.g., leverage FQHCs that do not have on site HIV care available).	PLWH	<ul style="list-style-type: none"> Number of new access points for HIV medical care Geographic distribution of new access points

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 2.1 By December 31, 2021, Los Angeles County will increase the percentage of newly diagnosed persons <u>linked</u> to HIV medical care within one month of their HIV diagnosis to at least 85%.				
Strategy 2.1.2 Educate medical and other providers.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By the end of 2021	DHSP; AETC	1. Educate public and private clinicians on NHAS and its targets as well as resources available to assist with linkage (e.g., navigator program). 2. Expand opportunities for medical students to learn about and have clinical practice working with diverse populations in HIV care and treatment.	Public and private medical care providers Medical students	<ul style="list-style-type: none"> Number of clinicians trained Number of medical students participating in programs developed
By the end of 2021	AETC; USC/UCLA medical schools; DHSP			
Strategy 2.1.3 Reduce stigma and address other social determinants of health that are barriers to linkage to care.				
By the end of 2017	DHSP; COH	1. Develop and implement a stigma reduction plan for Los Angeles County to address stigma that PLWH and high risk individuals may experience related to HIV, mental health, substance abuse, homelessness, and being LGBT. 2. Train physicians and other HIV providers regarding trauma-informed care, especially as it relates to mental health and substance abuse.	PLWH	<ul style="list-style-type: none"> Completed written plan Other indicators TBD after completion of written plan
By the end of 2018 and ongoing	DHSP; COH; AETC; SASC; DMH		PLWH receiving any DHSP-funded service	<ul style="list-style-type: none"> Number of persons trained

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 2.2 By December 31, 2021, Los Angeles County will increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care to at least 85%.

Strategy 2.2.1 Increase housing stability among PLWH.

Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By the end of June 2017	DHSP; COH; City of Los Angeles HOPWA program; Continuum of Care cities	1. Identify gaps in current housing system and utilize Ryan White funds to assist PLWH who are homeless or unstably housed who are in these gaps.	PLWH who are homeless or unstably housed	<ul style="list-style-type: none"> Written findings on gaps
By the end of 2018	DHSP; COH; City of Los Angeles HOPWA program; Continuum of Care cities; housing advocacy organizations	2. Develop a coordinated plan that is in aligned with larger homeless plans in Los Angeles County to increase availability of affordable housing for PLWH.	PLWH who are homeless or unstably housed	<ul style="list-style-type: none"> Written plan
By the end of 2017 and ongoing	DHSP-funded and other Ryan White directly-funded contractors (e.g., Part C, D, F)	3. Screen PLWH for housing status.	PLWH receiving any DHSP-funded or Ryan White-funded service	<ul style="list-style-type: none"> Percent screened Percent of PLWH screened identified as homeless and/or unstably housed
By the end of 2017 and ongoing	DHSP contracted agencies	4. Link all homeless PLWH to LAHSA Coordinated Entry System, HOPWA Housing Specialist Regional Office, or non-medical case management services within 48 hours of encounter as a rapid response; and link unstably housed PLWH to these resources.	PLWH receiving any DHSP-funded service	<ul style="list-style-type: none"> Percent homeless/unstably housed PLWH linked to case management services
By the end of 2017 and ongoing	DHSP; DHSP contracted agencies	5. Educate Medical Care Coordination teams, linkage/navigation staff, and non-medical case managers on available housing resources.	MCC teams; non-medical case managers; linkage/navigation staff	<ul style="list-style-type: none"> Number of staff trained
By the end of 2017 and ongoing	DHSP; COH	6. Establish a coordinated, DHSP-led Emergency Financial Assistance Program modeled after medical transportation program.	PLWH who are homeless or unstably housed	<ul style="list-style-type: none"> Restructured system
By the end of 2017 and ongoing	DHSP; COH	7. Address unemployment/under-employment needs in Ryan White-funded programs.	PLWH who are homeless or unstably housed	<ul style="list-style-type: none"> Revised/new contracts

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 2.2 By December 31, 2021, Los Angeles County will increase the percentage of persons with diagnosed HIV infection who are <i>retained</i> in HIV medical care to at least 85%.				
Strategy 2.2.2 Increase access to high quality behavioral health services.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By the end of 2017	DHSP	1. Engage the Los Angeles County Department of Health Services (DHS), Mental Health (DMH), Substance Abuse Prevention and Control (SAPC), and Medi-Cal in conversation to identify ways to use Ryan White as payer of last resort, while ensuring access to essential behavioral health services. For example, if DMH or SAPC do not have system capacity to address needs of PLWH, how can those needs be met?	PLWH with need for mental health and/or alcohol/substance abuse treatment	<ul style="list-style-type: none"> Protocol developed
By the end of 2018 and ongoing	DHSP; COH	2. Integrate SAMHSA's evidence based SBIRT (Screening, Brief Intervention, and Referral to Treatment) practice into substance abuse contracts to facilitate referral to appropriate treatment.	PLWH	<ul style="list-style-type: none"> Protocol developed Contracts revised Number of PLWH screened utilizing SBIRT model
By the end of 2018 and ongoing	DHSP	3. Expand use of Ryan White funds to support non-billable alcohol/substance abuse services (e.g., 12-step models).	PLWH with need for alcohol/ substance abuse treatment	<ul style="list-style-type: none"> Number of programs funded Number of participants
By the end of 2018 and ongoing	DHSP; DHSP contracted agencies	4. Expand use of Ryan White <i>psychosocial support</i> services category to fund clinician led support groups to address non-DSM V emotional/mental health support needs of PLWH.	PLWH with mental/emotional support needs	<ul style="list-style-type: none"> Number of support group participants HIV Care Continuum outcomes by service category
By the end of 2018 and ongoing	DMH; SAPC	5. Provide HIV/LGBTQ sensitivity training to DMH and SAPC-funded staff.	DMH/SAPC-funded staff	<ul style="list-style-type: none"> Number of staff trained
By the end of 2018 and ongoing	DHSP	6. Fund evidence-based integrated HIV/substance use prevention programs to lessen need for treatment programs.	Persons at risk for HIV and/or alcohol/substance abuse	<ul style="list-style-type: none"> Number of programs funded

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 2.2 By December 31, 2021, Los Angeles County will increase the percentage of persons with diagnosed HIV infection who are <u>retained</u> in HIV medical care to at least 85%.				
Strategy 2.2.3 Minimize administrative barriers to retention in care.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By the end of 2017	DHSP; COH; Consumer Caucus	1. Conduct analysis of recertification process to identify opportunities to remove redundancies and unnecessary paperwork (e.g., ongoing need to supply HIV diagnosis form).	PLWH	<ul style="list-style-type: none"> Written findings and recommendations Number of recommendations addressed
By the end of 2017	DHSP; COH	2. Identify best practice models in California and nationwide that streamline recertification process and implement models that will work in California and Los Angeles County	PLWH	<ul style="list-style-type: none"> Written findings of best practice models identified Number of best practice models implemented
By the end of 2018	DHSP	3. Purchase or develop a data system that streamlines recertification process and even allows for secure electronic transmission of documents (see Strategy 2.1.1).	DHSP; DHSP-funded contractors	<ul style="list-style-type: none"> New data system is in place
Strategy 2.2.4 Expand access to Ryan White-funded services.				
By the end of 2018	DHSP; COH	1. Increase the number of access points to Ryan White services through community based organizations by funding programs (e.g., Health Education/Risk Reduction, psychosocial support, non-medical case management, emergency financial assistance, housing services).	All PLWH	<ul style="list-style-type: none"> New service categories funded Number of new PLWH accessing Ryan White services through new access points
By the end of 2017	DHSP; COH	2. Remove financial eligibility criteria barriers to accessing Ryan White services such as: navigation, linkage to care, benefits speciality, psychosocial support, and HE/RR.	All PLWH	<ul style="list-style-type: none"> Service categories with updated financial eligibility criteria
By the end of 2018	DHSP; COH; AETC	3. Educate public/private providers about Ryan White services available for their patients.	Non Ryan White public/private providers	<ul style="list-style-type: none"> Number of persons trained

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

3. REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES.

Objective 3.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV diagnoses by at least 30% in the following groups: YMSM, Blacks/African Americans, Latino MSM, and Transgender Persons.				
Strategy 3.1.1 Have developmental and cultural specificity in HIV prevention efforts.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By end of 2017 and ongoing	DHSP; contracted agencies	1. Implement developmentally responsive services for YMSM of Color that incorporates principles of youth development.	YMSM	<ul style="list-style-type: none"> Revised contract language that reflects youth development RFP language Contract monitoring
By end of 2017	DHSP; contracted agencies	2. Expand integrated HIV/STI services.	YMSM	<ul style="list-style-type: none"> Number of new integrated HIV/STI testing programs
Beginning 2017 and ongoing	DHSP; COH; contracted agencies	3. Require engagement of young people in the development of services that target YMSM and other youth.	YMSM; other high risk youth	<ul style="list-style-type: none"> RFP language
By end of 2017	DHSP; contracted agencies	4. Update pocket guide to sexual health for youth to include PrEP.	YMSM; other high risk youth	<ul style="list-style-type: none"> Updated version of the guide
By end of 2017	DHSP; COH	5. Evaluate HIV testing sites (undercover) to determine the developmental and cultural responsiveness of these programs.	YMSM	<ul style="list-style-type: none"> Written findings
By end of 2017	DHSP; COH	6. Conduct a formative assessment that includes major stakeholders in the community (e.g., reproductive social justice) to guide future programming.	Blacks/African Americans	<ul style="list-style-type: none"> Written findings
By end of 2017	DHSP; COH; DHSP contracted agencies; Black AIDS Institute's African American HIV University	7. Develop a plan to diversify the HIV workforce.	Blacks/African Americans; other communities of color	<ul style="list-style-type: none"> Plan with recommended actions and timeline developed
By end of 2017 and ongoing	DHSP; COH; DHSP contracted agencies	8. Ensure that Blacks/African Americans are represented in HIV prevention messaging.	Blacks/African Americans	<ul style="list-style-type: none"> Number of prevention messages created and/or updated

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 3.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV diagnoses by at least 30% in the following groups: YMSM, Blacks/African Americans, Latino MSM, and Transgender Persons.				
Strategy 3.1.1 Have developmental and cultural specificity in HIV prevention efforts.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By end of 2018	DHSP; COH; Black AIDS Institute	9. Develop a leadership institute specifically for the Black community in partnership with existing organizations.	Blacks/African Americans	<ul style="list-style-type: none"> Leadership institute developed Number of persons completed
Beginning 2017 and ongoing	DHSP; COH; DHSP contracted agencies	10. Ensure that all messaging and outreach materials, services, and forms are translated into Spanish in a culturally appropriate way.	Latino MSM	<ul style="list-style-type: none"> Updated messaging Contract requirements added
By end of 2018	DHSP; DHSP contracted agencies	11. Recruit more Spanish speaking doctors into HIV clinical workforce.	Latino MSM	<ul style="list-style-type: none"> Number of Spanish-speaking clinical staff hired
By end of June 2018	DHSP; DHSP contracted agencies	12. Utilize social network models to increase health literacy and integrate into existing programs.	Latino MSM	<ul style="list-style-type: none"> Number of revised programs Incorporated into RFP language Incorporated into contracts
By end of 2018	DHSP; COH; City of Los Angeles	13. Identify/create a leadership development program.	Transgender persons	<ul style="list-style-type: none"> Leadership program developed Number of persons completed
By end of 2018	DHSP; COH	14. Revise all county forms to include a two-step process for reporting gender (i.e., sex at birth, gender identity).	Transgender persons	<ul style="list-style-type: none"> Number of forms revised
By end of 2017	DHSP	15. Add new data table solely for transgender persons in HIV surveillance reporting similar to American Indian/Alaska Native table.	Transgender persons	<ul style="list-style-type: none"> Data table added to HIV surveillance data reporting
Strategy 3.1.2 Increase PrEP and nPEP uptake in each population proportionate to their percent of recent diagnoses (2009-2013).				
By end of 2017	DHSP	1. Develop estimates of PrEP cascade for each targeted population to inform specific activities.	High risk persons in targeted groups	<ul style="list-style-type: none"> Population-specific PrEP cascades developed Recommended actions

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 3.1 By December 31, 2021, Los Angeles County will decrease the number of new HIV diagnoses by at least 30% in the following groups: YMSM, Blacks/African Americans, Latino MSM, and Transgender Persons.				
Strategy 3.1.2 Increase PrEP and nPEP uptake in each population proportionate to their percent of recent diagnoses (2009-2013).				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By end of 2017	DHSP	2. Expand access to PrEP and nPEP providers (i.e., geographic locations, convenient hours).	High risk persons in targeted groups	<ul style="list-style-type: none"> Number of PrEP/nPEP providers in each syndemic cluster area Number of PrEP/nPEP providers with night/weekend hours
By end of 2017	DHSP	3. Expand Get PrEP LA social marketing campaign in targeted communities.	High risk persons in targeted groups	<ul style="list-style-type: none"> Dates of campaign(s) Other indicators to be developed specific to campaign
By June 30, 2018	DHSP	4. Educate targeted populations about PrEP and nPEP to increase PrEP/nPEP uptake in these populations, including Black/African American women. Recommend use of peer-based social network approaches and/or community level interventions.	High risk persons in targeted groups	<ul style="list-style-type: none"> Number of PrEP/nPEP education interventions funded
Strategy 3.1.3 Reduce stigma and address other social determinants of health that are barriers to accessing the full continuum of services.				
By end of 2017	DHSP; COH	1. Ensure the stigma reduction plan reflects the targeted populations.	High risk persons/ PLWH in targeted groups	<ul style="list-style-type: none"> Final plan developed
By June 30, 2017 and ongoing	DHSP	2. Integrate employment and job readiness into programs.	High risk persons/ PLWH in targeted groups	<ul style="list-style-type: none"> Number of contracts Percent of funded programs that include employment and job readiness
By June 30, 2018	DHSP	3. Expand HIV prevention programming (homegrown or evidence-based) that addresses social determinants of health (SDH).	High risk persons/ PLWH in targeted groups	<ul style="list-style-type: none"> Number of contracts for each targeted group Percent of funded programs that address SDH

Notes: Reducing new HIV diagnoses must be accomplished without reducing current levels of publicly-funded HIV testing in targeted communities.

Bold signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 3.2 By December 31, 2021, Los Angeles County will increase to 80% viral suppression among the following groups: persons who inject drugs (PWID), youth (18-29 years), Ciswomen, transgender persons, Blacks/African Americans, and American Indians/Alaska Natives.				
Strategy 3.2.1 Decrease the percentage of PLWH who are out of care.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By January 1, 2017	DHSP; DHSP contracted agencies	1. Expand re-engagement services for PLWH in targeted groups who are not in care.	PLWH who are not in care in targeted groups	<ul style="list-style-type: none"> Number of PLWH who are considered not in care are reengaged to care
By end of 2017	DHSP; COH	2. Conduct an evaluation of the system to strengthen transition services between youth and adult care systems.	Youth PLWH (18-29 years)	<ul style="list-style-type: none"> Completed evaluation with recommended actions to improve system
By the end of 2021	DHSP	3. Design and implement an ongoing data-to-care program to identify PLWH in targeted groups who are not in care to re-engage in care.	PLWH who are not engaged in HIV medical care in targeted groups	<ul style="list-style-type: none"> Number/percent of PLWH identified as out-of-care with updated disposition Percent of diagnosed PLWH who are not in care
Strategy 3.2.2 Tailor services to address specific barriers to viral suppression for each group.				
By June 30, 2017	DHSP	1. Conduct analysis of HIV surveillance data to understand viral suppression across subpopulations of youth (e.g., young women, YMSM, men, by race/ethnicity) to inform programming.	Youth PLWH	<ul style="list-style-type: none"> Written findings with recommended actions
By June 30, 2017	DHSP; COH	2. Conduct formative evaluation to understand the reasons for the gap between <i>retention in care</i> and <i>viral suppression</i> for targeted groups to inform programming.	PLWH in targeted groups	<ul style="list-style-type: none"> Written findings with recommended actions
By end of 2017	DHSP; COH	3. Implement recommended actions from formative evaluation into service delivery and Standards of Care if applicable.	PLWH in targeted groups	<ul style="list-style-type: none"> Revised contracts RFP language Revised Standards of Care

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 3.2 By December 31, 2021, Los Angeles County will increase to 80% viral suppression among the following groups: persons who inject drugs (PWID), youth (18-29 years), Ciswomen, transgender persons, Blacks/African Americans, and American Indians/Alaska Natives					
Strategy 3.2.3 Ensure equitable access to high quality HIV care.					
By June 30, 2017	DHSP; COH		1. Conduct analysis of geographic distribution of services as compared with PLWH residence and develop a plan to address identified gaps.	PLWH	<ul style="list-style-type: none"> Gaps identified gaps Written plan to address gaps with specific actions recommended
By March 1, 2018	DHSP; COH		2. Increase access to Ryan White services through culturally responsive community settings (e.g., non-medical case management, psychosocial support services, peer-based treatment adherence counseling, social support groups, etc.) to support engagement, retention, and treatment adherence.	PLWH	<ul style="list-style-type: none"> Funds allocated to services Contracts implemented
By March 1, 2018	DHSP; AETC; COH		3. Conduct training to the DHSP-funded workforce regarding provider bias.	PLWH	<ul style="list-style-type: none"> Number of staff trained
By end of 2018	DHSP; COH		4. Provide capacity building assistance to infuse harm reduction model into HIV prevention and care services.	DHSP-funded contractors	<ul style="list-style-type: none"> Number of contractors provided with capacity building assistance
By end of 2018	DHSP; COH		5. Provide training to DHSP-funded workforce on harm reduction model with practical application on how to work with PWID in a way that does not stigmatize.	DHSP-funded workforce	<ul style="list-style-type: none"> Number of staff trained
By end of 2017 and ongoing	DHSP; DHSP contracted agencies		6. Educate PLWH on how to use/access services, client/patient rights, and grievance process.	PLWH	<ul style="list-style-type: none"> Contract language RFP language Number of PLWH educated Number of access-related grievances over time

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

4. CREATE A COLLABORATIVE SYSTEM, INCLUSIVE OF PUBLIC AND PRIVATE SECTORS THAT BEST RESPONDS TO HIV, STIs, AND SOCIAL DETERMINANTS OF HEALTH.

<p>Objective 4.1 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>internal efforts</i> to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.</p>				
<p>Strategy 4.1.1 Leverage the internal re-organization of the Los Angeles County Department of Health Services as an opportunity for strengthening internal relationships.</p>				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
Beginning 2017 and ongoing as long as needed	DHSP; COH	1. Actively participate on the Integration Advisory Board addressing the re-organization of the Departments of Health Services, Public Health, and Mental Health to ensure that the needs of PLWH and persons at risk for HIV are addressed.	PLWH who receive services through DHS	<ul style="list-style-type: none"> Number of meetings attended Inclusion of language related to PLWH and at risk persons in any plans developed
By end of 2017 and ongoing as needed	DHSP; COH; DMH	2. Actively meet with the DMH to develop a coordinated plan to address needs of PLWH to improve access to mental health services.	PLWH with mental illness	<ul style="list-style-type: none"> Written plan to improve access to publicly-funded mental health services and address gaps
By end of 2017 and ongoing as needed	DHSP; COH; SAPC	3. Actively meet with SAPC to develop a coordinated plan to improve access to alcohol/substance abuse treatment services.	PLWH in need of alcohol/substance abuse treatment	<ul style="list-style-type: none"> Written plan to improve access to publicly funded alcohol/substance abuse treatment and address gaps
<p>Strategy 4.1.2 Improve communication and coordination among HIV service providers.</p>				
By end of 2018	DHSP; COH	1. Streamline information sharing among service providers, while ensuring compliance with HIPAA.	DHSP-contracted agencies	<ul style="list-style-type: none"> Revised recommendations and/or protocol for communication
By end of 2017	DHSP	2. Improve referral process to reduce competition among providers and increase access to needed services.	DHSP-contracted agencies	<ul style="list-style-type: none"> Revised recommendations and/or protocol for referrals
By end of 2017 and ongoing as needed	DHSP	3. Educate DHSP-funded agencies on referral process and requirements.	DHSP-contracted agencies	<ul style="list-style-type: none"> Number of staff trained

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 4.1 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>internal</i> efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.			
Strategy 4.1.3 Actively participate in other strategic planning processes within the county.			
Timeframe	Responsible Parties	Activity	Data Indicators
By end of 2017	COH	1. Hire or procure consulting services for a strategic planner within the Commission on HIV to be responsible for coordination efforts.	<ul style="list-style-type: none"> Funding procured Staff person hired
By end of 2017 and yearly thereafter	COH	2. Identify upcoming countywide strategic planning efforts (e.g., SAPC) and participate on these groups to ensure that issues of PLWH are addressed.	<ul style="list-style-type: none"> Number of meetings attended Evidence of PLWH addressed in final written plans

Objective 4.2 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>external</i> efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.			
Strategy 4.2.1 Strengthen collaboration with the State Office of AIDS.			
Timeframe	Responsible Parties	Activity	Data Indicators
By end of 2016 and ongoing as needed	DHSP; COH	1. Participate in State Office of AIDS (OA) "Getting to Zero" meetings.	<ul style="list-style-type: none"> Date of meetings attended
By end of 2017	DHSP; COH	2. Re-energize the strategic partnership with the State Office of AIDS in an effort to reduce HIV infection in Los Angeles County (e.g., include OA in the COH Community Engagement Plan being developed by the COH Operations Committee).	<ul style="list-style-type: none"> System put in place
By end of 2018	DHSP; COH	3. Meet with ADAP staff to improve systems related to enrollment/recertification.	<ul style="list-style-type: none"> Meeting log Improved system in place

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 4.2 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>external</i> efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.			
Strategy 4.2.2 Strengthen collaboration with public (other than DHS) and private healthcare systems.			
Timeframe	Responsible Parties	Activity	Target Population(s)
By June 2018	DHSP; COH	1. Develop a plan with community health centers, including FQHCs, to increase their engagement in meeting the goals of the NHAS and HIV Care Continuum measures	Key stakeholders/collaborators
By June 2018	DHSP; COH	2. Work with the AETC to develop a comprehensive plan for educating private health care providers about PrEP/nPEP, NHAS, HIV Care Continuum and engaging their participation in meeting county goals.	Key stakeholders/collaborators
By end 2018	DHSP; COH; adolescent stakeholders; LAHSA	3. Work with large systems (e.g., Juvenile Justice, LAUSD and other school districts, and Department of Children and Family Services) to identify strategies to work with adolescents.	Key stakeholders/collaborators
Strategy 4.2.3 Strengthen collaboration with the Housing Continuum of Care in Los Angeles County, including HOPWA.			
Beginning in January 2017 and ongoing	DHSP; COH	1. Convene a new or leverage existing group of key housing stakeholders across all Housing Continuum of Care to meet quarterly to discuss how to meet housing needs of homeless and unstably housed PLWH.	Housing stakeholders
By end of 2017	DHSP; COH	2. Develop an agreement with the City of Los Angeles HOPWA program for regular data sharing of program activities/outcomes.	HOPWA program

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Objective 4.2 By December 31, 2021, the Los Angeles County Division of HIV and STD Programs and/or the Los Angeles Commission on HIV will implement at least three (3) <i>external</i> efforts to improve the coordination of HIV programs within the Los Angeles County Department of Health Services to increase coordination with key stakeholders.				
Strategy 4.2.3 Strengthen collaboration with the Housing Continuum of Care in Los Angeles County, including HOPWA.				
Timeframe	Responsible Parties	Activity	Target Population(s)	Data Indicators
By June 2018	DHSP; COH	3. Identify eligibility criteria and gaps across the housing continuum to develop a plan for using Ryan White funds to address gaps for PLWH who are ineligible or denied access to other programs due to waiting list or other capacity barriers.	HOPWA program and other low-income housing programs	<ul style="list-style-type: none"> Written plan developed
By March 1, 2017	DHSP; COH	4. Use Ryan White funds to support short-term rental/utility assistance to meet needs of PLWH who do not qualify for HOPWA or other housing programs (use model similar to transportation services to fund through DHSP).	PLWH who are unstably housed	<ul style="list-style-type: none"> Funds allocated for short-term rental/utility assistance Number of PLWH accessing program
By end of 2017	DHSP; COH	5. Train DHSP-funded workforce on the Coordinated Entry System (CES) and referral process for accessing services	DHSP-funded workforce	<ul style="list-style-type: none"> Number of staff trained
By end of 2018	DHSP; COH	6. Expand the number of landlords that accept HOPWA and Housing Choice Voucher Program.	Private landlords and low-income housing developers	<ul style="list-style-type: none"> Number of new landlords accepting vouchers

Note: **Bold** signifies activities that are intended to address gaps along the HIV Care Continuum.

Attachment D. Population Profiles

- HIV and Older Adults (50 years and older)
- HIV and Youth (18-29 years)
- HIV and Transgender Persons



HIV & Older Adults

Los Angeles County, California

Older Persons Living with HIV, AIDS, and Life Expectancy

Although older adults (50 years and older) comprise 30.3% of Los Angeles County's general population, they represent 44.6% (21,802) of all persons living with HIV, including AIDS (PLWH).¹⁻² Thus, older adults have a disproportionate burden of HIV than other age groups. Persons 50-59 years old are the most disproportionately impacted age group; they represent 13% of the general population and 30.9% of all PLWH.¹⁻² The next largest age group are PLWH 40-49 years old (14,307), who will enter the 50+ age group over the next ten years. There are significant differences by race/ethnicity. Fifty-nine percent of White PLWH are 50 years or older, compared to 45% of Black/African American PLWH, 38% of Latino/Hispanic PLWH, and 36% of American Indian/Alaska Native PLWH.³ The differences by sex at birth are less pronounced; about 45% of male PLWH are 50 years and older compared to 43% of female PLWH.³ However, only 27.5% of transgender persons are 50 years and older.⁴ Older persons also represent a disproportionate number of persons living with advanced Stage 3 HIV disease (i.e., AIDS) in Los Angeles County. About 56.4% of all PLWH in the county are persons living with AIDS (PLWA) (n=27,602).³ However among older adults (50 years and older), 68.9% are living with AIDS.³

The tremendous advances in treatment have improved the health and well-being of PLWH so that they are living longer. A recent study from Kaiser Permanente reported that the life expectancy of a 20 year old HIV positive individual in 1996-1997 was 19 years (i.e., 39 years old); this increased dramatically by 2011 to a life expectancy of 53 years (i.e., 73 years old).⁵ Factors that increased life expectancy further were (1) early initiation of ART, which added 5.2 years; (2) not having had hepatitis B or C added 5.9 years; (3) not having had problems with drugs or alcohol added 6.5 years; and (4) not ever having smoked added 7.7 years to life expectancy.⁵ As treatments continue to improve and interventions are implemented to address these factors, the number of older PLWH will continue to increase.

Health Concerns of the Aging Population

As PLWH age, HIV is only one of other health conditions that impact the aging population in general. Other conditions include arthritis, heart disease, cancer, respiratory diseases, Alzheimer's disease, osteoporosis, diabetes, influenza/pneumonia, falls, and substance abuse among others.⁶ In the case of heart disease for example, PLWH have been shown to have an increased risk for heart disease than non-HIV infected persons.⁷ In addition, the treatment of heart disease in a PLWH may be different than in an HIV-negative individual.⁷ Complications and side effects due to drug interactions between HIV and other disease medications also need to be closely monitored. Aging PLWH have increased need for medical care coordination that includes needing referrals and consultation with non-HIV medical specialists.

Indicators of Risk

Persons 50 years and older who are HIV negative are at risk for acquiring HIV. They represent 10.2% of recently diagnosed persons from 2010-2014.¹ Older PLWH are also at risk of transmitting HIV if they are undiagnosed, out of care, or not virally suppressed. The Los Angeles County Division of HIV and STD Programs (DHSP) conducted an analysis of several behavioral surveillance projects targeting various risk groups, medical

monitoring project (MMP) data for HIV-infected persons, and 2011 Los Angeles Coordinated HIV Needs Assessment (LACHNA-CARE) that targeted PLWH receiving Ryan White funded services.⁸ Table 1 below depicts the prevalence of condomless sex, ART prescription, and viral suppression of aging persons (50 years and older). Due to small numbers in some of the surveillance projects, the results should be interpreted with caution.

As seen in Table 1, except for the 2011 LACHNA-CARE respondents and MMP participants, there was a fairly high level of condomless sex among older persons. Condomless sex was highest among heterosexuals (87%) followed by PWID (63%), transgender persons (57%), and MSM (52%).⁸ Except for persons who inject drugs (PWID), ART prescription was 90% or higher among all groups; it was 75% among PWID. Viral suppression was high; 80% among MMP participants and 74% among 2011 LACHNA-CARE respondents.⁸ [Note: The National HIV/AIDS Strategy Update to 2020 target is 80%.⁹]

Table 1. DHSP surveillance projects and needs assessment data for Aging Persons (≥50 yrs)

Population/ Characteristics	National HIV Behavioral Surveillance MSM 2014 N=525	National HIV Behavioral Surveillance IDU (PWID) 2012 N=529	National HIV Behavioral Surveillance HET 2013 N=534	Transgender HIV Behavioral Surveillance 2009 N=102	Medical Monitoring Project 2009-2011 N=692	Los Angeles Coordinated HIV Needs Assessment 2010-2011 N=450
<i>Aging Persons (≥50 yrs)</i>	48 (9)	247 (47)	85 (16)	14 (14)	257 (38)	135 (30)
Condomless Sex	25 (52)	155 (63)	74 (87)	8 (57)	64 (25)	11 (8)
HIV-infected	14 (29)	12 (5)	<5 (-)	5 (36)	257 (100)	135 (100)
ART³	9 (90)	6 (75)	-	5 (100)	242 (95)	130 (96)
Virally-suppressed	-	-	-	-	201 (80)	100 (74)*

Source: DHSP, An Epidemiologic Profile of HIV in Los Angeles County 2015, Final Draft.

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HIV & Youth / Young Adults

Los Angeles County, California

Youth and Young Adults Living with HIV

As of December 31, 2014, there were 4,094 youth (13-24 years old) and young adults (25-29 years old) living with HIV in Los Angeles County; 96.6% of whom were 20-29 years old.¹ The majority of youth/young adult PLWH in 2014 were Latino/Hispanic (48.5%) or Black/African American (30.2%); 14.7% were White and 4.6% Other races.¹ About 12% of Youth/Young adults living with HIV were female (sex at birth) and 88% were male (sex at birth). However, there are significant sex differences by race/ethnicity. Among Black/African American youth/young adults living with HIV, 14.1% were female (sex at birth) in 2014, followed by 12.9% were Latino/Hispanic; only 6.7% of White youth/young adults living with HIV were White.¹ A total of 23.9% of youth/young adults living with HIV had a diagnosis of advanced Stage 3 HIV disease or AIDS in 2014.¹ Surprisingly, youth/young adult PLWH accounted for 23.1% of all deaths among PLWH in 2013, even though they accounted for only 8.4% of all PLWH at the end of 2014.²

Since 2010, youth and young adults 20-29 years old have had the highest rate of new HIV diagnoses per 100,000 population among all age groups in Los Angeles County; 39 per 100,000 population in 2013.² Thirty-seven percent (n=673) of all new HIV diagnoses (n=1,820) in 2013 are among youth/young adults less than 30 years of age; they account for more than 1 in 3 new HIV infections.¹ This pattern continues as 37.3% of newly diagnosed persons tested through Division of HIV and STD Programs (DHSP)-funded HIV testing services in 2015 are among youth/young adults 13-29 years old.³ Going beyond HIV diagnoses, HIV incidence (i.e., new HIV infections at the time of infection versus time of diagnosis) measures persons at highest risk for HIV. As part of its HIV incidence surveillance project, DHSP estimates that that younger persons (<35 years old) are at highest risk for new HIV infection and highest persons 18-29 years old.⁴ Across all age groups, DHSP estimates the highest rate of new HIV infection to be in young adults 25-29 years old (50 per 100,000 population) followed by youth 18-24 years old (44 per 100,000 population).⁴

Youth and young adult cisgender males are most likely to acquire HIV through male-to-male sexual risk (i.e., men who have sex with men [MSM]) and youth/young adult cisgender females are most likely to become infected through heterosexual transmission followed by injection drug use.⁵ DHSP estimates that the overall HIV prevalence among youth/young adults (13-24 years old) is 0.08%.⁴ However, the estimated HIV prevalence among young MSM (YMSM) in the same age group is 1.8%, nearly 23 times higher prevalence.⁴ Thus, YMSM are much more likely than non-MSM youth/young adults to be living with HIV. DHSP estimates that the HIV incidence rate among Black/African American YMSM (18-29 years old) is 45 per 1,000 population, more than double the rate of Latino/Hispanic YMSM (16 per 1,000 population) or White YMSM (15 per 1,000 population).⁴ Table 1 presents the race/ethnicity of the 3,422 YMSM (including YMSM and YMSM/injection drug use) by age group in Los Angeles County as of December 31, 2014. As seen, nearly half of all YMSM are Latino/Hispanic (48.1%) followed by Black/African American YMSM (29.3%).

Table 1. Youth and Young Adult YMSM 18-29 Years Old by Race/Ethnicity and Age Group as of December 31, 2014

Race/Ethnicity	YMSM 18-24 years old (N=937)		YMSM 25-29 years old (N=2,485)		Total YMSM (N=3,422)	
	Number	Percent	Number	Percent	Number	Percent
White	139	14.8%	392	15.8%	531	15.5%
Black/African American	274	29.2%	729	29.3%	1,003	29.3%
Latino/Hispanic	463	49.4%	1,184	47.7%	1,647	48.1%
Asian	24	2.6%	122	4.9%	146	4.3%
American Indian/Alaska Native	9	1.0%	14	0.6%	23	0.7%
Other/Unknown	28	3.0%	44	1.8%	72	2.1%

Source: Los Angeles County Division of HIV and STD Programs, 2016; eHARS data reported through August 2016.

Indicators of Risk

Youth and young adults engage in a number of behaviors that increase their risk for acquiring sexually transmitted infections (STIs), including HIV. These include having condomless sex, non-injection drug and/or alcohol use, and injection drug use (IDU). Los Angeles County participates in the national Youth Risk Behavior Surveillance (YRBS) project, which identifies HIV/STI risk behaviors among high school students. Results from the YRBS show that the following risk indicators among Los Angeles County high school students in 2013:⁵

- 32.7% have ever had sexual intercourse (28.0% females; 37.2% males^{†††})
- 19.1% currently sexually active (18.0% females; 20.2% males)
- 8.2% were forced to have sexual intercourse (10.2% female; 6.3% males)
- 7.7% have had sexual intercourse with four or more persons (4.7% females; 10.5% males)
- 63.3% used condom at last sexual intercourse (62.4% females; 64.4% males)
- 27.6% currently drink alcohol (31.5% females; 24.0% males)
- 13.3% have had five or more drinks in a row (14.1% females; 12.4% males)
- 5.1% have ever used methamphetamines (3.8% females; 6.4% males)
- 2.1% have ever injected an illegal drug (0.8% females; 3.0% males)
- 79.4% were ever taught about HIV or AIDS in school (80.8% females; 78.1% males)

STIs: Los Angeles County has some of the highest rates of chlamydia, gonorrhea, and syphilis in the nation. Given the level of self-reported sexual activity and drug/alcohol use, it is not surprising that sexually transmitted infections (STIs) in Los Angeles County are highest among younger age groups. Cismales account for 92% of all 2014 early syphilis cases in Los Angeles County and 78.2% of all cismale early syphilis cases are among bisexual males or MSM.² Youth and young adults (15-29 years old) account for 32.6% (N=739) of all cismale early syphilis cases and 48.1% (N=74) of cisfemale cases.² Although not stratified by age group, Latinos/Hispanics account for 47% of all early syphilis cases, Whites 26%, and Blacks/African Americans (20%).² Like early syphilis, gonorrhea is also more prevalent in cismales than cisfemales in Los Angeles County. In 2014, 71% of all gonorrhea cases were among cismales and 29% among cisfemales.² In 2014, a total of 14,555 cases of gonorrhea were reported, with a majority (60%) occurring in persons 15-29 years of age.² The highest rates are among Black/African American males ages 20-29 and Black/African American females ages 15-24.² Chlamydia is most prevalent among cisfemales and represent 62% of 2014 cases and 75.2% are among youth and young adults 15-29 years old.² Latinos/Hispanics account for 45% of all chlamydia cases, followed by Blacks/African Americans (18%).² For all three STIs, Blacks/African Americans are the most disproportionately impacted racial/ethnic group with the largest rates per 100,000 population.²

Other Concerns of Youth and Young Adults

A number of co-factors exacerbate HIV risk among youth and young adults. Among others, these include homelessness, drug use, engaging in survival sex, history of incarceration, poverty, low educational attainment, and unemployment. YMSM may also have a low perception of HIV risk, as well as experience homophobia, stigma, rejection, and social isolation.⁶ As seen above, only 79.4% of high school students reported having ever been taught about HIV and AIDS.⁵ Nearly 1 in 5 high school students lack education about HIV in Los Angeles County and may graduate without any.

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^{†††} Gender identity is not reported in the YRBS dataset and thus male and female refer to sex at birth.



HIV & Transgender Persons

Los Angeles County, California

Transgender Persons Living with HIV

According to the Division of HIV and STD Program's (DHSP) most recent estimate, there are 13,788 transgender persons living in Los Angeles County; approximately 50% are transgender women (i.e., male-to-female transgender persons) and 50% are transgender men (i.e., female-to-male transgender persons).¹ Based on a 2014 general population of 10,069,036 residents, transgender persons comprise an estimated 0.1% of the general Los Angeles County population.² However, in terms of HIV prevalence and recent diagnoses, transgender persons are disproportionately burdened by HIV as they represent 1.3% of all persons living with HIV (PLWH) as of December 31, 2014 and 1.4% of PLWH recently diagnosed from 2010 through 2013.³ DHSP estimates that the HIV prevalence of all transgender persons is 8.75% (one in every 11 persons).¹ However, there are significant differences between transgender women and transgender men; an estimated one in every six (16.71% HIV prevalence) transgender women are HIV-infected and one in every 128 (0.78% HIV prevalence) transgender men are HIV-infected; transgender women represent 96% of all HIV infections among transgender persons.¹ Black/African American transgender persons are the most likely to be HIV-infected (26.5%) followed by American Indian/Alaska Native transgender persons (25.6%).¹

Table 1 presents the selected demographic characteristics of transgender PLWH.⁴ As seen, more than half of all transgender PLWH are Latino/a (55%) and 28.3% are Black/African American.⁴ In terms of geographic residence (not depicted), nearly half (48.3%) of transgender PLWH live in Service Planning Area (SPA) 4: Metro, followed by SPA 2: San Fernando Valley (14.3%), SPA 8: South Bay (12.7%), and SPA 6: South (10.6%).

Table 1. 2014 HIV Prevalence among Transgender Persons by Race/Ethnicity and Age Group (N=615)

Demographic Characteristic	Number	Percentage
Race/Ethnicity		
White	52	8.5%
Black/African American	174	28.3%
Latino/Hispanic	338	55.0%
Asian	23	3.7%
American Indian/Alaska Native	13	2.1%
Other/Unknown	15	2.4%
Age		
<30 years	98	15.9%
30-39	139	22.6%
40-49	209	34.0%
50-59 years	135	22.0%
60 years and older	34	5.5%

Source: DHSP, 2014 HIV surveillance data reported as of December 31, 2015.

Indicators of Risk

The Division of HIV and STD Programs (DHSP) piloted a Transgender HIV Behavioral Surveillance project among Black and Latina transgender women in 2009; 56% were Latina/Hispanic and 44% Black/African American.¹ Despite the high prevalence of HIV among transgender persons, only 63% of participants reported testing for HIV in the past 12 months.¹ Table 2 presents the key findings of the 2009 Transgender HIV Behavioral Surveillance project for all participants as well as for selected subpopulations. Among all participants, 28% self-reported being HIV-infected; this was highest among aging transgender persons (35.7%).¹ In terms of sexual behavior, 64% of participants overall reported condomless anal sex; this was highest among incarcerated/post-incarcerated individuals (81.8%).¹ Not presented in the table, 41% of transgender participants reported exchanging sex for money or drugs, 45% reported injecting hormones, and 5% reported sharing hormones in the past 12 months.¹

Table 2. Transgender HIV Behavioral Surveillance, 2009 (N=102)

Population/ Characteristics	Number	Condomless		ART Prescription (among HIV-infected)
		Anal Sex	HIV-infected	
Total	102	64.0%	28.0%	82.0%
Homeless	49	65.3%	28.6%	78.6%
Incarcerated/Post Incarcerated	22	81.8%	27.3%	83.3%
Sex Worker/Exchange Sex	41	65.3%	24.4%	100%
Aging Persons (≥ 50 yrs)	14	57.1%	35.7%	100%

Source: Division of HIV and STD Programs, An Epidemiologic Profile of HIV in Los Angeles County 2015. Final Draft.

Health and Well-Being of Transgender Women and Men

Transgender individuals experience a number of disparities that impact their health and well being, including among others unemployment, poverty, homelessness, discrimination due to gender non-conforming status, history of incarceration, etc.⁵⁻⁶ Table 3 display selected data of transgender PLWH who are Ryan White clients. As seen, when compared to all Ryan White clients, transgender persons experience greater levels of poverty, homelessness, history of incarceration, and mental health treatment. They are more likely to be insured than other Ryan White clients.

Table 3. Socio-economic data for all PLWH and Transgender PLWH receiving Ryan White-funded services, 2013-2014

Characteristic	Overall		\leq Federal Poverty Level		Homeless		No Insurance		Incarcerated ≤ 24 mo.		Mental Health Treatment	
	n	% ¹	n	%	n	%	n	%	n	%	n	%
Total	18,134		12,178	67.2	1,115	6.1	8,343	46.0	2,305	12.7	653	3.6
Transgender Persons	305	1.7	256	83.9	23	7.5	172	56.4	56	18.4	17	5.6
Women	303	99.3	256	84.5	23	7.6	170	56.1	55	18.2	17	5.6
Men	<5	-	-	-	-	-	-	-	-	-	-	-

Data Source: Casewatch as of March 1, 2015.

¹Column percentage

Gender Identity Documentation: One of the major challenges that planners face is the limited availability of data for transgender persons, not only related to HIV data but across all other health and human services. Nationally, the CDC does not routinely report data for transgender persons in their annual HIV surveillance reports. The U.S. Census Bureau also does not collect data based on gender identity. Although DHSP routinely reports aggregate numbers of transgender persons in terms of HIV prevalence, diagnoses, and STI data, that information is not routinely presented for different subgroups (e.g., for transmen and transwomen, by race/ethnicity, age group, Service Planning Area, etc.). Also, in most other county departments outside of DHSP, a two-step data collection process to capture “sex at birth” and “current gender identity” has not yet been implemented, making it difficult to examine other health data (e.g., mental health, substance use, health insurance status, etc.) for transgender persons. Thus, although Los Angeles County is ahead of many other health jurisdictions in the nation, there is an ongoing need to improve data collection and reporting of transgender persons countywide.

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