2022-2026

County of Orange Integrated HIV Prevention and Care Plan

OC health CARE AGENCY

Section I: Executive Summary of Integrated Plan and Statewide Coordinated Statement of Need

Orange County is comprised of 798 square miles between Los Angeles and San Diego in Southern California. Orange County is the 6th largest county in the United States and includes 34 cities and an estimated 3.1 million people.[1] Orange County ranks 5th[2] in the total number of HIV cases among the state's 58 counties. As of December 31, 2021, there were 6,772 persons living with HIV (PLWH) in Orange County that were aware of their status. In addition, it is estimated that an additional 950 individuals are living with HIV but are unaware of their status.[3] HIV cases in Orange County are widely distributed throughout the county with the highest concentration of cases in the central to northern region. By residence at diagnosis, the majority of PLWH were residing in Santa Ana, an urban area with a disproportionately high population of Hispanic[4] and low-income residents.

Orange County's Integrated HIV Prevention and Care Plan for 2022-2026 (Integrated Plan) provides an overview of the current landscape of HIV services in the county and identifies goals and strategies to make progress towards ending the HIV epidemic. The Integrated Plan addresses the HIV Care Continuum including those that are at high-risk for HIV and aligns with the goals outlined in the National HIV/AIDS Strategy (NHAS) for 2022-2025. The goals of the plan are to: 1) prevent new HIV infections; 2) improve HIV-related health outcomes of people living with HIV; and 3) reduce HIV-related disparities and health inequities. Furthermore, Orange County's Integrated Plan complements the Statewide Integrated Strategic (End the Epidemics) Plan for 2022-2026 to address the syndemic of HIV, Sexually Transmitted Infections (STIs)[5], and Hepatitis C Virus (HCV) in California to ensure services are coordinated.

a. Approach

The approach to preparing the 2022-2026 Integrated Plan included a combination of the following:

- Updating the previously submitted Integrated Plan (2017-2021);
- Integrating sections of Orange County's Ending the HIV Epidemic (EHE) Plan; and
- Incorporating feedback from PLWH, community members, and key stakeholders, including the HIV Planning Council (Council), Integrated Plan Committee (Integrated Plan and EHE Steering Committee), HIV Client Advocacy Committee, Priority Setting, Allocations, and Planning Committee, individuals from priority populations, community partners, and service providers through meetings, surveys, focus groups, and other methods.

(Continued on next page)

[1] United States Census Bureau (2021). *County Population Totals: 2010-2019*. https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html

[2] California Department of Public Health Office of AIDS (2022). *California HIV Surveillance Report – 2020*. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/California_HIV_Surveillance_Report2020_ADA.pdf.

[3] The total number of persons estimated to be living with HIV is based on the Centers for Disease Control and Prevention calculation methodology updated in 2016. The calculation is the number of persons known to be living with HIV (6,772) divided by 0.877. The difference between this calculation (7,722) and 6,772 is the additional number of persons estimated to be living with HIV but are unaware of their diagnosis (950).

[4] Hispanic/Latino/Latinx used interchangeably throughout the Integrated Plan.

[5] Sexually Transmitted Diseases (STDs) and Sexually Transmitted Infections (STIs) used interchangeably throughout the Integrated Plan.

b. Documents submitted to meet requirements

Orange County's 2017-2021 Integrated Plan document was used as a foundation for the 2022-2026 Integrated Plan and the most current data was used to update the plan. In addition, Orange County's most current epidemiological profile (2021), National HIV AIDS Strategy (NHAS) for Orange County, and components of the situational analysis submitted with Orange County's EHE Plan were used to develop new material and meet submission requirements. Through participation in the California Planning Group, the statewide HIV planning body facilitated by the State Office of AIDS, Orange County ensured the Integrated Plan for 2022-2026 is in alignment and prevents duplication of services.

Section II: Community Engagement and Planning Process

1. Jurisdiction Planning Process

The planning process for Orange County's Integrated HIV Prevention and Care Plan for 2022-2026 (Integrated Plan) involved various entities to ensure coordination of HIV programs and that strategies effectively addressed HIV prevention and care needs identified. Service providers offer insight on the health care system and can positively impact the strategies in the Integrated Plan by developing and implementing innovate solutions that lead to positive health care outcomes. Orange County's planning process included representation from service providers which offer a wide range of prevention, care, and support services utilizing various funding sources, including federal (Ryan White Parts A, B, C, CDC, Ending the HIV Epidemic (CDC and HRSA), Housing Opportunities for Persons with HIV/AIDS (HOPWA), Substance Abuse and Mental Health Services Administration (SAMHSA)) as well as state funding sources The table below is a snapshot of the agencies (service providers), by service category, that were involved in the development of the Integrated Plan and will also support implementation throughout 2022-2026.

a. **Entities involved in process**

Service Category	Agencies (Various Funding Sources)
Outpatient/Ambulatory Medical Health Services	OCHCA Testing, Treatment, and Care (TTC) Clinic AltaMed University of California, Irvine (UCI)
Medical/Non-Medical Case Management (Including Jail Case Management)	TTC Clinic APAIT Radiant Health Centers (RHC) Shanti Orange County (Shanti OC)
Emergency Financial Assistance (EFA) – Medications/Health Insurance Premium and Cost Sharing Assistance	RHC Shanti OC
Oral Health Care	Private Dental Offices*
Mental Health Services	APAIT RHC Shanti OC OCHCA Recovery and Mental Health Services
Substance Abuse Outpatient Care	OCHCA Recovery and Mental Health Services

(Continued on next page)

Service Category	Agencies (Various Funding Sources)
Housing Services – EFA for Housing / Housing Coordination/ Transitional Housing/Short Term Supportive Housing (STSH): General Population/Transitional Housing/STSH: Substance Users	APAIT City of Anaheim, Anaheim Housing Authority RHC
Early Intervention Services	TTC Clinic
Home Health Care / Home and Community–Based Health Services / Hospice / Rehabilitation	RHC
Medical Nutrition Therapy / Food Bank / Home Delivered Meals / Nutritional Supplements	TTC Clinic RHC
Medical Transportation Services	TTC Clinic RHC Shanti OC
Other Professional Services including Legal Services	Public Law Center (PLC)
Independent Living Skills [HRSA Category Health Education / Risk Reduction]	RHC
Outreach Services	TTC Clinic
Prevention with Positives including Education and Prevention for HIV positive individuals [HRSA Category Health Education/Risk Reduction]	TTC Clinic APAIT RHC The LGBTQ Center OC
Psychosocial Support Services (support groups and counseling activities)	APAIT RHC Shanti OC The LGBTQ Center OC
Referral for Healthcare and Support Services	TTC Clinic RHC Shanti OC
Other	Alianza Translatinx

*Not currently on any of the committees of the Council but provide input through other mechanisms including through Dental Provider Meetings.

These agencies are comprised of key stakeholders, as follows:

- TTC:
  - Health department staff
  - Epidemiologists
  - HIV clinical care providers
  - STD clinics and programs
  - Substance use treatment providers
  - Mental health providers
- Alianza Translatinx
  - Community members resulting from new outreach efforts
  - Populations at risk or with HIV representing priority populations

(Continued on next page)

- Alta Med
    - Community-based organizations serving populations affected by HIV as well as HIV service providers
    - HIV clinical care providers
    - STD clinics and programs
- APAIT:
    - Community-based organizations serving populations affected by HIV as well as HIV service providers
    - STD clinics and programs
    - Substance use treatment providers
    - Mental health providers
    - Social services providers including housing and homeless services representatives
- City of Anaheim:
    - City department partner
- The LGBTQ Center OC
    - Community-based organizations serving populations affected by HIV as well as HIV service providers
    - STD clinics and programs
- OCHCA Recovery and Mental Health Services
    - Health department staff
    - Mental health providers
    - Substance use treatment providers
- Public Law Center
    - Community-based organizations serving populations affected by HIV as well as HIV service providers
- Radiant Health Centers
    - Community-based organizations serving populations affected by HIV as well as HIV service providers
    - HIV clinical care providers
    - STD clinics and programs
    - Substance use treatment providers
    - Mental health providers
    - Social services providers including housing and homeless services representatives
- UCI
    - HIV clinical care providers
    - Local academic institutions
    - STD clinics and programs
    - Hospital planning agencies

(Continued on next page)

b. **Role of the RWHAP Part A Planning Council/Planning Body**

Orange County HIV Planning Council (Council) – The Council is responsible for overseeing the work of the Integrated Plan Committee (IPC) and collaborated with the committee for implementation, monitoring, and evaluation of the prior Integrated Plan (2017-2021) and for development of the current Integrated Plan (2022-2026). Feedback provided by the Council was incorporated into the 2022-2026 Integrated Plan. Additionally, the Council provided final approval and concurrence with the 2022-2026 Integrated Plan submission to HRSA. As of November 9, 2022 (when Council provided concurrence for the 2022-2026 Integrated Plan), the Council was comprised of 14 members. The composition of Council membership satisfied the consumer participation requirement of 36% (5 of 14) and met the majority of HRSA required membership categories with the following six (6) vacant positions: Hospital Planning Agency, State Medicaid Agency, Healthcare Provider (including FQHC), Part D Provider, Community Based Organization or AIDS Services Organization (Serving Affected Populations), and Representative of/or incarcerated PLWH. Additionally, the Council membership was generally reflective of the HIV epidemic in Orange County in the sense that the majority of Council members are male, Hispanic, age 60 and older, and MSM. However, when comparing percentages there are a few exceptions:

Over-Representation Of*:

- Women with 36% of Council compared to 12% of the epidemic
- Age 30-39 years with 29% of Council compared to 16% of the epidemic
- Heterosexual with 29% of Council compared to 12% of the epidemic

Under-Representation Of*:

- Male with 57% of Council compared to 87% of the epidemic
- Age 50-59 years with 14% of Council compared to 28% of the epidemic
- MSM with 29% of Council compared to 73% of the epidemic

* It is important to note that due to the population size of the Council (14) compared to all PLWH in Orange County (6,772), any change to the number of Council members and demographics may skew overall percentages. It is also important to note that around the time of Integrated Plan submission, Orange County anticipates two (2) additional new members will be appointed to the Council on December 6, 2022, which will fill the following vacant positions: Part D Provider and Community Based Organization or AIDS Services Organization (Serving Affected Populations). While the percentages will change, the overall trends for Council demographics will remain the same.

c. **Role of Planning Bodies and Other Entities**

Integrated Plan Committee (IPC): In Orange County, the IPC, a subcommittee of the Council is the designated Integrated Plan Steering Committee and leads the development and implementation of the Integrated Plan. The committee meets monthly and focuses on identifying and addressing barriers to HIV prevention and care services and developing strategies to effectively impact the HIV Care Continuum. The committee's membership is categorized in a manner that ensures a comprehensive representation of stakeholder participation. IPC members are comprised of various service providers that represent HIV Care Services, HIV Prevention Services, HIV Support Services, and Affected Communities. The IPC thoroughly reviewed and developed a work plan in accordance with the HRSA and CDC Integrated Plan guidance (2022-2026) for Integrated Plan development. The committee developed, reviewed, and approved each section of the Integrated Plan for review by the Council. Additionally, IPC is also the designated Ending the HIV Epidemic (EHE) Steering Committee and collaborates with the Council, its subcommittees, and community partners and stakeholders to develop, implement, evaluate, and monitor Orange County's EHE Plan.

(Continued on next page)

Priority Setting, Allocations, and Planning (PSAP) Committee: The PSAP Committee, another subcommittee of the Council also provides input on Orange County's goals and strategies developed in accordance with the National HIV AIDS Strategy (NHAS) and for the Integrated Plan. IPC collaborates with PSAP to ensure that the goals and objectives indicated in NHAS align with the Integrated Plan to prevent duplication and gaps in the service delivery system and improve outcomes along the HIV Care Continuum.

d. **Collaboration with RWHAP Parts**

To avoid duplication and gaps in the service delivery system the Council and its various subcommittees, which have an integral role in the planning process for the Integrated Plan, include Ryan White Part A, B, and C providers as detailed above. A representative from the local AIDS Education and Training Center Program (Pacific AIDS Education and Training Centers) also participates on the Council. Furthermore, a Ryan White Part D provider representative was recently identified for participation on the Council and will contribute to Integrated Plan implementation, monitoring, and evaluation upon appointment. There are currently no Ryan White Part F Dental Programs in Orange County.

e. **Engagement of people with HIV**

HIV Client Advocacy Committee (HCAC) and Orange County HIV Planning Council (Council): HCAC, a subcommittee of the Council comprised of people living with HIV (PLWH) assisted in the development of needs assessments activities such as reviewing the language and content of the Client Needs Survey and selecting topics, developing questions, recruiting, and participating in focus groups. HCAC is also involved in the priority setting process and provides recommendations for service priorities for Ryan White services based on how important each service is to improve or maintain the health of PLWH as well as improving the HIV Care Continuum in Orange County. As of November 9, 2022 (when Council provided concurrence on the 2022-2026 Integrated Plan), 36% (5 of 14) of Council members were PLWH. PLWH represented in HCAC, and Council will be included in the implementation, evaluation, and improvement process of the Integrated Plan by reviewing data, quality indicators, and strategies associated with the Integrated Plan throughout the year. Additionally, PLWH represented on HCAC, and Council will be involved in both monitoring and evaluating the goals and objectives of the Integrated Plan through reviewing surveillance data and program data throughout the year. This data will allow for an understanding of the individuals that are newly diagnosed, all PLWH who are linked and retained in care, and those PLWH that are virally suppressed. During the review, PLWH on the committees will be involved in evaluating implementation strategies, outcomes, and target populations to see if Orange County is on track to reach the goals outlined in the Integrated Plan before the end of 2026.

Focus Groups – Focus groups provide qualitative data on a range of topics from the perspective of PLWH. Focus groups have covered various topics including oral health, barriers to care, case management, and the impact of the Affordable Care Act. Focus group participants are asked about their perceptions, opinions, beliefs, and attitudes towards a service or idea. Data from the focus groups allowed for the Integrated Plan Committee and the Council to ensure the voice of these communities and its need are addressed in the Integrated Plan.

(Continued on next page)

Surveys – Orange County has conducted various surveys to obtain information from PLWH and those at high-risk of contracting HIV including the Client Needs Survey and Client Satisfaction Surveys. These surveys are an important tool to capture the voice of those individuals that are not members of the Council or its subcommittees. Surveys are used to describe ideas, attitudes, knowledge, and needs of the larger population, especially if the demographics of individuals who completed the surveys align with the epidemic in Orange County.

f. **Priorities**

The following has been identified as priorities that arose out of the planning and community engagement process:

Priority Populations: Through the planning and community engagement process, the following priority populations were identified:

a. Men who have Sex with Men (MSM) of color (African American/Black or Hispanic/Latino);
b. Individuals who are incarcerated or who have a history of incarceration;
c. Individuals with history of substance use, including people who inject drugs (PWID)[6];
d. Other priority populations which existing HIV programs and services have had less capacity to reach:
    - Young people (19-25)
    - Transgender individuals
    - Pre-Exposure Prophylaxis (PrEP) eligible individuals
    - People Living with HIV (PLWH) who are not virally suppressed

The strategies and interventions detailed in the Integrated Plan are intended to reach priority populations, which are populations disproportionately impacted by HIV to ensure maximum impact and that the goals and objectives of the plan are met. The priority populations identified align with other planning documents in the jurisdiction, including Orange County's EHE Plan, Early Identification of Individuals with HIV/AIDS (EIIHA) Plan, and National HIV/AIDS Strategy Goals for Orange County.

Rapid Antiretroviral Therapy (ART) ART Expansion: Rapid ART has proven to be effective in decreasing the average amount of time it takes an individual to reach viral load suppression and thereby reducing the time the individual can potentially transmit the virus to partners.[7] Additionally, when Rapid ART was made available to all newly diagnosed individuals regardless of insurance type, disparities among people of color in achieving viral load suppression decreased. Thus, through the EHE planning process, expansion of Rapid ART through the OCHCA TTC Clinic as well as community based provides was identified as a priority.

(Continued on next page)

[6]Injection Drug User (IDU) and People Who Inject Drugs (PWID) are used interchangeably throughout plan
[7] Bacon O, Chin J, Hsu L, et al. The Rapid ART Program Initiative for HIV Diagoses (RAPID) in San Francisco. Paper presented at: Conference on Retroviruses and Opportunistic Infections2018; Boston, MA.

Testing Innovations - Mail to Home Self- Test Kit Program: One of the priorities identified through the needs assessment process was to make HIV testing more available to people at risk for HIV, especially priority populations as described below. Through the Building Online Healthy Communities (BHOC), TakeMeHome Program, HIV and STD self-test kits are mailed to an individual's home (or another preferred location). This helps eliminate barriers for accessing testing services for Orange County residents who have not tested in over a year or who have never tested.

Services to Support PLWH Outside of the Ryan White System of Care: Through the planning and community engagement process the need was identified to address disparities in healthcare outcomes along the HIV Care Continuum for PLWH outside of the Ryan White system of care through the following (new or existing) programs and services:

a. Community-Based Case Management Services: The purpose of these services will be to provide support to PLWH who are not virally suppressed and who receive care outside of the Ryan White system of care at community-based provider sites. Provider sites will be identified by the volume of patients who are not virally suppressed. Case management services will include patient intake and enrollment, patient needs assessments, follow-up between medical visits, assistance with referrals and program navigation, as needed.
b. Viral Load Suppression Incentive Program: The Viral Load Suppression Incentive Program is intended to increase linkage and retention in care and ultimately viral load suppression by offering incentives to PLWH (outside of the Ryan White system of care) who are not virally suppressed for reaching various milestones in their medical care. This program will be implemented through a partnership between the OCHCA's TTC Clinic and community provider sites.
c. High Acuity Program: Program services are intended for PLWH who are no longer eligible for the Ryan White program, experience challenges linking to or staying engaged in care, and/or navigating their respective system of care, and meet one (1) or more of the following criteria: not HIV medication adherent; fallen out of care; not virally suppressed; have medical co-morbidities, mental health, or substance use issues that impede medication adherence. Through this program, the OCHCA TTC Clinic provides comprehensive HIV care services and referrals to needed HIV support services to facilitate retention in care and viral load suppression.
d. Community Based Mental Health Services for Non-Ryan White: Through this program, community based mental health services are made available to PLWH who no longer qualify for Ryan White, are transitioning to other systems of care, and/or who face barriers to care. Services are limited to six (6) months and are intended to bridge the gap in services while the patient links to a mental health provider within their respective system of care.

(Continued on next page)

Trauma-Informed Prevention and Care Services for Black/African American (B/AA) and Transgender Populations: Through the community engagement process, the need to engage populations disproportionately impacted by HIV, specifically B/AA and Transgender communities and organizations or community groups that serve these populations was prioritized. The need to build capacity within HIV service providers to effectively serve these populations was also prioritized. These efforts are intended to identify barriers to care, inform service delivery, and build capacity within Orange County to provide culturally competent and trauma-informed care to B/AA and Transgender populations.

PrEP Navigation: Another priority identified through Orange County's planning process and PrEP needs assessment survey was to expand HIV Prevention, particularly PrEP Navigation Services to assist clients with PrEP access with public or private insurance.

Linkage to Care Innovations - Jail Viral Load Incentive Program: This program was developed to address disparities along the Continuum of HIV Care, specifically barriers in linkage to care identified through the planning process among individuals upon release from incarceration. The Jail Viral Load Incentive Program will incentivize individuals to link to care upon release from jail. This program will be implemented through a partnership between the OCHCA and Orange County Correctional Health Services. The program will be implemented by the Ryan White Linkage to Care Case Manager who works with individuals while incarcerated and develops a plan with the individuals to help link them to care and other support services upon release from jail.

HIV Outbreak Response: Through the planning process, the need to develop an Orange County specific HIV Outbreak Response Plan was identified. HIV cluster and outbreak identification and response activities will support Orange County's efforts to rapidly link HIV positive individuals to care as well as provided needed prevention services to individuals at risk of HIV. To ensure the plan is comprehensive, the development process will include input from key stakeholders, such as HIV service providers, local partners, and community members.

HIV Services Expansion: The need was identified to increase access to services for priority populations by expanding availability of services in non-traditional health care settings and/or during non-traditional hours. For example, expansion of services may include offering services during night and weekend hours or offering field-based or mobile services.

(Continued on next page)

Oral Health Services: Based on the Client Needs Survey conducted in 2013, 2015, 2017, and 2019 dental care services and advance dental care services, such as root canals and crowns, have consistently ranked in the top five (5) (#1 and #2) most important services by PLWH. Dental services are generally not fully covered by public and private insurance and can be cost prohibitive for clients to pay out of pocket. The. The need for advanced dental services has at times been met through partnerships with dental schools in the region, including neighboring counties. Through coordination of multiple funding sources, specifically Ryan White Part A and C, Orange County is making progress towards meeting the need for oral health services.

g. **Updates to Other Strategic Plans Used to Meet Requirements**
The OCHCA did not use portions of another local strategic plan to satisfy/address Section II: Community Engagement and Planning Process

Section III: Contributing Data Sets and Assessments

1. Data Sharing and Use

The following is an overview of data available to Orange County used to support the planning process and Integrated Plan 2022-2026 development.

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

  RSR data is used to determine the number of individuals that receive services, trends in service need based on utilization over a period of time and assists in determining changes in service utilization. More specifically RSR data provides a deeper understanding of Ryan White clients at various steps of the HIV Care Continuum by understanding their ability to reach and maintain viral load suppression. Furthermore, RSR data informs the community planning process by providing information to understand how a specific service, such as case management, which is meant to assist clients in linking and staying retained in medical care, compares to other support services or to non-Ryan White clients in supporting persons living with HIV (PLWH) reach and maintain viral load suppression. RSR data also provides information on client demographics, city of residence, and/or other characteristics that help to identify different service needs and disparities along the HIV Care Continuum based on the various demographic measures.

(Continued on next page)

- Surveillance Data – Public health surveillance data is the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. HIV surveillance data provides information on the impact of an intervention or may track progress towards specified goals. HIV surveillance data reported to the public health department includes name, contact information, demographics, residence, medical facility information, risk categories, positive HIV test results, CD4 and/or viral load results, opportunistic infections, payer source, pregnancy information, and other sexually transmitted diseases (STDs).

  Each year surveillance data is used to determine the number of PLWH who are aware of their status, unaware of their status, are not in care, and have unmet need (aware of their status but not in care). This information assists planners in determining the number of individuals that need to be outreached to for testing and linkage to care, or reengagement in care. Additionally, surveillance data is critical in developing the HIV Care Continuum. Using lab information (CD4 and viral load results), applying definitions from the National HIV/AIDS Strategy (NHAS), and CDC guidance, estimates are developed for each component of the HIV Care Continuum including the number of PLWH that know their status, have been linked to care, retained in care, and have reached viral load suppression. The continuum provides a benchmark for comparing Orange County efforts to the state and nation.

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

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

  In 2021, focus groups were also conducted with the Transgender and Gender Non-Conforming (TGNC) Latinx community, which has been identified as an additional priority population through the Ending the HIV Epidemic (EHE) planning process for Orange. EHE priority populations were identified as those that are disproportionately impacted by HIV and who have not historically participated in the planning process. The focus groups provide information to community planners about the HIV/STD service needs and barriers to care for this population.

(Continued on next page)

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

  Orange County has conducted the Client Needs Survey on odd years since 2003 targeting PLWH that may or may not receive Ryan White Services. The Client Needs Survey asks participants about most important services, services they felt they needed, whether they received the service, and reason service was not received. The Client Needs Survey is one of the needs assessment activities conducted by the HIV Planning Council (Council) and subcommittees. The information collected is used as part of the planning process such as when setting service priorities. Needs assessment information provides data that can inform planners on service priorities, gaps in services, and possible allocation needs.

  Orange County has conducted the Client Satisfaction Survey on even years since 2007 targeting PLWH that receive Ryan White Services. The Client Satisfaction Survey asks participants about their experience and satisfaction with Ryan White Act-funded services in Orange County. This information is used by the Council subcommittees to improve service delivery and identify future Quality Improvement Initiatives.

  Orange County has also conducted surveys that target high-risk HIV negative individuals. In 2019, Orange County conducted a PrEP survey to assess awareness of PrEP, sources of knowledge regarding PrEP, PrEP use, reasons for not using PrEP, and HIV and STD testing behaviors. This information was used as part of the planning process to assess HIV and STD testing behaviors and identify the barriers for accessing and using PrEP. In 2021, Orange County conducted a survey in collaboration with a community-based organization to help identify HIV/STD service needs and barriers to care for the TGNC community. Survey questions focused on satisfaction with HIV/STD service providers, barriers to care, healthcare experiences, and other service needs.

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

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

(Continued on next page)

- Local Evaluation Online (LEO) - LEO is an online system that assists in tracking information about California Department of Public Health (CDPH), Office of AIDS (OA)-funded HIV education and prevention programs, including HIV counseling and testing services.
  LEO provides planners information about those who are being tested for HIV. This information includes where individuals are getting tested, their level of risk, demographic detail. Additionally, this information provides a variety of HIV and PrEP testing activity indicators including the number of HIV testing encounters, newly identified and/or previous confirmed positives, linkage to care, Partner Services, PrEP eligibility screening, PrEP eligible referrals, referral to a PrEP prescriber, linkage to a PrEP prescriber, obtaining a PrEP prescription, initiating PrEP, and attending one (1) or more PrEP follow-up sessions. This information can be used to develop interventions that can reduce the number of individuals that do not know their HIV status and further improve the HIV Care Continuum.

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

  CalREDIE provides planners information about high-risk HIV negative individuals and PLWH. This data includes demographic detail; clinical information; treatment information; reported risks for substance use, social history, and risk factors; STD history, including Hepatitis C (HCV); HIV status; partner information; and interview information of individuals that have tested positive for STDs, such as syphilis, that may categorize the individual as high risk for HIV. This information can be used to develop interventions that further improve the HIV Care Continuum and address the syndemic of HIV, STDs, and HCV.

2. Epidemiologic Snapshot

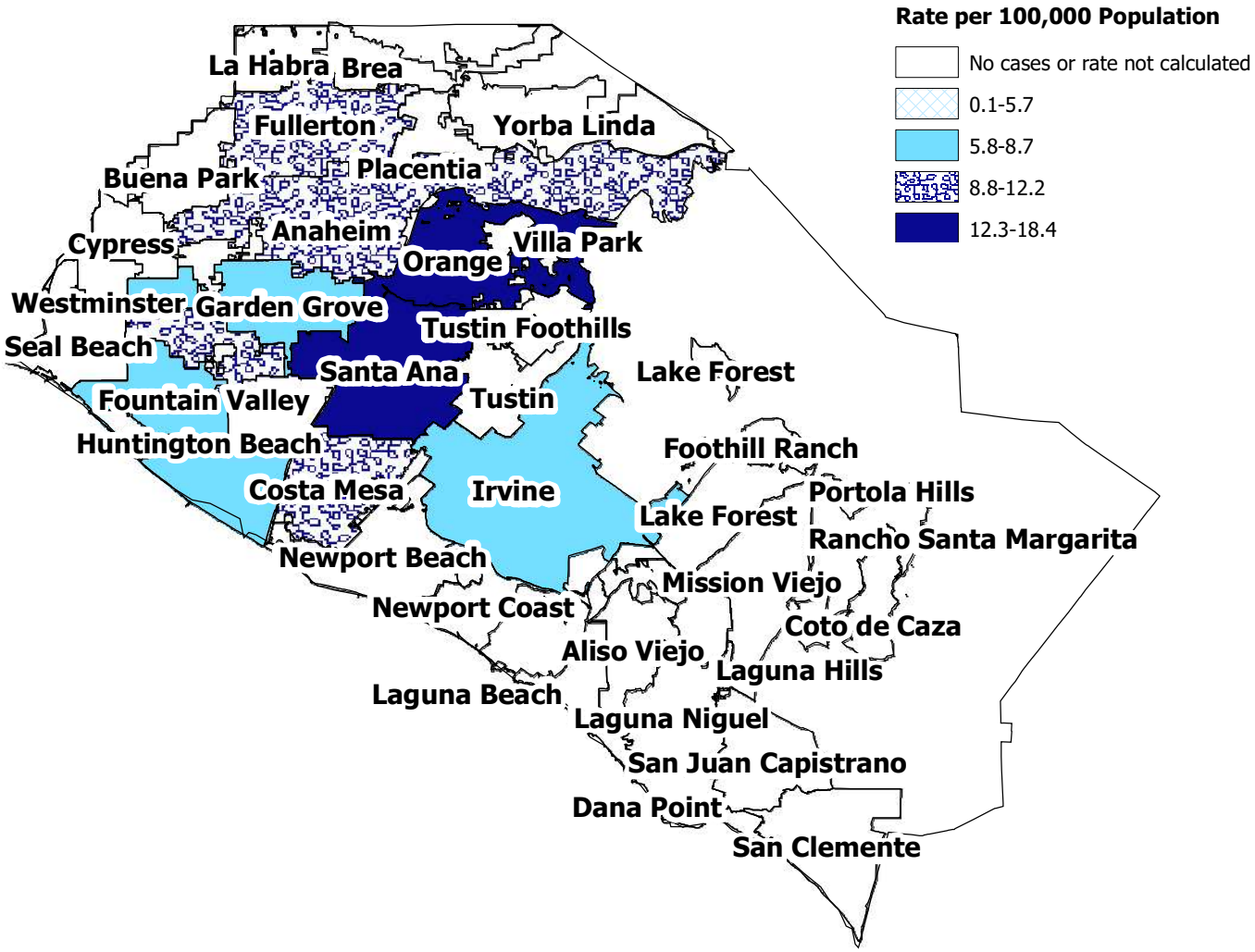
A. Epidemiological Overview

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

The map below displays the rate per 100,000 population of persons newly diagnosed with HIV in 2021 by city of residence at the time of diagnosis. Santa Ana has the highest rate at 18.4 and Irvine has the lowest rate at 8.5. Rates are not calculated for cities with fewer than ten (10) diagnosed cases or where population estimates are unavailable.

(Continued on next page)

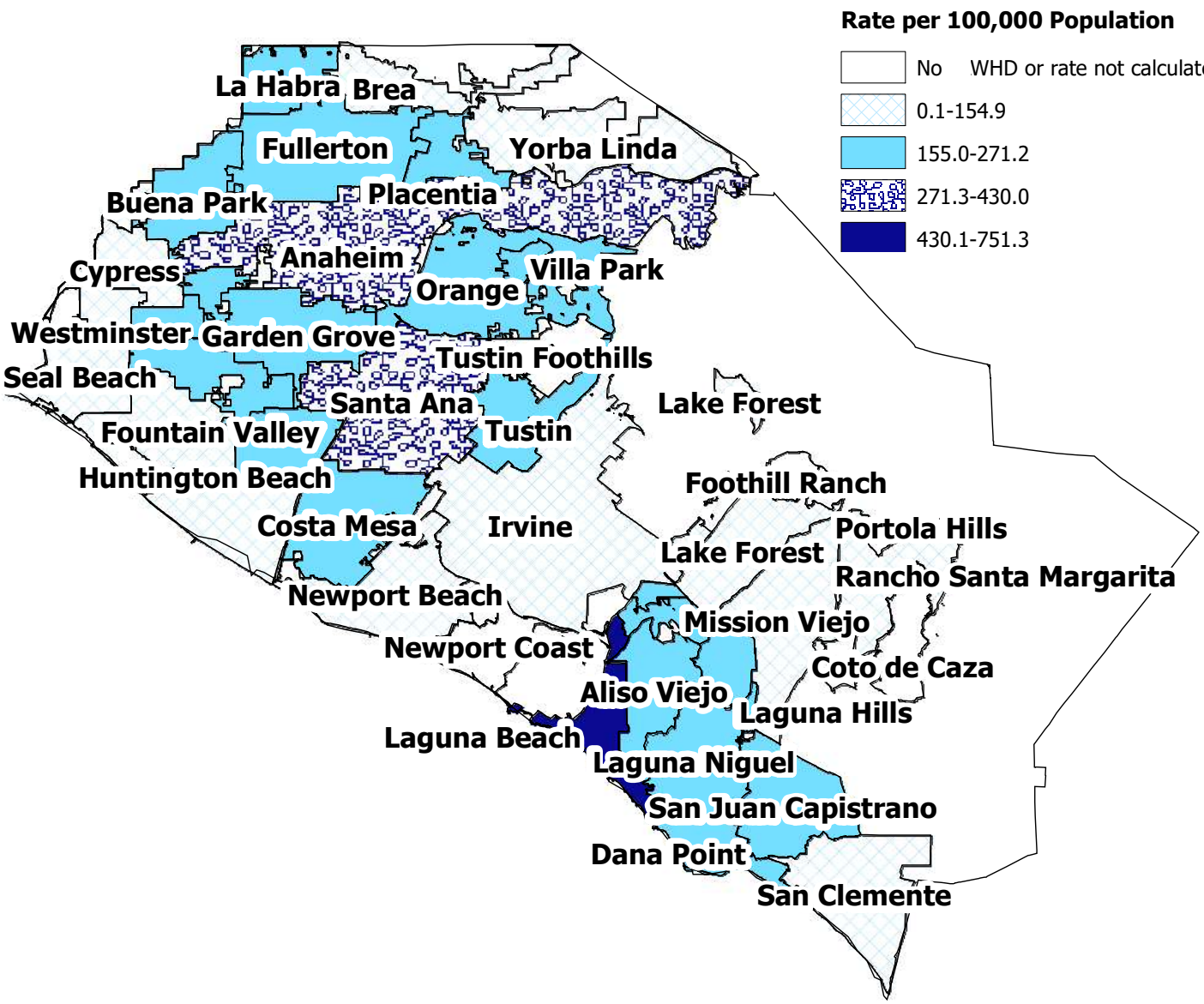
Figure 1:
Rate per 100,000 Population of New HIV Diagnoses by City of Residence at Time of Diagnosis, Orange County 2021



(Continued on next page)

Additionally, the map below shows the rate per 100,000 population of persons living with HIV (PLWH) by city of residence at the time of diagnosis. Laguna Beach has the highest rate at 751.3, followed by the central county cities of Santa Ana (430.0) and Anaheim (305.3).

Figure 2:
Rate per 100,000 Population of People Living with HIV by City of Residence, Orange County 2021



(Continued on next page)

B. Socio Demographic Characteristics of Newly Diagnosed, PLWH, and Persons at Higher Risk for HIV infection

i. The table below shows the demographic detail for all newly diagnosed individuals, PLWH, and high-risk populations[8] that received a California Department of Health (CDPH) State Office of AIDS (SOA) funded HIV test utilizing the most current data available. The demographic detail includes gender, race/ethnicity, age at diagnosis, and risk factor.

- A comparison of those newly diagnosed in 2021 to those living with HIV shows higher percentages (1.0% or more) of cases among the following populations:
  - Males
  - Hispanics
  - Asians
  - 19-35 Year-Old
  - Injection Drug User (IDU)
- A comparison of high-risk testers to those newly diagnosed in 2021 and those living with HIV shows lower percentages (1.0% or more) of cases among the following populations:
  - Females
  - Blacks
  - Hispanics
  - Individuals 46 years and Older
  - IDU
  - Men who have sex with Men (MSM)/IDU

Table 1: Demographic Detail for 2021 Newly Diagnosed Individuals, PLWH, and High-Risk Populations

	Newly Diagnosed (2021)		PLWH		High-Risk Populations	
	Number	Percent	Number	Percent	Number	Percent
Total Number of Cases	**274**	**100.0%**	**6,772**	**100.0%**	**2,044**	**100.0%**
Gender/Sex						
Male	242	88.3%	5,851	86.4%	1,800	88.1%
Female	27	9.9%	810	12.0%	31	1.5%
Transgender	*	*	111	1.6%	175	8.6%
Gender Queer/Non-Binary	N/A[8]	N/A	N/A[8]	N/A	29	1.4%
Unknown	0	0.0%	0	0.0%	9	0.4%
Race/Ethnicity						
Black	14	5.1%	364	5.4%	47	2.3%
Hispanic	143	52.2%	3,343	49.4%	910	44.5%
White	79	28.8%	2,338	34.5%	534	26.1%
Asian	33	12.0%	574	8.5%	468	22.9%
Other/More than One Race/ Unknown	*	*	153	2.3%	85	4.2%
Age at Diagnosis						
0-18 Years	*	*	17	0.3%	45	2.2%
19-25 Years	57	20.8%	224	3.3%	540	26.4%
26-35 Years	89	32.5%	1,110	16.4%	857	41.9%
36-45 Years	51	18.6%	1,448	21.4%	361	17.7%
46-55 Years	42	15.3%	1,713	25.3%	163	8.0%
56 Years and Older	29	10.6%	2,260	33.4%	75	3.7%
Unknown	0	0.0%	0	0.0%	3	0.1%

*Fewer than 10 cases diagnosed. Other Race/Ethnicity includes Native American/Alaskan Native. Other Mode of Exposure includes recipients of transfusions or transplants, persons who received treatment for hemophilia, and all pediatric modes of transmission.

[8] High-risk populations determined by Centers for Disease Control and Prevention risk hierarchy

Table 2: Demographic Detail for 2021 Newly Diagnosed Individuals, PLWH, and High-Risk Populations

	Newly Diagnosed (2021)		PLWH		High-Risk Populations	
	Number	Percent	Number	Percent	Number	Percent
Total Number of Cases	**274**	**100.0%**	**6,772**	**100.0%**	**2,044**	**100.0%**
Risk Factor/Transmission Category						
Men Having Sex With Men (MSM)	185	67.5%	4,858	71.7%	1,712	83.8%
Transgender	*	*	111	1.6%	175	8.6%
Gender Queer/Non-Binary	N/A[9]	N/A	N/A[8]	N/A	29	1.4%
Injection Drug User (IDU)	20	7.3%	400	5.9%	67	3.3%
MSM/IDU	*	*	298	4.4%	61	3.0%
Other/Unknown	56	20.4%	1,105	16.3%	0	0.0%

*Fewer than 10 cases diagnosed. Other Race/Ethnicity includes Native American/Alaskan Native. Other Mode of Exposure includes recipients of transfusions or transplants, persons who received treatment for hemophilia, and all pediatric modes of transmission.

ii. The table below shows available socioeconomic data for individuals that were newly diagnosed in 2021 and PLWH in the Ryan White system. Income, federal poverty level, and health status is shown below, when available. In previous years, insurance information was captured for high-risk populations who received CDPH SOA funded HIV testing. Starting in 2018, these data elements were no longer collected or reported in the SOA testing database.

Table 3: Socioeconomic Detail for 2021 Newly Diagnosed Individuals and Ryan White

	Newly Diagnosed (2021)		Ryan White[10]	
	Number	Percent	Number	Percent
Total Number of Cases	**274[11]**	**100.0%**	**2,350**	**100.0%**
Federal Poverty Level (FPL)				
Under 100% FPL	59	21.5%	460	57.8%
101-138% FPL	11	4.0%	283	13.9%
139-200% FPL	24	8.8%	373	13.5%
201-250% FPL	16	5.8%	231	6.1%
251-400% FPL	15	5.5%	350	7.6%
401-500% FPL	*	*	83	0.7%
501% FPL and above	*	*	12	0.2%
Not Reported	147	53.6%	558	0.4%
Health Insurance Status				
Private Insurance	88	32.1%	670	N/A
Medi-Cal/Medicare	85	31.0%	1,475	N/A
No Insurance	77	28.1%	1,491	N/A
Unknown	21	7.7%	52	N/A
Other[12]	*	*	725	N/A

*Fewer than 10 cases diagnosed.

[9] Gender Queer/Non-Binary risk factor is not captured in the local surveillance or AIDS Regional Information and Evaluation System (ARIES) databases.

[10] Individuals may have more than one insurance type listed in AIDS Regional Information and Evaluation System (ARIES) because an individual may move through different payer sources in the same year, thus numbers and percentages listed exceed total number of Ryan White clients and related percentages.

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

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

C. Description of the burden of HIV in the service area

The tables and graphs below show the burden of HIV in Orange County based on the characteristics of the population. The information includes total number of PLWH, concurrent diagnoses, rates by gender, rates by race/ethnicity, rates by age at diagnosis, and rates based on mode of exposure. Data in some of the graphs is grouped into three (3) year groupings. This is done in order to understand trends and to stabilize the data by removing variability caused by a spike (increase or decrease) in the number of cases from one year to the next that may skew the data.

Figure 3 below displays the number of persons diagnosed and living with HIV since 2017. Over the five (5) year period of 2017 through 2021 there has been an increase of 1,053 PLWH in Orange County. This is an average increase of 211 individuals a year. This number does not include individuals that have passed away or have been confirmed to have moved outside of Orange County.

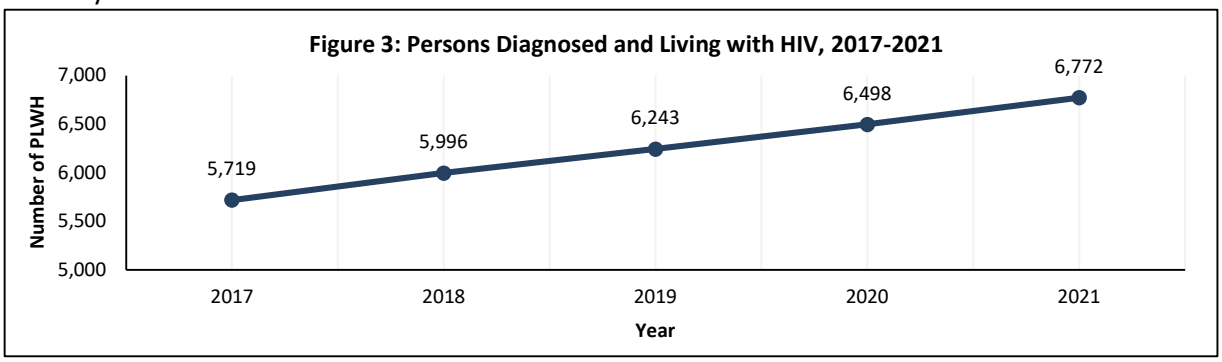


Figure 4 below shows the number of individuals that are newly diagnosed by year of diagnosis. In addition, the line graph shows the number of newly diagnosed individuals that were diagnosed with HIV and AIDS within the same month. This graph shows the number of individuals that are tested late (concurrently diagnosed with HIV and AIDS). Over the past five (5) years, the number of concurrently diagnosed individuals has decreased by 10.0%.

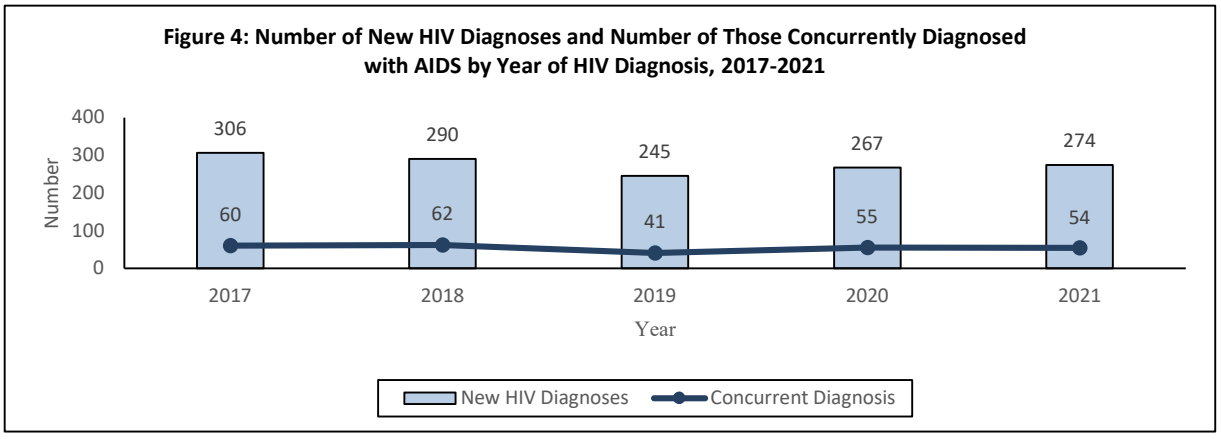
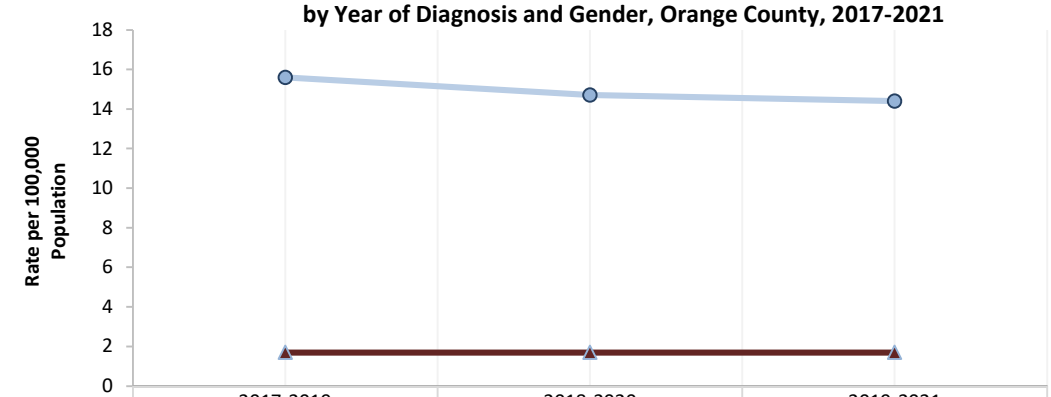


Figure 5 below displays the three (3) year average rate of HIV cases by gender.[13] Over the last five (5) years, case rates have decreased by 7.7% for males and have remained relatively steady for females.

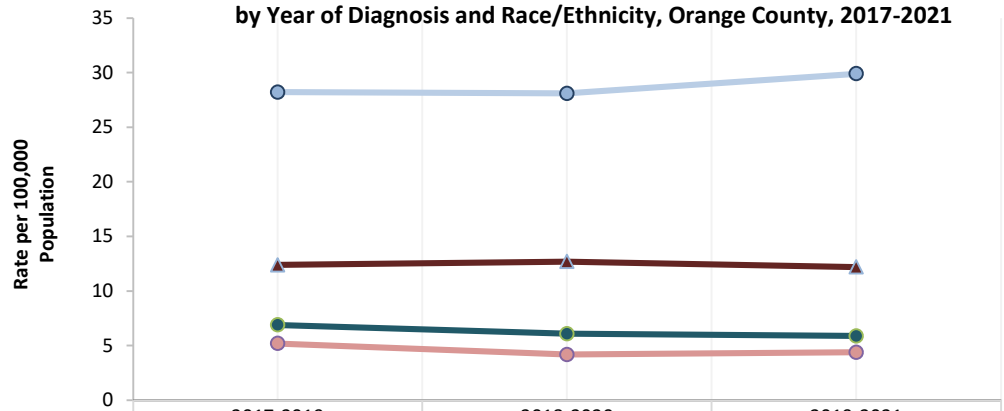
Figure 5: Rolling Three Year Average Rate per 100,000 Population of HIV Cases by Year of Diagnosis and Gender, Orange County, 2017-2021



	2017-2019	2018-2020	2019-2021
Male	15.6	14.7	14.4
Female	1.7	1.7	1.7

Figure 6 below shows the rolling three (3) year average rate of HIV cases per 100,000 population by race/ethnicity. Over the last five (5) years, case rates for the Black/African American population have increased by 6.0%, while rates for Hispanics, Whites, and Asians have decreased by 1.6%, 14.5%, and 15.4% respectively.

Figure 6: Rolling Three Year Average Rate per 100,000 Population of HIV Cases by Year of Diagnosis and Race/Ethnicity, Orange County, 2017-2021

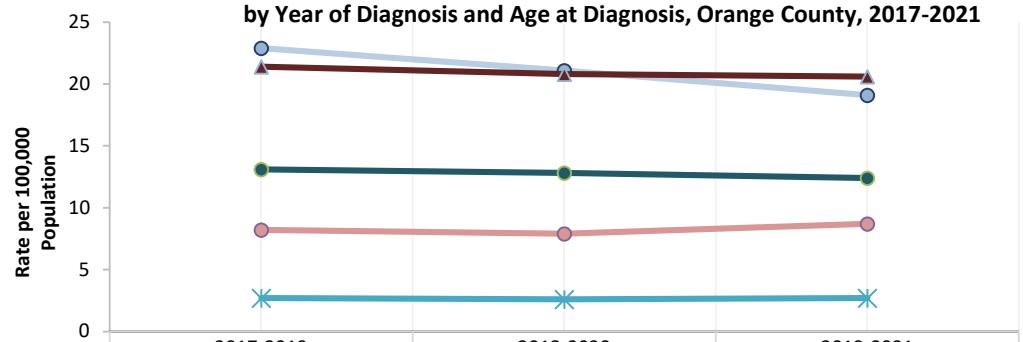


	2017-2019	2018-2020	2019-2021
Black	28.2	28.1	29.9
Hispanic	12.4	12.7	12.2
White	6.9	6.1	5.9
Asian	5.2	4.2	4.4

[13] There have been fewer than 10 cases reported for transgender individuals and that is why there is no data available for this gender group.

Figure 7 below displays the rolling three (3) year average rate of HIV cases per 100,000 population by age at diagnosis. Over the last five (5) years, case rates for the following age groups 19-25, 26-35, and 36-45 have decreased by 16.6%, 3.7%, 5.3% respectively, while case rates for the 46-55 age group have increased by 6.1%. Case rates have been relatively stable for those age 56 years and over.

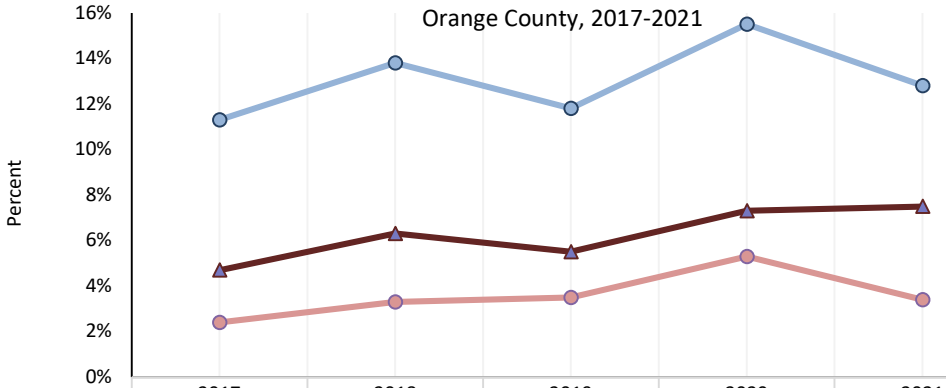
Figure 7: Rolling Three Year Average Rate per 100,000 Population of HIV Cases by Year of Diagnosis and Age at Diagnosis, Orange County, 2017-2021



	2017-2019	2018-2020	2019-2021
19-25	22.9	21.1	19.1
26-35	21.4	20.8	20.6
36-45	13.1	12.8	12.4
46-55	8.2	7.9	8.7
56+	2.7	2.6	2.7

Figure 8 below shows percent of total HIV cases by mode of exposure or risk factor each year for 2017-2021. Additionally, the red arrow below indicates that the line for MSM is not displayed in order to demonstrate and highlight the differences and changes among the other modes of exposures or risk factors. Over the last five (5) years, there has been a 5.9%, 1.5%, 2.8%, and 1.0% increase in the percentage of HIV cases for MSM, Heterosexual, IDU, and MSM/IDU respectively.

Figure 8: Percent of HIV Cases by Year of Diagnosis and Mode of Exposure, Orange County, 2017-2021

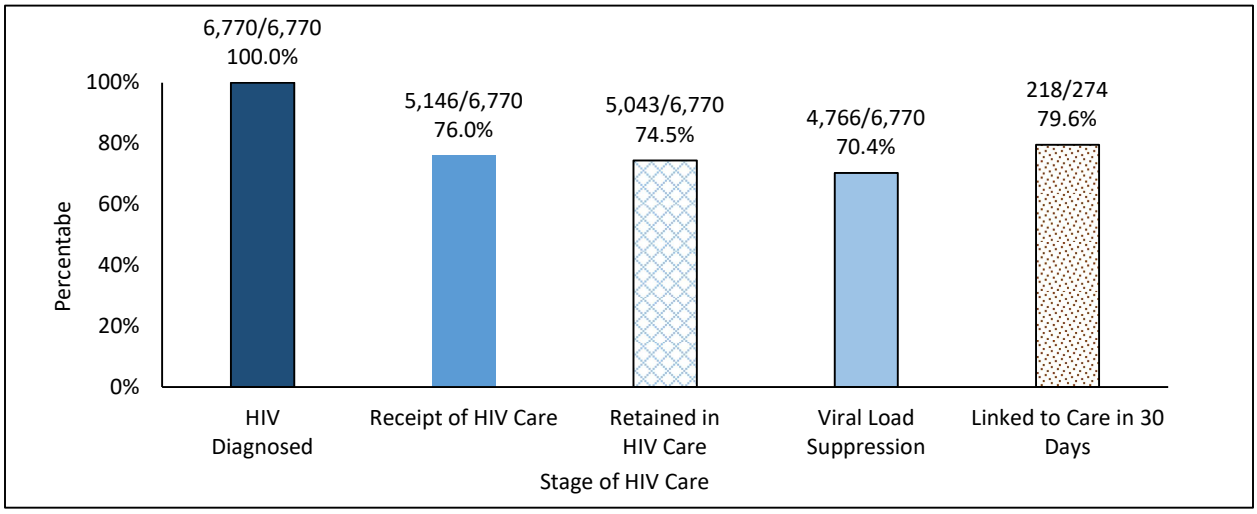


	2017	2018	2019	2020	2021
MSM	65.0%	67.1%	61.2%	71.0%	70.9%
Heterosexual	11.3%	13.8%	11.8%	15.5%	12.8%
IDU	4.7%	6.3%	5.5%	7.3%	7.5%
MSM/IDU	2.4%	3.3%	3.5%	5.3%	3.4%

Orange County uses a diagnosed-based HIV Care continuum in accordance with CDC guidance released in 2019 which includes the following stages:

1. **Diagnosed with HIV**: This is the percent of the total number of people living with HIV age 13 years and over who are aware of their status;
2. **Receipt of HIV care**: This is the percent of persons age 13 years and over diagnosed with HIV who had at least one (1) medical care visit (as indicated by having at least one viral load and/or CD4 count blood test) during 2021;
3. **Retained in HIV care**: This is the percent of persons age 13 years and over diagnosed with HIV, whose most current address was in Orange County as of December 31, 2021 and had at least two (2) CD4 or viral load results with at least three (3) months in-between the first and last result. For persons diagnosed prior to 2021, the two results occurred in 2020 and/or 2021. For persons diagnosed in 2021, the results occurred between January 1, 2021 and February 28, 2022;
4. **HIV Viral Load Suppression**: This is the percent of persons age 13 years and over diagnosed with HIV with a viral load test result of less than 200 copies/mL at the most recent viral load test during 2021;
5. **Linked to Care**: This is the percent of persons age 13 years and over diagnosed with HIV in 2021 who had one (1) or more medical care visits (as indicated by having at least one (1) viral load and/or CD4 count blood test) within 30 days of their diagnosis.

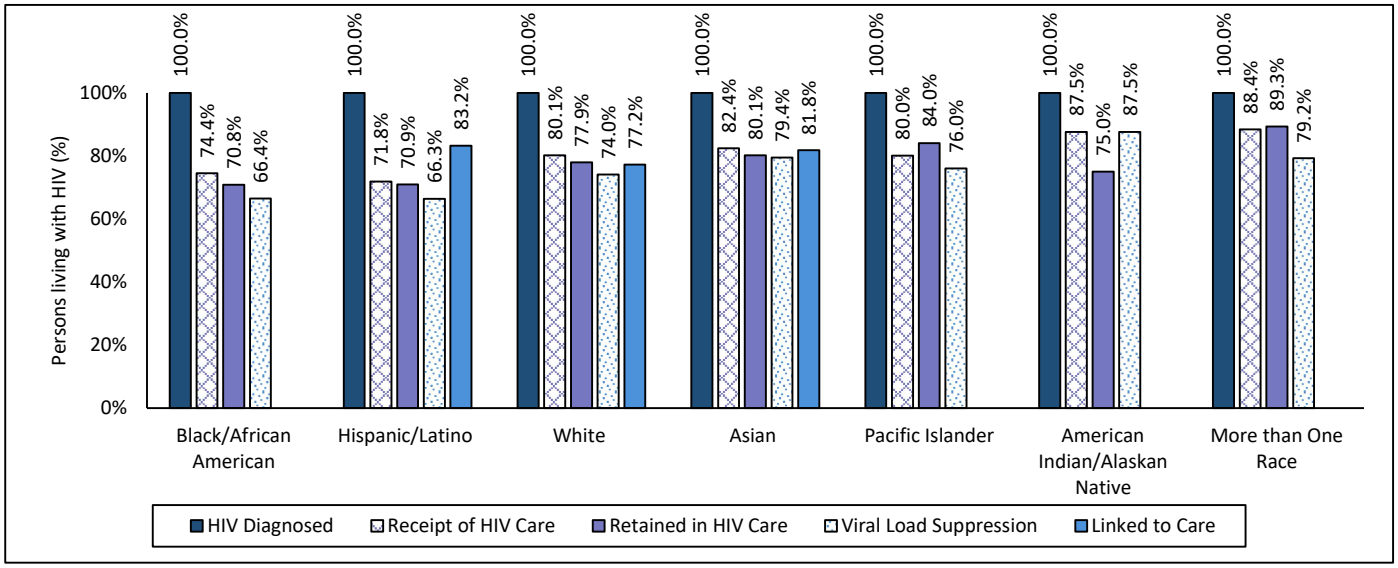
Figure 9: The Continuum of HIV Care: Orange County, 2021



- Of the 6,770 diagnosed persons age 13 years and over living with HIV in Orange County in 2021:
  - 5,146 (76.0%) received HIV care.
  - 5,043 (74.5%) were retained in HIV care.
  - 4,766 (70.4%) achieved viral suppression.
- Of the 274 persons age 13 years and over diagnosed with HIV in Orange County in 2021:
  - 218 (79.6%) were linked to care in 30 days.

(Continued on next page)

Figure 10: Continuum of HIV Care by Race/Ethnicity: Orange County 2021

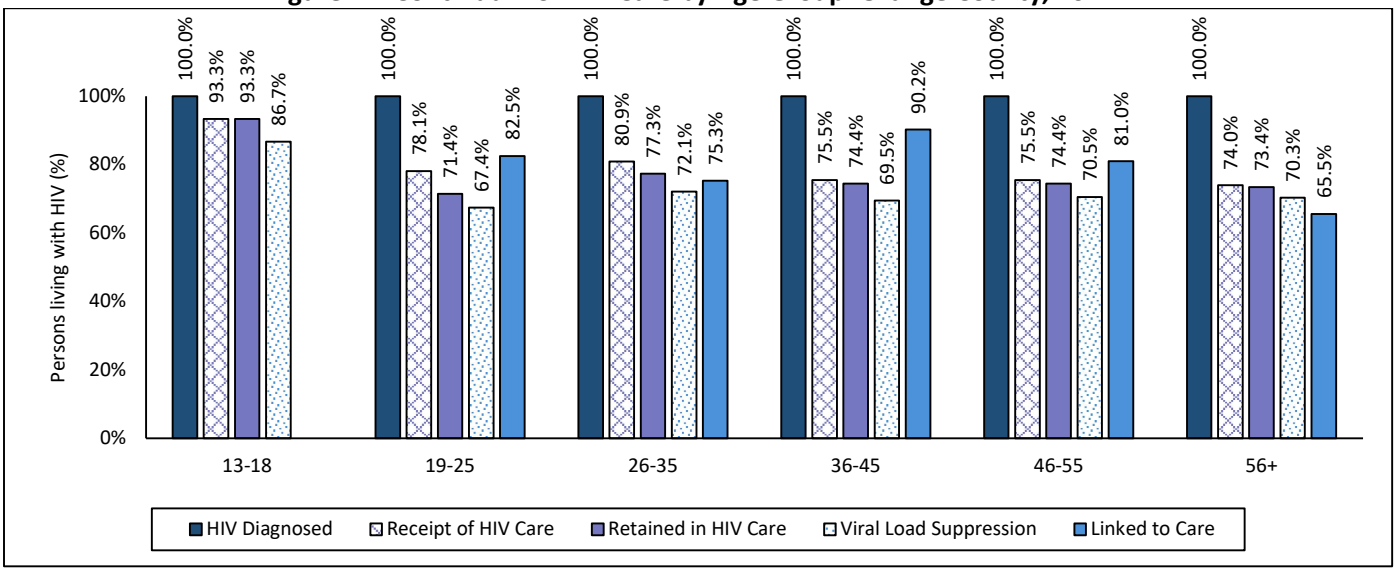


Note: There were fewer than 10 Black/African American, Pacific Islanders, American Indian/Alaskan Native, and persons of more than one race diagnosed in 2021. Thus, Linkage to Care data for these ethnic groups are not included in the figure.

- Hispanics have the lowest percentages of receiving care (71.8%) and being virally suppressed (66.3%), Blacks have the lowest percentage of being retained in care (70.8%), and Whites have the lowest percentage of being linked to care (77.2%).
- Persons of more than one race have the highest percentage of receiving care (88.4%) and being retained in care (89.3%), American Indian/Alaskan Natives have the highest percentage of viral suppression (87.5%), and Hispanics have the highest percentage of being linked to care (83.2%).
- Percentages for Pacific Islanders, American Indian/Alaskan Natives, More than One Race are based on a small number of PLWH and should be compared with caution.

(Continued on next page)

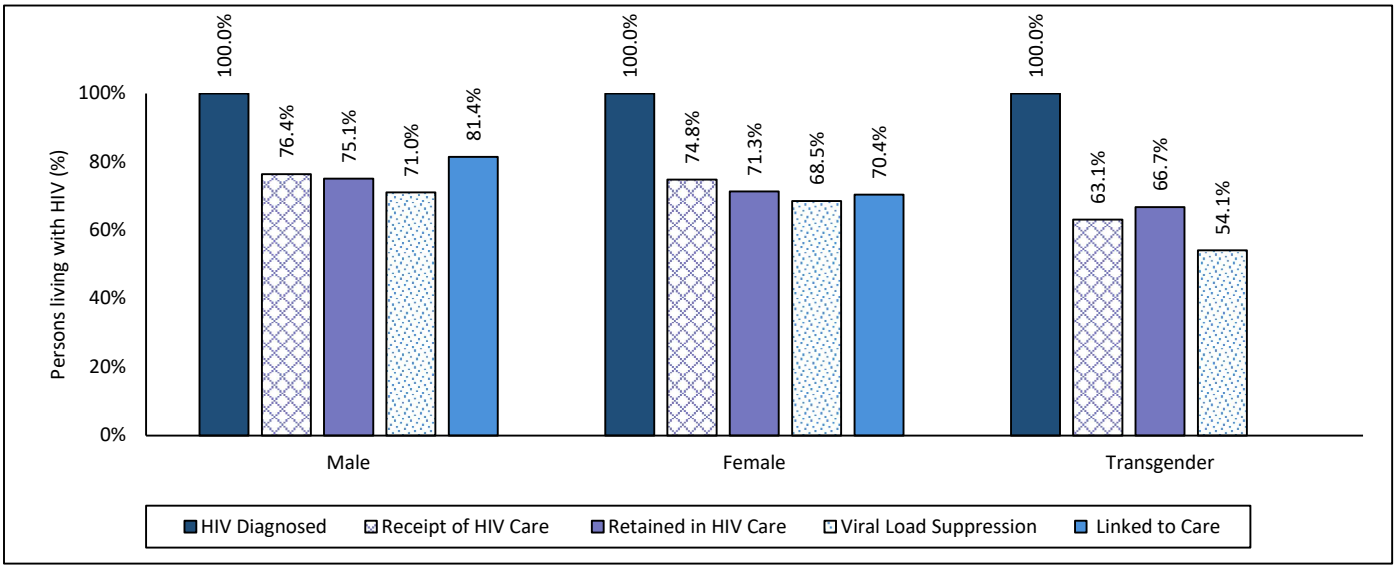
Figure 11: Continuum of HIV Care by Age Group: Orange County, 2021



Note: There were fewer than 10 persons aged 13-18 diagnosed in 2021. Thus, Linkage to Care data for this age group is not included in the figure.

- Persons aged 56 years and over have the lowest percentages of receiving care (74.0%) and being linked to care (65.5%), while persons aged 19-25 years have the lowest percentages of being retained in care (71.4%) and being virally suppressed (67.4%).
- Persons age 13-18 years have the highest percentages of receiving care (93.3%), being retained in care (93.3%), and being virally suppressed (86.7%), while persons age 36-45 years have the highest percentage of being linked to care (90.2%).

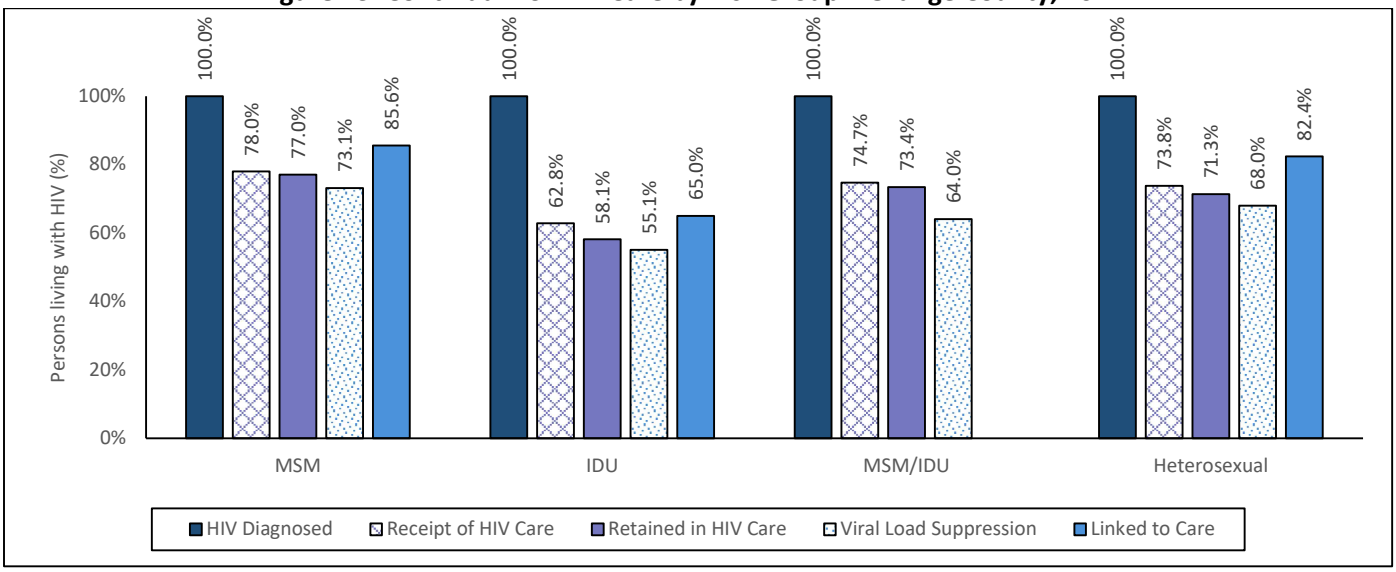
Figure 12: Continuum of HIV care by Gender: Orange County, 2021



Note: There were fewer than 10 transgender individuals diagnosed in 2021. Thus, Linkage to Care data for this gender is not included in the figure.

- Transgender individuals have the lowest percentages of receiving care (63.1%), being retained in care (66.7%), and being virally suppressed (54.1%), while females have the lowest percentage of being linked to care (70.4%).
- Males have the highest percentages of receiving care (76.4%), being retained in care (75.1%), being virally suppressed (71.0%), and being linked to care (81.4%).

Figure 13: Continuum of HIV Care by Risk Group – Orange County, 2021



Note: MSM=men who have sex with men. IDU=injection drug users.
There were fewer than 10 MSM/IDU diagnosed in 2021.Thus, Linkage to Care data for this risk group is not included in the figure. This figure does not include people infected as children, infected through a blood transfusion, are hemophiliacs, or are of unknown transmission source.

- Persons who inject drugs (PWID) have the lowest percentages of receiving care (62.8%), being retained in care (58.1%), being virally suppressed (55.1%), and being linked to care (65.0%).
- MSM have the highest percentages of receiving care (78.0%), being retained in care (77.0%), being virally suppressed (73.1%), and being linked to care (85.6%).

D. HIV Clusters

i. **Description of Cluster Detection Activities**

Orange County collaborates with the CDPH SOA to analyze CDC time-space clusters monthly. The time period of interest is the most recent 12 months, which is compared to the prior three (3) years. The following five (5) outcomes are evaluated and compared to the previous three (3) years:

1. All people with HIV infection diagnosed in the past 12 months
2. All IDU with HIV infection diagnosed in the past 12 months
3. All MSM who report injection drug use (MSM/IDU) with HIV infection diagnosed in the past 12 months
4. All IDU and MSM/IDU with HIV infection diagnosed in the past 12 months
5. Females of childbearing age, ages 12-44, with HIV infection diagnosed in the past 12 months

Orange County also collaborates with CDPH SOA to analyze molecular clusters. Molecular clusters are identified at the 0.5% molecular distance and priority clusters are defined as clusters with 5 or more people who have been diagnosed in the past 12 months and whose viral sequences are highly related at the 0.5% molecular distance. Among these clusters, the larger clusters (> 20 people) and clusters with low rates of viral suppression are prioritized for outreach.

(Continued on next page)

ii. **HIV Cluster Characteristics**
In June 2021, CDPH OA identified one (1) time-space cluster that included individuals from Orange County that was of concern. The cluster identified 21 females in Orange County diagnosed with HIV in the last 12 months, at least two (2) may have been pregnant. Nine (9) of the females reported injection drug use. The common characteristics between cases was substance use (primarily methamphetamine), co-infected with sexually transmitted diseases (STD), unstably housed, incarceration history, and partners who inject drugs. On average, there are approximately 16 women newly diagnosed with HIV in Orange County annually. This cluster represents a significant increase, especially in a year (2021) where there was reduced testing across the state due to COVID-19.

iii. **Response and Gaps Identified and addressed through HIV cluster response**
Orange County responded to the HIV cluster identified above by reaching out to people in affected networks, including people with undiagnosed HIV, people with diagnosed HIV who might not be accessing HIV care or other services, and people who do not have HIV but would benefit from prevention services. Gaps identified and addressed through HIV clusters include improved opportunities for testing priority populations, linking people to care, and accessing PrEP.

E. Description of the indicators of risk for HIV infection
The data below is used to analyze and identify indicators for populations at higher risk for HIV infection in Orange County.

i. **Behavioral surveillance data such as National HIV Behavioral Surveillance System, Youth Risk Behavioral Surveillance System, Behavioral Risk Factor Surveillance System**
These data systems do not include Orange County specific data and are not currently used as part of the planning process.

ii. **HIV surveillance data including HIV testing program data**
Tables 4 and 5 below shows information about the 6,990 tests that were conducted in Orange County in 2021 through the CDPH SOA funded targeted testing program. The tests resulted in 54 newly identified confirmed positives and 37 previously identified positives. Of the 54 newly identified confirmed positives (NICPs), 49 (90.7%) were linked to medical care within 30 days and received a viral load test. Of the 37 previously identified positives, 33 (89.2%) were linked to medical care within 30 days and received a viral load test.

Table 4: Testing Outcomes – Orange County, 2021

NICPs and Testing Outcomes – Orange County, 2021	Total
Number of HIV tests conducted	**6,990**
Number of NICPs	**54**
Positivity Rate	**0.8%***
Number (and percentage) of NICPs Informed of Positive Result	**54** (100.0%) **
Number (and percentage) of NICPS linked to HIV medical care ≤7 Days	**46** (85.2%) **
Number (and percentage) of NICPS linked to HIV medical care ≤14 Days	**46** (85.2%) **
Number (and percentage) of NICPS linked to HIV medical care ≤30 Days	**49** (90.7%) **
Number (and percentage) of Partner Services Interviews Conducted	**39/40*** ** (98.0%)

(Continued on next page)

Table 5: Testing Outcomes – Orange County, 2021

Previously Identified Positives and Testing Outcomes – Orange County, 2021	Total
Number of HIV test conducted	**6,990**
Number of Previously Identified Positives	**37**
Positivity Rate	**0.5%***
Number (and percentage) of previously identified positives that re-engaged in HIV medical care ≤30 Days	**33** (89.2%) **
Number (and percentage) of Partner Services Interviews Conducted	**20** (54.1%) ***

* Percentage based on the total NICPs divided by the number of HIV tests conducted.
**Percentages shown are calculated using the category number divided by the total NICPs.
***Partner Services may be conducted at Community-Based Organizations (CBOs), however, all NICPs tested at CBOs are offered Partner Services by the County. Thus, data reflects only Partner Services conducted at the County.
Includes tests from OCHCA Testing, Treatment and Care, Radiant Health Centers, APAIT, and The LGBTQ Center OC.
Data sources: Local Evaluation Online (LEO) data as of April 2022.
HIV Case Registry, Data as of April 2022.

F. Other relevant demographic data including STD/STI and comorbidities

Table 6 below show the cases and case rate of STD/STIs among the general population in Orange County in comparison to the number of cases and case rate among PLWH in Orange County for 2021. Additionally, the comparison among Orange County residents and PLWH in Orange County is also done for comorbidities such as homelessness, incarcerated, mental illness, and substance use. In every category, except mental illness and substance use, there is a higher case rate among PLWH than there is for the general population.

Table 6: Overview of Co-occurring Conditions Table, 2021*

		Incidence within General TGA Population		Incidence among PLWH		Risk Ratio
		Cases	Case Rate Per 100,000	Cases	Case Rate Per 100,000	
a)	Acute[1] Hepatitis C Virus (HCV)	0[2]	0.00	0[8]	0.0	0
b)	Sexually Transmitted Infections					
	Syphilis (All stages)	2,086[2,3]	66.0	537[8]	7,929.7	120.1
	Gonorrhea	5,407[2]	171.0	399[8]	5,891.9	34.5
	Chlamydia	11,864[2]	375.2	385[8]	5,685.2	15.2
c)	Mental Illness	138,721[4]	4,583.1	215[9]	2,879.72	0.6
d)	Substance Use Disorder	224,783[5]	6,840.6	145[9]	1,942	0.3
e)	Homelessness/Unstably Housed	6,978[6]	220.3	104[9]	1,588.3	7.2
f)	Formerly Incarcerated	3,371[7]	106.6	149[10]	2,200.2	20.6

*At the time this table was compiled local prevalence estimates were not available for the TGA for conditions co-occurring with HIV.

(Continued on next page)

Data Sources for General Population:

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

[2] County of Orange, CalREDIE, Data downloaded 5/16/2022.

[3] County of Orange, Health Care Agency, Disease Control, CalREDIE Database and Syphilis Access Database, May 2022. Includes both diagnosed cases of Syphilis and positive Syphilis results that were not investigated due to patient's history or priority level for incidences created in 2021.

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

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

[6] Everyone Counts 2020 Point in Time Summary Report, Orange County, California.

[7] Orange County Sheriff's Department, Average Daily Inmate Population, Board of Corrections Jail Profile Survey, December 2021.

Data Sources for PLWH Population:

[8] HIV/AIDS Case Registry, PLWH as of January 31, 2022, Cases diagnosed with Syphilis, Chlamydia, Gonorrhea, or Hepatitis C in 2021.

[9] ARIES 2021, Orange County. Case rates are based on Ryan White client report and is used an estimate for all PLWH in Orange County.

[10] Cases reported in 2021 from the County or City Jail or lab reports in 2021 from the County or City Jail.

3. **HIV Prevention, Care and Treatment Resource Inventory**

The funding table provides an estimated overview of funding, by funding source, available in Orange County to address the HIV Care Continuum. Information presented may not fully represent all funding available for PLWH and those at risk for HIV in Orange County. **(See Attachment A labeled HIV Prevention, Care and Treatment Resource Inventory)**

a. Strengths and Gaps

Strengths in the HIV prevention, care and treatment inventory for the jurisdiction:

- Comprehensive tiered Case Management system that addresses the specific needs of clients at different stages of care. For example, newly diagnosed individuals are engaged in Linkage to Care services, which is based on the Anti-Retroviral Treatment and Access to Services (ARTAS) model, to specifically focus efforts on linking individuals to medical care. Additionally, Orange County's Case Management system includes Minority AIDS Initiative (MAI) Case Management to focus efforts on addressing the needs of Black/African American and Hispanic/Latino populations in an effort to reduce and ultimately eliminate health disparities among these populations. Lastly, through the use of Ending the HIV Epidemic (EHE) funding, Orange County provide Case Management services to PLWH outside of the Ryan White system of care who need support with navigating the healthcare system and who are not virally suppressed.

(Continued on next page)

- Availability of support services such as food bank, legal services, and medical transportation that are reflective of the needs of PLWH as identified in the client needs surveys.
- Services are located in areas and cities where there are the highest rates of HIV, such as Santa Ana.
- Increased focus on health equity at the agency level, including development of an Office of Population Health & Equity within the Orange County Health Care Agency (OCHCA) to coordinate efforts throughout the county.
- Provision of services utilizing telehealth during the COVID-19 pandemic allowed Orange County to continue serving PLWH, a vulnerable population with increased risk for COVID-19.
- Services that are available to PLWH regardless of immigration status. Immigration status and the impact of accessing public benefits on citizenship and the naturalization process is of concern to some clients. These concerns were compounded in 2020 when changes to the federal Public Charge Rule were enacted. Although Ryan White clients were not impacted by the Public Charge Rule, this created fear and hesitation to engage in care for many individuals. The County continues to make efforts to keep patients informed and avoid having patients fall out of care.
- Engagement of priority populations and new partners, including the Transgender and Gender Non-Conforming (TGNC) Latinx community to inform the delivery of HIV prevention and care services, improve access to care, and ultimately improve health care outcomes. Efforts are ongoing to ensure involvement of the TGNC community and organizations who serve this population in the planning process.
- Coordination of various funding sources to ensure availability of HIV care and prevention services for PLWH or at risk for HIV in Orange County. This includes coordination across various service areas within the OCHCA, including but not limited to Correctional Health Services, Public Health Services, and Mental Health & Recovery Services to ensure access to services such as substance use prevention and treatment services in combination with HIV prevention and care services.

<u>Gaps in the HIV prevention, care and treatment inventory for the jurisdiction:</u>

- Ongoing challenges with implementing harm reduction activities at a county level.
- Although HIV service providers are located in areas where there are higher rates of HIV, there are individuals who may need to travel across the County for services. Individuals often take the bus, which is not always reliable. However, in recent years, ride share options have helped reduce transportation barriers for clients so that they are able to get to their appointments efficiently.

(Continued on next page)

- Need for increased engagement of some priority populations, specifically the Black/African American population, youth, and injection drug users/people who inject drugs. However, efforts are underway to develop and/or strengthen relationships with these communities and organizations who serve these populations to build capacity for service delivery.
- Impact of increased homelessness and drug use, can pose challenges for engaging individuals in HIV prevention and care services through traditional health care delivery models as well as for coordination provision of other services, such as substance use services.
- Limited knowledge of PrEP among some health care providers and low community uptake of PrEP. However, the county has made concerted efforts to improve both provider awareness and PrEP uptake through provider education and availability of PrEP Navigation services through both county and community-based providers.
- Opportunity to strengthen HIV cluster and outbreak response protocols. Concerted efforts are underway to develop a county specific plan. Orange County is also participating in a National HIV Cluster and Outbreak Detection and Response Implementation Learning Collaborative (CDR ILC), facilitated by NASTAD in collaboration with CDC to facilitate this process.

b. **Approaches and partnerships**

As the recipient of Ryan White Part A, Part B, Part C, Ending the HIV Epidemic (EHE) CDC (Component A and C), and EHE HRSA grant funding, this information was readily available to be included in the resource inventory. Additionally, the Grant Recipient requests information from current services providers and partners as part of the annual Ryan White Part A grant application and priority setting and resource allocation process. HIV Service providers are asked to submit other grant/funding allocations for Ryan White eligible service categories. The Grant Recipient also conducts outreach to other service providers and community partners (new and existing) in Orange County to obtain additional information to be included in the resource inventory.

4. **Needs Assessments, Priorities, Actions Taken, Approach**
    1. **Services people at-risk for HIV need to access HIV testing and stay HIV negative**
        - **Orange County Pre-Exposure Prophylaxis (PrEP) Coalition**: The Orange County PrEP Coalition consists of key HIV Providers and stakeholders in the community. Their mission is to decrease HIV infection rates in Orange County through educating, empowering, and connecting individuals to PrEP Services. The Coalition conducted a PrEP survey to assess PrEP awareness, knowledge, needs, and barriers in Orange County in 2016 and 2019. A summary of survey findings is presented below.

(Continued on next page)

- **2019 PrEP Survey**: The findings from the 2016 PrEP survey indicated that there was a lack of information and understanding regarding PrEP, especially among those most at risk for HIV which may be an obstacle to initiate and stay of PrEP. The goal of the 2019 PrEP survey was to assess progress in improving awareness of PrEP, identifying sources of knowledge regarding PrEP, PrEP use, barriers for not using PrEP, and HIV and STD testing behaviors. The survey (English and Spanish) was distributed at various community-based organizations (CBOs), including HIV prevention and care service providers throughout Orange County. Key findings include:
  - Increased knowledge/PrEP awareness (heard of PrEP and knew what it was) since 2016 (61% in 2019 versus 38% in 2016)
  - Increased PrEP use (1% in 2016 versus 18% in 2019)
  - Need for additional information about PrEP as 39% of respondents reported they did not know or were not sure they knew about PrEP
  - Need for increased awareness about HIV testing as only 38% of respondents reported testing for HIV at least once a year

- **Orange County's Ending the HIV Epidemic (EHE) Plan:** The development of Orange County's EHE Plan included an assessment of needs of people at-risk for HIV with a focus on priority populations, which are those populations disproportionately impacted by HIV. In Orange County, priority populations are:
  - Men who have Sex with Men (MSM) of color (African American/Black or Hispanic/Latino);
  - Individuals with history of incarceration;
  - Individuals with history of substance use, including people who inject drugs;
  - Other priority populations which existing HIV programs and services have had less capacity to reach as defined in Orange County's EHE plan including young people (19-25), transgender individuals, and PrEP eligible individuals.
- **Community Planning Process:** Based on input from Orange County's HIV Planning Council (Council), subcommittees of the Council, service providers, CBOs, key stakeholders, and community members representing priority populations the following needs related to accessing HIV testing and staying HIV negative were identified for people at-risk for HIV:
  - **Testing Innovations:** Need to develop innovative strategies to mitigate barriers to HIV testing. This includes expanding existing testing programs and services to reach priority populations more effectively, including testing in Orange County jails.
  - **PrEP Navigation:** Need to expand HIV prevention activities based on feedback from priority populations during the EHE planning process and results from the 2019 PrEP Survey.
  - **Status Neutral Service Delivery:** Need to offer HIV testing, treatment, and prevention services utilizing a status neutral approach.
  - **Harm Reduction Services:** Need to improve availability and access to harm reduction services to effectively address disparities.

(Continued on next page)

- **Orange County Sexually Transmitted Infection (STI) Coalition:** The mission of the STI Coalition is to decrease the number of STI's in Orange County through community education and advocacy. The STI Coalition is comprised of various CBOs and service providers. As part of the EHE planning process, the STI Coalition identified the need to address the syndemic of HIV, Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) through community planning processes. This includes engaging a range of community stakeholders to address the economic and social conditions that drive these epidemics, including stigma, poverty, and unstable housing.
- **2021 Transgender and Gender Non-Conforming (TGNC) Needs Assessment Survey and Focus Groups:** Orange County conducted a survey and a series of focus groups in collaboration with a TGNC serving CBO to help identify HIV/STD service needs and barriers to care for the TGNC Latinx community. The needs assessment activities focused on satisfaction with HIV/STD service providers, barriers to care, healthcare experiences, and other service needs. Key findings include:
    - Based on the need assessment survey, top reasons to why services in Orange County may not meet transgender individuals needs include inconvenient hours of operation, staff not being welcoming or helpful, communication/language barriers, and lack of sensitivity in using appropriate pronouns.
    - Based on the focus group, top reasons for barriers to access to care include reported long wait times, difficulty getting an appointment and lack of follow through with referrals (by the referring provider). Additionally, several participants reported they an overall lack of understanding from medical professionals related to needs of transgender individuals

- **2022 Health Equity for African American League (HEAAL) Collective Community Health Survey:** The HEAAL Collective is comprised of various African American/Black churches in Orange County and was recently formed as part of Orange County's Equity in OC Initiative. In partnership with the HEAAL Collective, HIV/STD related questions were included in the community health survey to assess the needs of the Black/African American community in Orange County. The survey was implemented starting in September 2022 and results and findings will be available in early 2023.

2. **Services people with HIV need to rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis**

    Community Planning Process: Based on input from Orange County's HIV Planning Council (Council), subcommittees of the Council, service providers, CBOs, key stakeholders, and community members representing priority populations the following needs pertaining to HIV Medical Care and Treatment linkage were identified:
    - **Rapid ART:** Need to expand Rapid ART services to include the County HIV Clinic and five (5) county jails to ensure rapid access to treatment and linkage to HIV medical care for those who are newly diagnosed or have fallen out of care.
    - **Linkage to Care (LTC):** Need to increase rapid LTC for individuals newly diagnosed with HIV infection at County STD clinics and increase number of PLWH re-engaging in care who are not virally suppressed.
    - **Services for PLWH Outside of the Ryan White System of Care:** Need for support services for PLWH outside of the Ryan White system of care to effectively link to care to address disparities in healthcare outcomes.

3. **Services that people with HIV need to stay in HIV care and treatment and achieve viral suppression**
    - **Client Needs Surveys**: The goal of the Client Needs Surveys is to identify service needs of PLWH, experiences with accessing HIV care and support services, and barriers to care. The Client Needs Survey is conducted every odd year (e.g., 2021, 2019, 2017, etc.). The survey identifies the following:
        - The five (5) more important services include dental care (basic), dental care (advanced), AIDS drug assistance program (ADAP), medical care, and Health Insurance Premium Payment Assistance/Eligibility Services.
        - The top (2) cited (barriers) to accessing services were didn't know about service and didn't know where to go.
    - **Services for PLWH Outside of the Ryan White System of Care:** The need for support services for PLWH outside of the Ryan White system of care was also identified as it pertains to helping these individuals stay in care and reach and maintain viral suppression.
    - **Focus Group Data**: The goal of the focus groups is to choose a specific topic for which qualitative data can be gathered to uncover trends in thoughts or opinions about needs. Focus group topics have included: Impact of the Affordable Care Act, Identifying Case Management needs, Assessing Barriers to Care, Assessing Legal Services Needs for PLWHD, and Identifying Need to Stay In Care and Reach Viral Suppression. Focus group results have included:
        - Development of recommendations to increase access to services.
        - Creation of materials to promote knowledge about services available.
        - Increase training and education for service providers.
    - **HIV Surveillance Data**: The goal of assessing surveillance data is to identify needs of populations who may be disproportionately impacted by HIV. Surveillance data has helped identify priority populations in Orange County where the largest disparities exist as detailed mentioned above.
    - **Service Utilization Data**: The goal of reviewing service utilization data is to identify trends in HIV care service utilization. Utilization trends are reported annually by gender, race/ethnicity, reported mode of transmission, age, and income level for all Ryan White-funded service categories. Utilization trends provide the following information:
        - Trends in service utilization (increases and decreases).
        - Identification of service categories that may require increased or decreased funding based on utilization.
        - Identification of specific populations that would be impacted by changes in funding.
4. **Barriers to accessing existing HIV testing, including State laws and regulations, HIV prevention services, and HIV care and treatment service**
    - Social and Structural Barriers
        - Language and Culture: The HIV epidemic in Orange County has shifted in the last 30 years from predominantly affecting White MSM to now affecting a larger number of Latino MSM. The barriers to prevention and care service for Latino MSM may be different than for White MSM and can include linguistic and cultural barriers.

(Continued on next page)

There is a need to have information and outreach conducted in Spanish, because Latino MSM may be monolingual Spanish speakers or simply feel more comfortable speaking Spanish. Cultural barriers for Latinos can include things like the foods they eat. In order to reduce some of these barriers, in Orange County food offerings under food bank have expanded to include items like tortillas instead of bread for Latino PLWH that seek foods that are more culturally appropriate.

- Stigma: Orange County community members described experiencing stigma because of their gender identity, sexuality, or HIV status.
- Undocumented Status: As of 2019[14], Orange County had the 6th largest foreign-born population of all U.S. counties, with one third (30.5%) of its residents born outside of the U.S. Community members have anecdotally shared fear of deportation and other negative consequences as a result of participating in government sponsored health services and disenrollment from public benefits.
- Cost of Living in Orange County: Based on data from the U.S. Bureau of Economic Analysis[15] the cost of living in Orange County is on average at least 19 percent higher than national benchmark cities. According to the Massachusetts Institute of Technology's[16] living wage calculator in 2022 a single individual living in Orange County would need to earn at least $24.92 an hour or $51,834 annually to make a living wage. However, the minimum wage in California[17] is $15.00 an hour or $31,200 annually and those living on disability or social security make on average less than minimum wage. This can result in housing instability, food shortages, and other barriers to care that can lead to PLWH falling out of care.
- Homelessness: The number of people who are experiencing homelessness in Orange County has increased year over year. Most current data available from the 2020 Point In Time (PIT) Homelessness Count[18] estimated that there were 6,978 people experiencing homelessness in Orange County, a 46% increase since 2017. Of these individuals, nearly 2% indicated they were living with HIV, which is likely an undercount. Data from the 2021 Client Needs Survey of revealed that 17.4% reported being unstably housed in the previous 12 months. In addition, the high cost of living in Orange County severely limits low-income communities from being able to afford safe and affordable housing, placing them at an increased risk for displacement. PLWH experiencing homelessness are likely to prioritize daily shelter and food over medical care, which may pose a barrier for accessing HIV prevention and care services.

(Continued on next page)

[14] Migration Policy Institute (2019). *U.S. Immigrant Population by State and County.* *https://www.migrationpolicy.org/programs/data-hub/charts/us-immigrant-population-state-and-county*
[15] U.S. Bureau of Economic Analysis (2021). *Real Personal Consumption Expenditures and Personal Income by State, 2020*. https://www.bea.gov/news/2021/real-personal-consumption-expenditures-and-personal-income-state-2020
[16] Massachusetts Institute of Technology (2022). *Living Wage Calculator.* https://livingwage.mit.edu
[17] State of California Department of Industrial Relations (2022). *Minimum Wage.* *https://www.dir.ca.gov/dlse/faq_minimumwage.htm*
[18] United States Department of Housing and Urban Development (2020). *Santa Ana, Anaheim, Orange County CoC.* https://files.hudexchange.info/reports/published/CoC_PopSub_CoC_CA-602-2020_CA_2020.pdf

- Federal, State, or Local Policy Barriers
    - Integration of Various Payer Sources: The full implementation of the Affordable Care Act in California and the creation of the healthcare exchange through Covered California has led to more PLWH being transitioned through various payer sources. Additionally, the expansion of Medicaid (Medi-Cal) in California provides healthcare to adults 50 years or older (as of May 2022) and all adults ages 26 through 49 (starting in January 2024) regardless of immigration status will continue to lead more PLWH being transitioned through other payer sources. These providers have varying experience treating PLWH. In addition, PLWH may have to navigate a health care system that is based on referrals, limited healthcare providers, a complex preauthorization process, and that relies on the self-advocacy of the patient to get their needed care. This process is very different from the Ryan White system and continues to cause a barrier to PLWH in Orange County.

- Health Department Barriers
    - Recruitment for Vacant Positions: Orange County's lengthy hiring process that includes multiple steps such as getting assigned a recruitment, posting the recruitment, screening eligible candidates, conducting interviews, and offering job offers. This has caused delays in the process to recruit and fill vacancies which in turn makes it difficult to be proactive or flexible to changes in the needs of the community.
    - Data Systems: Data systems in California are fragmented between prevention, care services, housing, and surveillance. As a result, Orange County utilizes a combination of Local Evaluation Online (LEO), AIDS Regional Information and Evaluation System (ARIES), California Reportable Disease Information Exchange (CalREDIE), Enhanced HIV/AIDS Reporting System (eHARS), Cerner Electronic Health Record (EHR), Homeless Management Information System (HMIS), and Access databases to track all data points and develop reports for monitoring program implementation. This poses a barrier because there is limited system integration resulting in staff inputting data in multiple systems. Additionally, reporting can also be a challenge because data is pulled from different systems to track and monitor outcomes.
    - Communication: Communications and social media through Orange County Health Care Agency is centralized and is not program specific. This poses a barrier because our program does not have an online presence, which limits the ability to outreach and promote HIV/STD related activities to the community.

- Program Barriers
    - Coordination with Medical Providers: As more Ryan White clients and PLWH obtain medical care outside of the Ryan White System, Ryan White service providers have found it difficult to obtain medical information about clients from the medical provider. When clients receive medical care under Ryan White, there is an established coordination of care and services between the Ryan White medical staff, case managers, and support service providers. However, there is not always an established coordination of care with medical providers outside the Ryan White system of care. This causes increase difficulty managing clients due to many medical providers having lack of knowledge of the Ryan White system.

(Continued on next page)

- Service Provider Barriers
    - Health Care Systems: Some of the largest managed care systems in Orange County include Kaiser Permanente as a private insurance and medical provider, and CalOptima who manages Medi-Cal (Medicaid in California). These systems are rarely at the planning table which hinders the ability to effectively work with service providers to assist PLWH who are having difficulties staying engage in care. These systems see a large number of PLWH who are not a part of the Ryan White system and epidemiological data show that these patients experience poorer health outcomes along the HIV Continuum of Care compared to those in the Ryan White system.
    - Lack of Integration: There is a lack of integration among service providers to ensure engagement and coordination with Mental Health, Substance Use, Housing/Homelessness, and prevention services. Moreover, there is a lack of harm reduction services available in Orange County.

- Client Barriers
    - Lack of Information: According to the 2021 Client Needs Survey, the top two (2) most common problems among the 62% (346 of 732) of individuals that indicated why they had a problem getting needed services was because they "Didn't know about service" or "Didn't know where to go". Moreover, the biggest barrier according to the most recent Client Needs Survey was the lack of information the survey completed believed they had about the services. Ryan White as a system will need to ensure that information is disseminated utilizing various modalities and in all threshold languages for Orange County to reach all PLWH including those not currently receiving Ryan White funded services.

a. **Priorities**

The following has been identified as priorities arising from the needs assessment process:

i. Expand community engagement efforts of priority populations to identify barriers to HIV care, inform service delivery, and build capacity within Orange County
ii. Increase PrEP coverage, particularly among priority populations at high risk for HIV infection, and availability of PrEP Navigation Services
iii. Expand availability of HIV prevention and care services in non-traditional health care settings to effectively reach priority populations, which existing services have had less capacity to reach
iv. Expand Rapid ART services through community-based providers
v. Improve outcomes along the HIV Care Continuum for PLWH outside of the Ryan White system of care
vi. Implement testing innovations to improve access to testing for individuals who are HIV positive and unaware of their status and link them to care
vii. Develop an HIV Outbreak Response Plan to provide needed care and prevention services to reduce risk among affected populations and ultimately reduce HIV transmission

(Continued on next page)

b. **Actions Taken**

i. Expand community engagement efforts of priority populations to identify barriers to HIV care, inform service delivery, and build capacity within Orange County

- Trauma-Informed Prevention and Care Services for Black/African American (Black/AA) and Transgender Populations: There is a need to build capacity among HIV service providers to more effectively serve populations disproportionately impacted by HIV, specifically Black/AA and TGNC communities. As detailed above, Orange County conducted a survey and a series of focus groups in collaboration with a TGNC serving CBO to help identify HIV/STD service needs and barriers to care for the TGNC Latinx community. Additionally, Orange County has partnered with the HEAAL Collective, to include HIV/STD related questions in the community health survey to assess the needs of the Black/AA community in Orange County. Additional community engagement activities are planned with priority populations.

ii. Increase PrEP coverage, particularly among priority populations at high risk for HIV infection, And availability of PrEP Navigation Services

- PrEP Navigation: A PrEP needs assessment survey conducted identified the need to expand PrEP coverage and availability of PrEP Navigation Services. To address this need, Orange County offers PrEP Navigation Services through the OCHCA's TTC Clinic as has also contracted with a CBO to provide PREP Navigation Services to assist clients with PrEP access with public or private insurance.

iii. Expand availability of HIV prevention and care services in non-traditional health care settings to effectively reach priority populations, which existing services have had less capacity to reach

- HIV Services Expansion: Increasing access to HIV services for priority populations was identified as a need through the planning process. Orange County released a related Request for Proposals (RFP) for HIV services in September 2022 and proposals are currently being reviewed.

iv. Expand Rapid ART services through community-based providers

- Rapid ART Expansion: The expansion of Rapid ART through community-based providers was identified as a priority to improve outcomes along the HIV Care Continuum and to help reduce transmitting the virus to partners. The OCHCA's TTC Clinic and a CBO provider currently provide Rapid ART services.

v. Improve outcomes along the HIV Care Continuum for PLWH outside of the Ryan White system of care

- Services to Support PLWH Outside of the Ryan White System of Care: There is a need to address disparities in healthcare outcomes along the HIV Care Continuum for PLWH outside of the Ryan White system of care through the needs assessment process. As a result, the following programs and services have been implemented and/or are planned:

(Continued on next page)

- Community-Based Case Management Services (Planned): Provide case management to PLWH who are not virally suppressed and who receive care outside of the Ryan White system of care at community-based provider sites, identified by the volume of patients who are not virally suppressed.
- Viral Load Suppression Incentive Program (Planned): Increase linkage and retention in care and ultimately viral load suppression by offering incentives to PLWH (outside of the Ryan White system of care) who are not virally suppressed for reaching various milestones in their medical care. This program will be implemented through a partnership between the OCHCA's TTC Clinic and community provider sites.
- High Acuity Program (Implemented): Provide comprehensive HIV care services and referrals to needed HIV support services to facilitate retention in care and viral load suppression for PLWH who are no longer eligible for the Ryan White program, experience challenges linking to or staying engaged in care, and/or navigating their respective system of care, and meet one or more of the following criteria: not HIV medication adherent; fallen out of care; not virally suppressed; have medical co-morbidities, mental health, or substance use issues that impede medication adherence.
- Community Based Mental Health Services for Non-Ryan White (Implemented): Provide mental health services to PLWH who no longer qualify for Ryan White, are transitioning to other systems of care, and/or who face barriers to care. This service is intended to assist bridging the gap in services while the patient links to a mental health provider within their respective system of care.

vi. Implement testing innovations to improve access to testing for individuals who are HIV positive and unaware of their status and link them to care

- Testing Innovations - Mail to Home Self- Test Kit Program: The need to make HIV testing more available to people at risk for HIV, especially priority populations, was identified. Through the Building Online Healthy Communities (BHOC) and TakeMeHome Program, individuals in Orange County are mailed HIV and STD self-test kits to their home (or another preferred location).

vii. Develop an HIV Outbreak Response Plan

- HIV Outbreak Response: The need to develop an Orange County specific HIV Outbreak Response Plan was identified to help rapidly link HIV positive individuals to care as well as provided needed prevention services to individuals at risk of HIV. The HIV Outbreak Response plan is currently being developed.

(Continued on next page)

c. **Approach**

- Planning Committees: The Council has designated the Integrated Plan Committee (IPC) as the Integrated Plan Steering Committee because of its focus on addressing HIV prevention and care needs in the County. The IPC meetings are open community meetings with a structured membership that allowed for stability in the creation of the Integrated Plan but also allowed the flexibility for PLWH, high-risk populations, and subject matter experts to contribute throughout the process without having to be a member. Needs were identified through the discussion and review of epidemiological data, client needs survey data, performance outcome measures, prevention data, and service utilization data at committee meetings. Additionally, needs were identified through discussions at other Planning Council subcommittees in which PLWH are members of. Some of the work include:
    - Priority Setting, Allocations, and Planning (PSAP) Committee: PSAP has continuously worked on the goals and strategies of NHAS and those developed for the Integrated Plan. PSAP has worked on prioritizing services that align with the Integrated Plan and improve outcomes among the HIV Care Continuum.
    - HIV Client Advocacy Committee (HCAC): HCAC has assisted in the development of the needs assessments including the wording and distribution of the needs survey. The work has including selecting topics, developing questions, recruitment, and participation in the focus groups used to develop the needs assessment.

(Continued on next page)

Section IV: Situational Analysis

The Situational Analysis provides a high-level overview of the strengths, identified needs, and challenges, including gaps and barriers related to HIV prevention and care in Orange County. It synthesizes information from the epidemiological profile, community engagement efforts, planning process, and feedback from key stakeholders, including HIV service providers.

The Situational Analysis is organized into the following three (3) sections: Methods, Situational Analysis Snapshot, and Summary of Resources and Gaps.

Methods

Orange County's needs assessment consisted of documenting HIV-related community needs and assets, describing the existing resources to meet those needs, and identifying gaps to fully meet the needs (**Table 1 and Table2**).

Table 1. Methods and data sources used for Orange County's situational analysis

Method	Description
Needs assessment to identify needs, resources, and service gaps	• Community engagement efforts and related data and reports • County information on existing services, including service utilization data and outcomes • California Directory of Syringe Services Programs[19] • Orange County's 2021 HIV/AIDS Client Needs Survey Highlights[20] • Orange County's 2021 HIV Continuum of Care[21] • Orange County's 2021 Epidemiological Profile • Orange County's 2021 HIV Fact Sheet[22] • HIV surveillance data • Unmet Need of HIV Primary Medical Care in Orange County (2021)
Review of secondary data and reports	• EHE AHEAD Dashboard[23] • 2020 Point in Time Homeless Count[5] • 2017 Orange County Immigration Profile[24] • U.S. Census Population Estimates for Orange County[1]
Community engagement and consultation	• Orange County HIV Planning Council (Council) • Subcommittees of the Council, including the HIV Client Advocacy Committee and Integrated Plan Committee • Service providers and community-based organizations • Community members who represent priority populations (populations disproportionately impacted by HIV)

[19] California Department of Public Health. Directory of Syringe Services Programs in California. 2022. https://www.cdph.ca.gov/programs/cid/doa/pages/oa_prev_sepdirectory.aspx
[20] Orange County Health Care Agency. 2021 HIV/AIDS Client Needs Survey Highlights. 2022. https://ochealthinfo.com/sites/healthcare/files/2022-05/2021_Client_Needs_Survey_Results_Highlights.pdf
[21] Orange County Health Care Agency. 2021 HIV Continuum of Care. 2022. https://ochealthinfo.com/sites/healthcare/files/2022-07/The_Continuum_of_HIV_Care_2021_FINAL_2022-07-13.pdf
[22] Orange County Health Care Agency. 2021 HIV Fact Sheet. 2022. https://ochealthinfo.com/sites/healthcare/files/2022-12/HIV_Fact_Sheet_2021_FINAL_Rev_2022-07-13.pdf
[23] AHEAD Dashboard. Orange County, CA. 2022. https://ahead.hiv.gov/locations/orange-county-ca
[24] Orange County Opportunity Initiative, Wong TK. Orange County Immigration Profile. 2017. https://donor.oc-cf.org/file/OC_Opportunity_Initiative_Report.pdf

Table 2. Methods and data sources used for Orange County's situational analysis

Method	Description
Review of relevant County and State plans	• Orange County's 2017-2021 Integrated HIV Prevention and Care Plan[5] • Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan for 2017-2021[1] • Orange County's Ending the HIV Epidemic Plan • Ending the Epidemics: California's Integrated Statewide Strategic Plan to Address the Syndemic of HIV, HCV and STIs • PS 20-2010 Evaluation and Performance Measure Measurement Plan (EPMP) and Work Plan[26]
Consultation with key stakeholders	• Local: Health department staff, HIV service providers, and community-based organizations • Regional and State: California Department of Public Health (CDPH), California Planning Group (CPG), other EHE and Ryan White funded jurisdictions

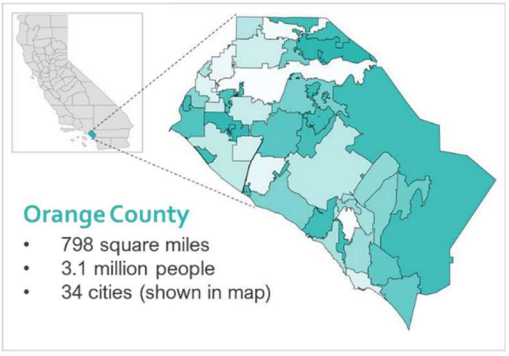
Situational Analysis Snapshot

Situational Analysis Summary

Orange County (**Figure1**) covers an area of 798 square miles and is located in Southern California, bordered by Los Angeles County, San Diego County, and the Pacific Ocean. It includes 34 cities and has an estimated population of 3.1 million people. It is the 3rd most populous and second most dense county in California, and the 6th most populous in the United States.[1] Santa Ana, which is an urban area of the county with a high concentration of Latinx and low-income residents, also has the greatest number of people living with HIV (PLWH) in the county. Several HIV clinical services are located in Santa Ana including the Orange County Health Care Agency's (OCHCA) HIV/STD Testing, Treatment and Care (TTC) Clinic. The meeting facility for Orange County's HIV Planning Council (Council) is also located in Santa Ana.

Orange County ranks 5th in total number of PLWH among all California counties.[2] At the end of 2021, there were 6,772 PLWH in the county who were aware of their HIV status and an estimated 950 individuals who were unaware of their status.[22] In 2021, there were 274 people newly diagnosed with HIV, 79.6% of these individuals were linked to care within 1 month of their diagnosis.[22]

Figure 1. Orange County Map and Overview



Viral suppression among PLWH in the Ryan White system of care was 86.0% in 2021, which exceeds viral suppression among PLWH outside of the Ryan White system of care of 70.4% .[21,22] Further, the OCHCA has developed partnerships with non-Ryan White service providers to help improve community viral suppression rates. Orange County has also focused on increasing PrEP uptake through lessons learned from participating in a three (3) year CDC-funded demonstration project (Project PrIDE) focused on Latinx MSM and Transgender women. Finally, OCHCA is improving surveillance coordination with the California Department of Public Health (CDPH) and other county partners, increasing capacity for data to prevention and care activities.

While Orange County has made progress to achieve HIV prevention and care goals, there are populations that continue to be disproportionately affected by HIV. In 2021, Men who have Sex with Men (MSM) and Injection Drug Users(IDU) combined comprised 75.9% of new HIV diagnoses.[22] Among MSM, most HIV diagnoses have shifted from white MSM to Latinx MSM and other MSM of color.[22] Young people under 35 years of age are also disproportionately affected, representing 53.3% of new diagnoses in 2021.[4] While IDUs represent only 7.3% of new diagnoses in 2021, they are a group that is considered underserved in the county by current programs.[22] Similarly, Transgender women of color and individuals with a history of incarceration represent population groups whom there is less data and less capacity to reach with current programs and services. **Table 3** summarizes Orange County's strategies to reach HIV prevention and care goals to end the HIV epidemic.

Table 3. Orange County's Strategies to Reach HIV Prevention and Care Goals
• Expand community engagement efforts of priority populations to identify barriers to HIV care, inform service delivery, and build capacity within Orange County
• Increase PrEP coverage particularly among priority populations at high risk for HIV infection
• Increase availability of PrEP Navigation Services
• Expand availability of HIV prevention and care services in non-traditional health care settings to effectively reach priority populations, which existing services have had less capacity to reach
• Expand Rapid ART services through community-based providers
• Improve outcomes along the HIV Care Continuum for PLWH outside of the Ryan White system of care
• Implement testing innovations to improve access to testing for individuals who are HIV positive and unaware of their status and link them to care
• Develop an HIV Outbreak Response Plan to provide needed care and prevention services to reduce risk among affected populations and ultimately reduce HIV transmission

Through needs assessment and community engagement work, the OCHCA has identified key resources, gaps, and challenges related to the HIV epidemic and how to address them. These issues will be discussed throughout the situational analysis.

Situational Analysis Snapshot by Pillar: Diagnose

As indicated above, new HIV diagnoses are still affecting MSM more than any other risk group in Orange County, with 68.6% of new infections occurring among this group in 2021. By comparison, 12.4% of diagnoses were attributed to heterosexual contact and 7.3% were associated with IDU transmission.[22] Furthermore, in 2021, more than two-thirds of new HIV diagnoses were among people of color, with Latinx individuals comprising 52.2% of new diagnoses overall.[22]

Needs assessment data suggests HIV stigma and low perceived risk of HIV among MSM remain barriers to HIV testing. The Latinx MSM population also experiences other barriers, such as limited cultural and linguistic capacity among some service providers. In addition, community engagement efforts suggest HIV messaging is not reaching Latinx MSM, putting them at elevated risk for testing late after HIV infection. The growing numbers of other STI infections in the county among MSM of color are also an indication of a potential increase of HIV infections without further intervention.[25]

Moreover, findings from the Gay Men's Health Summit (2019) suggest that HIV stigma can be lessened if MSM health is shifted from a problem-based framework to a wellness framework. Community engagement efforts suggest MSM need a wellness model which includes but is not limited to sexual health, HIV prevention and care. The OCHCA has committed to implementing additional summits and other innovations in HIV testing to ensure MSM and other people at high risk for HIV are diagnosed as early as possible.

Situational Analysis Snapshot by Pillar: Treat

In 2021, 79.6% of individuals newly diagnosed with HIV in Orange County were linked to care within 1 month (30 days). Among all PLWH, viral suppression was 70.4% in 2021.

Needs assessment data suggest opportunities for improvement. Trauma and medical mistrust are more prevalent among communities of color and must be addressed to make progress.[26] According to community engagement efforts, the burden of trauma and medical mistrust disproportionately affects Black/African American and Transgender communities.[27] Rapid ART has decreased disparities among people of color in achieving viral suppression in other communities but has only been implemented in limited capacity in Orange County.

(Continued on next page)

[25] HIV/AIDS Case Registry, PLWH as of January 31, 2022, Cases diagnosed with Syphilis, Chlamydia, Gonorrhea, or Hepatitis C in 2021.
[26] Eaton LA, Driffin DD, Kegler C, et al. The role of stigma and medical mistrust in the routine health care engagement of black men who have sex with men. American journal of public health. 2015;105(2):e75-82.
[27] D'Avanzo PA, Bass SB, Brajuha J, et al. Medical Mistrust and PrEP Perceptions Among Transgender Women: A Cluster Analysis. Behavioral medicine. 2019;45(2):143-152.

2021 estimates of Unmet Need of HIV Primary Medical Care in Orange County indicate that 141 individuals (12.6%) were in-care but were not virally suppressed. These PLWH are in care but are not able to reach and/or maintain viral load suppression because of comorbidities such as mental health and/or substance use issues, which impact their ability to be HIV treatment adherent. These individuals require support from case managers to address barriers to achieving and/or maintaining viral load suppression.

The complexity of health care coverage is a barrier to both clients and providers of HIV care. In Orange County, accessing HIV treatment may require navigating multiple layers of private and public health care coverage. PLWH may also need assistance transitioning between payer sources due to changes in employment, not completing required eligibility screening for services, or simply deciding to discontinue coverage. Furthermore, PLWH report challenges with accessing care outside of the Ryan White system due to service providers or networks not accepting new patients or limited availability of service providers who offer services in their preferred language and who are culturally congruent. As a result, the burden is on PLWH to identify service providers and transition through different networks and medical providers. The difficulty in navigating these systems of care can lead to a higher number of PLWH falling out of care. Community engagement and needs assessment activities identified expansion of rapid antiretroviral therapy (ART) services to link people to care immediately after diagnosis and services to help PLWH transition between systems of care and address gaps in services to reach sustained viral suppression.

Situational Analysis Snapshot by Pillar: Prevent

While there were 274 new HIV diagnoses in 2021 in Orange County, there has been a steady decrease in the HIV transmission rate (new diagnoses per 100 PLWH) from 6.2 in 2012 to 4.0 in 2021.[22]

Furthermore, PrEP coverage, defined as the number of individuals who were prescribed PrEP in Orange County among the estimated number of individuals with indications for PrEP, has increased from 10.5% in 2017 to 27.1% in 2021 as detailed in **Table 4**.[28] While PrEP coverage in Orange County in 2021 was slightly lower than PrEP coverage in California, 27.1% compared to 30.6%, Orange County experienced a slightly greater increase in PrEP coverage compared to California during this timeframe at 16.6% and14.9%, respectively.

(Continued on next page)

[28] Centers for Disease Control and Prevention. Core indicators for monitoring the Ending the HIV Epidemic initiative: National HIV Surveillance System data reported through December 2021; and preexposure prophylaxis (PrEP) data reported through September 2021. HIV Surveillance Data Tables 2022;3(1). https://www.cdc.gov/hiv/library/reports/surveillance-data-tables/. Published May 2022.

Table 4: Estimated PrEP Coverage in Orange County and California, 2017 and 2021

	PrEP Coverage	Total No. Prescribed PrEP	Total No. with Indications for PrEP	Percentage
2017	California	26,160	166,150	15.7%
	Orange County	1,052	9,990	10.5%
2021	California	50,476	165,030	30.6%
	Orange County	2,849	10,510	27.1%

OCHCA recognizes the importance of increasing PrEP coverage as a vital step to reach community HIV prevention goals. Orange County's efforts to increase PrEP coverage have been ongoing and include participation in Project PrIDE, a three (3) year CDC demonstration project from 2015 - 2018 which focused on PrEP education and outreach to Latinx MSM as well as other populations in partnership with a community-based provider, AltaMed Health Services. There have also been efforts to increase PrEP awareness among other priority populations, including the Latinx Transgender population. In June 2021, OCHCA implemented a PrEP education event in partnership with Alianza Translatinx, a community-based organization that serves the Latinx Transgender population in Orange County. The event featured a presentation on PrEP in Spanish, HIV testing, and PrEP enrollment. Furthermore, in 2021, OCHCA expanded availability of PrEP Navigation Services through the TTC Clinic and a community-based provider, Radiant Health Centers.

While PrEP uptake has increased in Orange County, there is still much work to do to reach Orange County's PrEP coverage goals.

Community efforts to reach Latinx, Transgender, and other priority populations need to be scaled-up. Community engagement efforts suggest that peers should be recruited as PrEP champions. Educational materials should also feature images of peers and be available in multiple languages.

Situational Analysis Snapshot by Pillar: Respond

OCHCA's capacity to coordinate between prevention and HIV surveillance activities has been bolstered by CDC's integrated approach facilitated by PS18-1802.

OCHCA is working to further integrate linkage to care and partner services through cross-training and the use of surveillance data to identify individuals for linkage to care and partner services. However, barriers exist, including some service providers not complying with completion of mandated paperwork for new HIV diagnoses and other STIs or not cooperating with disease intervention specialists (DIS) to contact and engage newly diagnosed individuals. OCHCA plans to engage a provider liaison to offer education and training about HIV standards of care, reporting requirements, and availability of linkage to care and partner services to providers outside of the Ryan White system of care.

OCHCA coordinates with CDPH's HIV Surveillance Branch on all aspects of HIV reporting, including potential HIV cluster investigations involving Orange County cases. OCHCA's surveillance team works closely with neighboring counties to address cross-jurisdictional cases as well as with other counties throughout the state that may be involved in the case.

In 2014, OCHCA initiated a surveillance-based HIV Partner Services Program integrating surveillance activities with disease investigation. All newly diagnosed individuals are contacted to ensure that they are aware of their HIV status, linked to care, and offered Partner Services.
Since 2020, Rapid ART referrals have been added as part of this program.

Data to Care (DTC) is another effort to coordinate with HIV Surveillance. Historically, OCHCA conducted DTC with individuals identified through surveillance data as being out of care for over 18 months. However, in 2019, OCHCA shifted focus to those newly diagnosed and lost to care as follows:

- Newly Diagnosed: Newly diagnosed individual who 1) never had a confirmatory HIV test result disclosed; 2) does not have a verified medical visit within 30 days of HIV diagnosis or Linkage to Care referral; or 3) has not been successfully linked to a Linkage to Care Coordinator.

- Lost to Care: Based on HIV surveillance data, an individual does not have any HIV labs (viral load or CD4 lab) reported within 18 months or an individual who has never linked to care.

The goal of these efforts is to address the barriers to linkage/retention in care and partner services. Furthermore, in November 2022 Orange County was selected to participate in the National Cluster and Outbreak Detection and Response Implementation Learning Collaborative led by NASTAD in collaboration with the CDC. The intent of the collaborative is to identify best practices for planning and implementation of HIV cluster and outbreak identification and response activities. Participation in the learning collaborative will aid Orange County in developing an HIV Outbreak Response Plan to ensure HIV positive individuals identified through these activities are rapidly linked to care. The plan will be developed with input from key stakeholders, HIV service providers, and community members.

Summary of Resources and Gaps

Resources and Assets

Table 5 highlights selected resources and assets identified in the needs assessment process. These pillar-specific and cross-pillar resources represent strengths that can be leveraged to enhance HIV prevention and care planning and implementation. For example, Orange County has a robust HIV testing program that supported 6,990 HIV tests in 2021 through PS18-1802 funded county and community-based providers. Routine opt-out testing (ROOT) in the five (5) county jails has been ongoing since 2012.

(Continued on next page)

Furthermore, HIV testing access has been increased through the implementation of the Building Healthy Online Communities (BHOC) TakeMeHome Program in 2020, which offers rapid HIV self-test kits directly to priority populations in Orange County. Investments in PrEP have resulted in increased uptake and in lessons learned to inform program expansion. Viral suppression in Ryan White funded programs exceeds that of other systems of care in the County. Additional resources and assets are also presented in **Table 5** and described in the narrative that follows.

Table 5: Orange County Resources and Assets	1: Diagnose	2: Treat	3: Prevent	4: Respond
By Pillar				
HIV Testing (Targeted Testing and Community Based HIV Testing)	●			
Mail-to-Home Testing (TakeMeHome Program)	●			
Access to HIV Care for Undocumented		●		
Viral Suppression within Ryan White System of Care		●		
Scaling up PrEP, including PrEP Navigation Services			●	
HIV surveillance - Data to Care and Partner Services	●	●		●
Availability of Rapid ART Services		●		
COVID-19 response to support access to care for PLWH		●		
Cross-Pillar				
• **Promising trends in new HIV diagnoses** • **Strong HIV leadership from OCHCA** • **HIV Planning Council engagement** • **Strong partnerships with key HIV service providers** • **Gay Men's Health Summit** • **Expansion of Medicaid (Medi-Cal) in California** • **Engagement of priority populations**				

HIV Testing. Targeted community-based[7] and routine jail-based[29] HIV testing accounted for 23% (64 of 274) of people newly diagnosed in 2021. Ten (10) individuals were newly diagnosed through routine jail testing and 54 individuals were identified through targeted testing. Targeted testing approaches have yielded good results in the county, and lessons learned from this strategy can be

[29] Cases reported in 2021 from the County or City Jail or lab reports in 2021 from the County or City Jail.

applied innovatively to better reach priority populations and other populations who may not access services through traditional health care settings.

Mail-to-Home Testing. To increase access to HIV testing for priority populations as well as the number of individuals aware of their status, OCHCA partnered with BHOC to implement the TakeMeHome Program in 2020. In 2022, the program was expanded to also include STI (syphilis, chlamydia, and/or gonorrhea) testing. Through this program individuals who have never tested for HIV, who have not tested in more than a year, and/or who might be hesitant to access testing services in a traditional health care setting can request that a test kit is mailed to their home or another preferred location.

Since the program was implemented in Orange County, a total of 755 individuals have ordered an HIV and/or STI test kit, of which 98% (741 of 755) requested an HIV test kit alone or in combination with an STI test kit. In 2021, approximately 46.7% (136 of 291) of individuals who requested test kits reported never having tested for HIV. OCHA continues to work with BHOC to improve data collection and reporting to have better insight into outcomes/results from test kits requested. The transition from rapid to dry blood spot testing will facilitate this process.

Viral suppression in Ryan White system of care. Viral suppression among clients in the Ryan White system of care was 86.0% in 2021.[21] Ryan White providers have extensive experience with HIV standards of care. Furthermore, they provide both care and support services, such as case management and medical transportation, which may not be available or easily accessible in other systems of care. Access to these services provides clients with the tools they need to achieve and maintain viral suppression.

Availability of Rapid ART. Rapid ART services are available through the OCHCA's TTC Clinic and five (5) county jails, which accounted for 23.4% (64 of 274) of all new positives in 2021. While this is an asset for addressing the HIV epidemic in Orange County, there is a need to expand the availability of Rapid ART services through community-based providers throughout the county as there is currently one (1) known funded Rapid ART services provider.

Scaling up PrEP including PrEP Navigation Services. OCHCA has made significant efforts to expand PrEP uptake in Orange County. For example, the OCHCA's TTC Clinic hired a nurse to provide PrEP education and medical follow-up to all new and existing PrEP patients. OCHCA is also in the process of scaling up community capacity for PrEP. This includes providing training to clinicians on how to assess clients for PrEP and developing PrEP educational materials for community-based organizations (CBOs), Federally Qualified Health Centers (FQHCs), and other organizations to distribute to PrEP eligible clients. Starting in 2021, PrEP Navigation Services were available through the TTC Clinic and a community-based provider. PrEP Navigation Services are intended to link persons at risk for HIV to PrEP care, provide assistance with health insurance and/or enrollment in medication assistance programs, reduce barriers to care including coordinating referrals to needed support services, provide education including risk reduction counseling, and provide support with medication adherence. It is anticipated that additional community-based PrEP Navigation Service providers will be available in early 2023.

(Continued on next page)

Promising Trends in New HIV Diagnoses. Orange County has been successful in decreasing the rate of new HIV diagnoses over the past ten years (2012 – 2021) from 6.2 in 2012 to 4.0 in 2021 (per 100 persons living with HIV). [22]This achievement reflects targeted prevention and treatment efforts. The greatest progress has been made among white MSM. However, other communities have not benefited equally; currently, most new HIV diagnoses occur among Latinx MSM and other communities of color.[4] Other successes include a 22% decrease in late testing between 2012-2021 as shown by a reduction in the number of concurrent HIV and AIDS diagnoses from 69 in 2012 to 54 in 2021.[22] Lessons learned from these successes have helped Orange County to develop innovative strategies to reach populations who continue to be disproportionately impacted by HIV in order to further decrease new diagnoses and ultimately get to zero new diagnoses.

Strong HIV Leadership. At the center of the HIV work and progress in the county is strong community and health department leadership. OCHCA leadership and staff are diverse, skilled, and actively engaged in the planning of care and prevention strategies for the county. They have developed a strong team and structure to respond effectively to challenges and to administer HIV programming. It is also important to note that HIV and STI program staff are integrated so that the county can more effectively respond to the interrelated epidemics of HIV and STIs. The health department leadership also takes purposeful steps to engage with the HIV Planning Council and its subcommittees to ensure their needs, priorities, and voices are lifted in the process.

HIV Planning Council (Council). The Council is composed of consumers, HIV care and support service providers, and other key stakeholders that serve people living with and/or at risk for HIV. The Council recognizes the significance of ongoing community engagement to ensure priority populations, which are those disproportionately impacted by HIV in Orange County are meaningfully engaged in the planning process. As a result, the Council includes Latinx members whose preferred language is Spanish to reflect the changes in the local HIV epidemic. Organizations that provide mental health and other key services to PLWH continue to have seats at the table.

Strong Partnerships with Key Service Providers. Partnerships with service providers are pivotal to reach priority populations. The OCHCA has established strong partnerships with providers in alignment with changes in the HIV landscape. For example, as the Latinx MSM population has become more impacted by HIV, the county has used Minority AIDS Initiative (MAI) funding to support culturally and linguistically appropriate case management services for Latinx PLWH, as well as other populations. The provision of culturally and linguistically appropriate care is at the forefront of service delivery, for example, ensuring that food bank services include culturally appropriate food options for Latinx people. Community partnerships go beyond HIV and STIs to address the growing needs of the community, including the social determinants of health.

(Continued on next page)

Gay Men's Health Summit. The Orange County Gay Men's Health Summit was implemented in 2019 through a collaboration between the OCHCA and local partners including the LGBTQ Center OC, Radiant Health Centers, and Pacific AIDS Education & Training Center (PAETC), among others in 2019. The purpose of the summit was to engage both community members and health care providers to increase awareness of gay men's health issues and identify tools and resources to specifically address barriers to care and stigma experienced by gay men in Orange County. In response to feedback provided by the community, another Gay Men's Health Summit is being planned as well as a separate health summit to specially address the needs of the Transgender population in Orange County.

Access to HIV Care for Undocumented and Medicaid Expansion. Recent (May 2022) Medi-Cal (Medicaid) expansion efforts in California have increased access to care for income eligible older adults (50 and older) regardless of immigration status. This is part of a larger effort to increase access to care to undocumented individuals, previous efforts have focused on children and young adults. In January 2024, Medi-Cal expansion will provide coverage to individuals 26 to 49 years regardless of immigration status.

Engagement of Priority Populations. Orange County has made a concerted effort to increase engagement of priority populations in the HIV planning process, including the Latinx Transgender population. Community engagement and needs assessment activities are also being planned with the Black/African American population to address disparities more effectively in the HIV Care Continuum in Orange County. Other partnerships are also being explored to reach other priority populations.

COVID-19 Response. Ryan White providers offered services remotely through telephone and/or telehealth in response to COVID-19 to ensure PLWH continued to receive needed services. Lessons learned through the COVID-19 response were applied to Monkeypox (MPX) response efforts.

Gaps and Challenges

Orange County has identified challenges and gaps in services **(Table 6**) that will need to be addressed in order to reach HIV prevention and care goals. For example, further expanding routine opt out testing (ROOT), improving rapid linkage to care and ART initiation, and working with non-Ryan White providers to improve the quality of HIV care.

(Continued on next page)

Table 6: Orange County Gaps and Challenges	1: Diagnose	2: Treat	3: Prevent	4: Respond
Pillar-Specific				
Need for implementation of ROOT in new healthcare provider settings	●			
HIV clinical provider shortages		●		
Limited availability of Rapid ART		●		
Need for support services for priority populations to achieve viral suppression		●		
Need for improvements in linkage to HIV care post-incarceration		●		
Worse health outcomes for PLWH receiving care outside the Ryan White system		●		
Low community PrEP coverage			●	
Increasing STI rates			●	
Need to strengthen protocols for outbreak response				●
Cross-Pillar				
• **Social determinants of health** • **Low perception of risk of acquiring HIV among MSM** • **Stigma** • **Fear of deportation among undocumented** • **Increase in homelessness** • **Barriers to reaching IDU/PWID and limited availability of harm reduction services** • **Difficult-to-navigate system of care** • **Substance use and other comorbidities** • **Limited availability of services in non-traditional healthcare settings**				

Routine Opt-Out Testing (ROOT). While ROOT has been ongoing in Orange County jails since 2012, there is need to expand ROOT to new healthcare settings in Orange County to ensure people with HIV are diagnosed as early as possible. OCHCA will build upon existing successes and work to expand ROOT in other healthcare settings, with a focus on those organizations that serve priority populations.

(Continued on next page)

HIV Clinical Provider Shortages. There are not enough medical providers, specifically infection disease doctors to serve all the PLWH insured by Medicaid (Medi-Cal in California) in Orange County. In 2021, there were an estimated 1,475 PLWH[30] on Medi-Cal, yet there were only 32 HIV Medi-Cal[31] providers in Orange County. Some of these providers are not accepting new patients because they have reached capacity. Among this limited number of providers there are even fewer with linguistic and cultural competency to serve the full diversity of PLWH in the county.

Need for support services for priority populations to achieve viral suppression. As indicated by unmet need data, engagement in care does not always result in viral suppression. Some PLWH are unable to maintain viral load suppression despite being engaged in care and therefore require additional support, such as medical case management services, mental health services, housing, and/or other support services to address related barriers.

Worse health outcomes for PLWH receiving care outside of the Ryan White system. PLWH receiving care outside of the Ryan White (RW) system of care experience worse outcomes along the HIV continuum of care. Ensuring that non-RW providers are knowledgeable of and trained to deliver care in accordance with HIV Standards of Care is key to closing this gap. There is also a need to effectively coordinate with the large systems of care outside of the RW system including Kaiser and CalOptima (Medicaid managed care organization for Orange County). EHE funded activities include community-based case management services, which are intended for PLWH who are not in the RW system of care and who are not virally suppressed. There are also EHE funded services specifically for PLWH who no longer qualify for RW and are transitioning between systems of care to address gaps in services during the transition, specifically mental health services.

Linkage to Care Post-Incarceration. Orange County has five (5) county jails. Compared to the general U.S. population, people who are incarcerated have a disproportionately high risk of HIV infection. Additionally, many jails and prisons provide ART to PLWH; however, maintaining ART after release can be challenging.[32]

In Orange County, only 68% (42 of 62) of previously incarcerated people maintained care after release from jail in 2021. To make improvements and to create a seamless continuum of care from the jail system to release and re-entry, collaboration among HIV clinicians, Correction Health Services, public health department, and re-entry organizations needs to be strengthened in Orange County.

(Continued on next page)

[30] ARIES 2021 Orange County. Case rates are based on Ryan White client report and is used an estimate for all PLWH in Orange County.
[31] Cal Optima. Provider Search and Directories. 2022. https://www.caloptima.org/en/ForProviders/Resources/ProviderSearch.aspx
[32] Westergaard RP, Spaulding AC, Flanigan TP. HIV among persons incarcerated in the USA: a review of evolving concepts in testing, treatment, and linkage to community care. Current opinion in infectious diseases. 2013;26(1):10-16.

In response to this need, Orange County will be implementing a Jail Viral Load Incentive Program (EHE funded) to incentivize individuals to link to care upon release from jail. This program is being implemented through a partnership between the OCHCA and Orange County Correctional Health Services. The program will be implemented by the RW Linkage to Care Case Manager who works with PLWH while incarcerated to develop a plan to help link them to care and other support services upon release from jail.

Low PrEP Coverage. Despite recent increases in PrEP coverage in Orange County, PrEP coverage remains low. Based on data available through the EHE AHEAD Dashboard, in 2021, PrEP coverage in Orange County was 27.1%. Multiple barriers can hinder PrEP uptake, including health insurance coverage limitations, provider practices around screening and prescription, stigma, and lack of knowledge. In a 2019 local survey on PrEP, only 60.9% (157 of 258) of respondents had heard of PrEP and knew what it was, providing further evidence of the lack of awareness and knowledge among community members. Despite the strong evidence on the efficacy of PrEP, many populations at risk for HIV are not using PrEP. Significant efforts are needed to increase uptake among priority populations, including Black/African American MSM, Latinx MSM, people who inject drugs (PWID), and Transgender populations. The availability of PrEP Navigation services through county and community-based providers is intended to increase PrEP uptake in Orange County to help achieve HIV prevention goals.

Barriers to reaching PWID and Limited Availability of Harm Reduction Services. PWID made up 7.5% of new HIV diagnoses in 2021, up 2% from 2019.[22] This population is often hard to reach if there are no established linkages or gatekeepers to facilitate access. Furthermore, people who use substances are less likely to access healthcare or HIV testing if they are dealing with addiction, homelessness, or extreme poverty.

In 2021, due to the COVID-19 pandemic, there was a 40.0% decrease in targeted testing for HIV compared to 2019 (2,556 compared to 3,704) as testing services were temporarily unavailable, reduced, or limited to symptomatic patients only. There was also a decrease in the number of individuals who reported PWID as their risk factor through targeted testing efforts in Orange County. In 2017, 415 individuals who tested for HIV reported PWID as their risk factor, with the elimination of the Needle Exchange Program in 2018 that number decreased to 289, and further decreased in the years that followed (96 in 2019, 19 in 2020, and 62 in 2021).

Anecdotally, some PWID believe sharing needles with a small circle of friends will prevent HIV transmission. Without appropriate education related to risk reduction techniques, these beliefs could lead to increased transmission. As indicated in the most recent (2021) Client Needs Survey, substance use services were among the services that were less likely to be reported received when needed. [20] While there is currently no wait list for treatment services, there may be a general lack of knowledge among PWID about services available. A point of outreach to PWID could be harm reduction services. As of December 2022, Orange County had no syringe services programs authorized by the California Department of Public Health.

(Continued on next page)

Increasing STI rates. The rates of gonorrhea (GC) and syphilis continue to trend up in Orange County, with rates increasing by 31.0% and 33.4% respectively between 2017-2020.[33] Additionally, the rates of GC and syphilis have increased among all genders. For GC, there has been a 13.4% increase in males and a 67.0% increase in females. For syphilis, there has been a 20.9% in males and a 237.5% increase in females. Furthermore, the rates of GC and syphilis have also increased among various ethnic groups. For GC, there has been increases among Hispanics, Pacific Islanders, and American Indians/Alaska Natives by 36.1%, 32.4%, 120.1% respectively. For syphilis, there has been increases among Whites, Hispanics, and Asians by 20.5%, 42.7%, and 32.1% respectively. HIV and STIs are interrelated epidemics disproportionately impacting communities of color, MSM, Transgender populations, and other underserved communities. There is a need to reframe education, prevention, and treatment efforts to focus on addressing the epidemics of HIV and STIs concurrently and address social determinants of health to reduce health disparities. This approach aligns with the California Department of Public Health's (CDPH) Ending the Epidemics Integrated Statewide Strategic Plan for 2022-2026 to address HIV, Hepatitis C (HCV), and STIs. Locally, Orange County is implementing programs and services to increase access to HIV and STI testing and treatment for priority populations, including the TakeMeHome Program (mail-to-home HIV and STI test kits) and increasing efforts to offer HIV and STI services through nontraditional health care settings (mobile and/or field based) in partnership with community-based organizations that serve priority populations.

Lack of a protocol for HIV outbreak response. Although Orange County has an interdisciplinary HIV surveillance team, there is no formal protocol for HIV outbreak response. As a result, if an HIV cluster were identified in Orange County, an appropriate response might not be as timely or coordinated as needed, which could pose challenges to effective containment and response. Through EHE efforts, Orange County will be developing an HIV Outbreak Response Plan. Furthermore, as of November 2022 Orange County is participating in the National Cluster and Outbreak Detection and Response Implementation Learning Collaborative led by NASTAD/CDC to identify best practices for plan development. Orange County will also continue to collaborate with the CDPH Office of AIDS (OA) Outbreak and Field Investigation Unit for technical assistance in accordance with the OA Outbreak Response Plan.

Social Determinants of Health. Addressing social determinants of health (SDOH) remains a challenge in the county. To create conditions to achieve a reduction in new HIV infections and reduce health disparities, the following SDOH in Orange County must be addressed: systemic discrimination, the high cost of living, and homelessness.

- **Systemic discrimination** manifests in homophobia, transphobia, sexism, racism, and sex negativity which creates structural barriers to HIV testing, treatment, and prevention. Systematic marginalization of groups, such as MSM of color, in turn determines whether these individuals will seek information and resources to manage HIV risk or medical care.

(Continued on next page)

[33] Orange County Health Care Agency. Sexually Transmitted Diseases Data Summary 2017-2020. Public Health Services, Community Disease Control;2021. https://hca.oc.prod.acquia.prometdev.com/sites/hca/files/2021-05/2017-2020_STD_Data_Summary_chart.pdf

- **Cost of living**[34] in Orange County is 19% higher than the national average. An individual working a minimum wage job ($15/hour) is likely unable to afford housing in the county[35]. This particularly affects low-income individuals, including PLWH or those who rely on disability and Social Security income and typically make less than minimum wage, increasing their risk for displacement.
- **Homelessness**[36] has increased in Orange County. Most current data available from the 2020 Point In Time count indicates that there were 3,961 unsheltered individuals (1.7% reported living with HIV/AIDS) and 3,017 sheltered individuals (1.2% reported living with HIV/AIDS) experiencing homelessness in Orange County in 2022. Among those that were unsheltered, 49.4% reported experiencing chronic homelessness, 30.9% reported substance use issues, and 30% reported mental health issues. Amon those that were sheltered, 28.3% reported chronic homeless, 17.3% reported substance use issues, and 18.2% reported mental health issues.

Low Perception of Risk. Anecdotally, some MSM in Orange County have a low perceived risk of acquiring HIV. This phenomenon is not unique to Orange County and may reflect changes in the epidemic over decades. In the early days of HIV, there was a sense of urgency and a high-perceived risk among MSM as deaths soared and prevention tools were limited. While the new prevention approaches available are cause for celebration, the downside is that this sense of urgency has been replaced by a sense of "invincibility" related to acquiring HIV. Similarly, since HIV is no longer a death sentence, this also impacts the sense of importance around prevention.

Stigma. Some communities face stigma based on their sexual identity, gender orientation, sexual behaviors, and HIV status. Stigma has negative effects on health outcomes and health behaviors. It often produces feelings of shame and isolation, impacting mental and emotional health.[12] Stigma can also prevent people from seeking HIV/STI screening and treatment due to fear of being identified as HIV-positive or even being at risk for HIV. This fear is especially salient for communities of color who face unique stigma-related factors such as culture. Internalized stigma may also be prevalent among gay or bisexual populations and among individuals who do not identify as gay or bisexual but engage in same-gender sexual activities. Orange County's efforts to address HIV stigma, include an anti-stigma campaign "*HIV: It's a Human Thing*." The multimedia campaign included a digital component and indoor/outdoor ads at restaurants, billboards, bus stops, and other strategic locations with highest rate of HIV infections in the county. Providers and community members can visit the campaign site and download materials for distribution with messages about HIV education, PrEP, testing, and HIV status disclosure.

(Continued on next page)

[34]U.S. Bureau of Economic Analysis (2021). *Real Personal Consumption Expenditures and Personal Income by State, 2020*. https://www.bea.gov/news/2021/real-personal-consumption-expenditures-and-personal-income-state-2020
[35] State of California Department of Industrial Relations (2022). *Minimum Wage.* https://www.dir.ca.gov/dlse/faq_minimumwage.htm
[36] United States Department of Housing and Urban Development (2020). *Santa Ana, Anaheim, Orange County CoC.*. https://files.hudexchange.info/reports/published/CoC_PopSub_CoC_CA-602-2020_CA_2020.pdf

Fear of Deportation. Some undocumented residents in Orange County reported being fearful of receiving services from governmental organizations because of the potential impact to their ability to stay in the United States. There were also reports that changes to federal immigration policy in recent years, including heightened immigration enforcement and expansion of the "public charge" rule, were causing fear and confusion leading to families dropping out of public assistance programs.[37] Anecdotally, DIS workers reported people falling out of care because of fears about how accessing services may affect their ability to obtain legal residency. Other anecdotal reports include individuals discontinuing insurance coverage or declining treatment because of concerns over the public charge rule. This highlighted the need to provide information as well as support services, including legal services and case management services to undocumented communities in conjunction with other social services.

Cultural and language barriers must be addressed given the increase in new diagnoses among Latinx MSM in the county. Latinx MSM experience unique barriers to prevention and care services. There is a high level of stigma in the Latinx community associated with HIV, as well as a need for information and outreach in Spanish.[6] Culturally and linguistically appropriate outreach, information and services must be enhanced to better meet the needs of this population.

Difficult-to-Navigate System of Care. PLWH, especially those newly diagnosed, can have difficulties navigating the various systems of care in Orange County. When trying to access care, clients can face multiple hurdles. Individuals need to find a provider who accepts their insurance, is accepting new patients, and has appointments readily available. The burden is on PLWH to find medical care and transition through different networks and medical providers. Medi-Cal regulations pose additional barriers. Individuals can only be enrolled in Medi-Cal in one county, meaning if they move to another county, they must reapply in that county. That process can take as long as six (6) months in some jurisdictions, leaving people without health insurance, which is a barrier to accessing and staying in care. PLWH may also require assistance transitioning between payer sources due to changes in employment, not completing eligibility screening, or simply deciding to discontinue coverage. These barriers can make it difficult for PLWH to reach and maintain viral suppression. Orange County has made a concerted effort to support PLWH transitioning between systems of care. This includes providing EHE funded HIV care and support services through the Rapid ART Program, High Acuity Program, Community Based Case Management Services, and Mental Health Services to PLWH to address gaps in services during the transition process.

Limited availability of services in non-traditional healthcare settings. The need to increase access to HIV prevention and care services in non-traditional healthcare settings and during non-traditional hours was identified through the community engagement and needs assessment process. Doing so can reduce barriers related to distance and transportation and bring services to the community. There are also individuals who may fear and/or have mistrust of traditional health care settings. This is particularly relevant for some priority populations. Orange County is exploring partnership to expand service availability in the community through mobile and field-based services.

[37] Urban Institute. Understanding the Consequences of Current Immigration Policy. 2019. https://www.urban.org/features/understanding-consequences-current-immigration-policy

Section V: 2022-2026 Goals and Objectives

The 2022-2026 Integrated Plan goals and objectives align with Orange County's National HIV AIDS/Strategy (NHAS) and Ending the HIV Epidemic (EHE) Plan goals and objectives. The goals for Orange County were reviewed and updated by the HIV Planning Council and its subcommittees. Additionally, the OCHCA did not use portions of another local strategic plan to satisfy/address Section V: 2022-2026 Goals and Objectives.

NHAS Goal 1:	Prevent New HIV Infections
2022-2026 Objective 1.1:	By the end of 2026, increase the percentage of people living with HIV (PLWH) who know their serostatus to at least 90.0% (from 84.3% in 2020 to 90.0% in 2026).
Strategies:	• Promote HIV testing as part of routine health care through routine opt-out testing (ROOT) • Offer targeted HIV testing in non-healthcare settings • Use Partner Services to help HIV-positive individuals disclose their status to sex or needle sharing partners • Develop HIV Outbreak Response Plan to provide needed prevention services to individuals at risk for HIV, including partners of PLWH identified through response activities
Needs/Barriers Addressed	• ROOT in healthcare settings • Limited availability of services in non-traditional healthcare settings • Lack of a protocol for HIV outbreak response

EHE Pillar	Key Partners	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
1-Diagnose 3-Prevent 4-Respond	• Orange County Health Care Agency (OCHCA) • Testing Providers • Community Based Organizations (CBOs) • Community Based Medical Providers • Building Healthy Online Communities (BHOC) (TakeMeHome Program)	• Increase ROOT in healthcare settings • Continue to offer testing in the jails and targeted testing at community agencies, events, nightclubs, or other community-based locations	• Men who have sex with Men (MSM) • Substance Users (Persons who inject drugs (PWID)) • Incarcerated individuals or those with a history of incarceration • Partners of people living with HIV	• Number of HIV tests • HIV positivity rate • Number of partners reached and tested through Partner Services • Number of medical providers who	• Ryan White (HRSA) • Prevention PS 18-1802 (CDC/State Office of AIDS (SOA)) • Ending the HIV Epidemic (EHE) (CDC) • STD Prevention Management and Collaboration (State STD Control Branch)

		• Continue to use both surveillance-based and venue-based Partner Services • Continue to offer HIV and/or STD self- test kits mailed to home or preferred location • Develop HIV Outbreak Response Plan to immediately respond to any molecular clusters and/or outbreaks to get people tested	• Transgender individuals • Sex workers • Individuals at risk for HIV identified through outbreak response activities	implement ROOT • Number of self-test kits ordered	

(Continued on next page)

NHAS Goal 1:	Prevent New HIV Infections
2022-2026 Objective 1.2:	By the end of 2026: • Reduce the number of new HIV infections per 100 people estimated to be living with HIV by 75%[38] (from 2.4 per 100 people living with HIV (PLWH) in 2020 to 0.6 per 100 PLWH in 2026) • Reduce the number of new HIV diagnoses by 75%[39] (from 264 in 2020 to 66 in 2026)
Strategies:	• Condom distribution to HIV-positive and high-risk populations • Utilize social marketing, media, and community mobilization strategies to promote HIV prevention and testing • Leverage partnerships with CBOs to reach priority populations (populations disproportionately impacted by HIV) • Ongoing community engagement of priority populations • Increase capacity to offer trauma informed prevention services to priority populations • Utilize surveillance data to provide needed prevention services to geographic areas throughout the county with increasing rates of HIV
Needs/Barriers Addressed:	• Low Perception of Risk • Stigma • Social Determinants of Health

EHE Pillar	Key Partners	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
1-Diagnose 3-Prevent 4-Respond	• OCHCA • CBOs • SOA	• Condom distribution through CBOs, clinic, and targeted events • Promotion of TakeMeHome program	• MSM • Young MSM • PLWH	• Number of newly identified positive individuals	• Ryan White (HRSA) • Prevention PS 18-1802 (CDC/SOA • EHE (CDC)

[38] The Reduce new HIV infections indicator is defined in the NHAS as follows: Incidence is the estimated number of new HIV infections among persons aged ≥13 years that occurred in the measurement year and includes diagnosed and undiagnosed infections. Additional information is available at the following link: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf. The indicator is calculated as HIV transmission rate which is defined as the number of new HIV infections per 100 people estimated to be living with HIV (diagnosed and undiagnosed). For 2021, the rate was calculated using 2019 data, which is the most current data available. Numerator: estimated number of new HIV infections in 2019 (N=200), data source EHE AHEAD (America's HIV Epidemic Analysis) Dashboard available at: Orange County, CA | AHEAD (hiv.gov). Denominator: estimated prevalence, which includes persons diagnosed and undiagnosed in 2019 (N=8,200), data source CDC available at: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-26-1.pdf.

[39] The Reduce new HIV diagnoses indicator is defined in the NHAS as follows: Number of persons ≥13 years who have received laboratory or clinical confirmation of HIV in a measurement year. Additional information is available at the following link: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf.

	• BHOC (TakeMeHome Program)	through social media apps through BHOC • Utilize molecular cluster data to identify areas with increasing rates of HIV to deploy needed prevention services in collaboration with community partners. • Social media promotion of HIV and STD programs and services available in the County • Implement health summits for priority populations to increase awareness of health issues and to provide information about prevention resources available • Implement training and related activities to build capacity among service providers for trauma informed prevention and care services • Community engagement of priority populations to identify and more effectively address barriers to HIV prevention services	• High-risk HIV negative individuals • Substance Users • Transgender individuals	• Number of individuals from priority populations that participate in community engagement activities, including health summits • Social media metrics (i.e., clicks, impressions, downloads, etc. • Community engagement activities implemented • Provider capacity building and training activities implemented	

NHAS Goal 1:	Prevent New HIV Infections
2022-2026 Objective 1.3:	By the end of 2026, increase PrEP coverage to at least 50.0% (from 21.2%[40] in 2020 to 50.0 % in 2026).
Strategies:	• Continue to provide Pre-Exposure Prophylaxis (PrEP) • Expand availability of PrEP Navigation Services through OCHCA and community-based providers • Increase awareness of PrEP among priority populations
Needs/Barriers Addressed:	• Low PrEP Coverage

EHE Pillar	Responsible Parties	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
3-Prevent	• OCHCA • CBOs	• Implementation of PrEP clinics • Expand availability of PrEP Navigation Services	• HIV negative individuals • High-risk HIV negative individuals (e.g., MSM, TGNC, PWID)	• Number of individuals who are screened for PrEP eligibility • Number of persons eligible for PrEP who are provided a PrEP referral • Number of persons provided with a Prep referral who are assisted with linkage to a Prep provider • Number of persons linked to a PrEP provider who obtain a PrEP prescription • Number of persons with a PreP prescription who initiate PrEP • Number of persons who initiate PrEP who attend one or more PrEP follow-up sessions post-initiation	• Prevention PS 18-1802 (CDC/SOA) • EHE (CDC)

[40]Orange County PrEP coverage data for 2020 and 2021 was obtained from the EHE AHEAD Dashboard. PrEP coverage is calculated as the number of persons aged ≥16 years classified as having been prescribed PrEP divided by the estimated number of persons who had indications for PrEP. Different data sources were used for the numerator and denominator; therefore, it is unknown whether all persons prescribed PrEP (numerator) are also contained in the estimate of the number of persons with indications for PrEP (denominator). Thus, caution should be used when interpreting PrEP coverage percentages. Additional information regarding data methods is available at https://ahead.hiv.gov/resources/data-methods/prep-coverage.

NHAS Goal 2:	Improve HIV-Health Related Outcomes of People Living with HIV
2022-2026 Objective 2.1:	By the end of 2026, increase Rapid antiretroviral therapy (ART) initiation for newly diagnosed individuals within 0-5 days of diagnosis to at least 33.0%[41] (from 19.0% in 2021 to 33.0% in 2026).
Strategies:	• Provide Rapid ART Services for newly identified HIV-positive individuals • Provide Re-Rapid ART Services for those who have been out of care • Expand availability of Rapid/Re-Rapid ART Services through OCHCA and community-based providers
Needs/Barriers Addressed:	• Worse health outcomes for PLWH receiving care outside of the Ryan White system

EHE Pillar	Responsible Parties	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
2- Treat	• OCHCA • CBOs • Correctional Health Services (CHS)	• Continue to provide Rapid ART and Re-Rapid ART services through the OCHCA's Testing, Treatment, and Care Clinic (TTC) Clinic and Correctional Health Services • Increase number of community-based providers who offer Rapid ART Services	• Newly identified HIV -positive individuals • Individuals who have been out of care for 6 months or more and are not taking ART medication	• Number of individuals who receive Rapid ART services • Number of individuals who receive Re-Rapid ART services • Viral suppression	• Ending the HIV Epidemic (CDC/HRSA) • SOA AIDS Drug Assistance Program (ADAP) • SOA (General Funds)

[41]A Rapid ART progress indicator was not included in the NHAS; this is an Orange County specific progress indicator. Same-day initiation or Rapid ART is listed as a strategy to achieve objective 2.1. The outcome for this progress indicator was calculated based on total number of newly diagnosed individuals who initiated ART within 0-5 days of diagnosis in Orange County. The data is not provider specific; it includes all data available.

NHAS Goal 2:	Improve HIV-Related Health Outcomes of People Living with HIV
2022-2026 Objective 2.2:	By the end of 2026, increase linkage to care within one (1) month of HIV diagnosis to at least 85.0% (from 78.7% in 2020 to 85.0% in 2026).
Strategies:	• Expand network of medical providers serving PLWH • Educate community medical providers about available services for PLWH • Apply interventions that link newly diagnosed patients to care • Utilize Partner Services to reach newly identified HIV-positive individuals
Needs/Barriers Addressed:	• Difficult-to-Navigate System of Care

EHE Pillar	Responsible Parties	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
2-Treat	• OCHCA • CBOs • CHS • Community Based Medical Providers • Insurance networks (i.e., Kaiser, CalOptima, Covered California, etc.)	• Continued collaboration between Ryan White service providers and medical offices to ensure PLWH are able to access medical care • Continue implementing Anti-Retroviral Treatment and Access to Services (ARTAS) to assist newly identified positives to quickly engage in and link to care • Continued collaboration between the OCHCA's surveillance staff and medical providers to ensure the most	• Newly identified HIV -positive individuals	• Reported CD4/Viral Load labs to surveillance • Number of individuals contacted by DIS • Number of PLWH who participate in LTC services	• Ryan White (HRSA) • EHE (HRSA)

		current patient information is available • Continue to utilize Partner Services through Disease Intervention Specialist (DIS) to reach every new identified positive to engage them in care • Implement linkage to care incentive programs in the community (in partnership with CBOs) and in the jails (in partnership with CHS)			

(Continued on next page)

NHAS Goal 2:	Improve HIV-Related Health Outcomes of People Living with HIV
2022-2026 Objective 2.3:	By the end of 2026, increase the percentage of persons with diagnosed HIV who are retained in HIV medical care to at least 80.0%[42] (from 77.3% in 2020 to 80.0% in 2026). By the end of 2026, increase viral suppression among people diagnosed with HIV to at least 80.0%(from 71.5% in 2020 to 80.0% in 2026).
Strategies:	• Assist PLWH to access services regardless of payer sources or health care coverage • Expand services that bring individuals back into care • Offer various levels of case management that assist clients to engage in and stay in care • Ensure PLWH have access to continuum of HIV services • Ensure access to HIV medications • Provide education and support for adherence to medications • Educate HIV specialists about offering treatment based on clinical guidelines • Educate providers about referring to HIV specialist for treatment • Offer incentives for reaching viral load suppression • Implement Community-Based Case Management Services • Develop HIV Outbreak Response Plan to provide needed care and treatment services to individuals living with HIV who have been identified as part of a cluster
Needs/Barriers Addressed	• Need to support services for priority populations to achieve viral suppression • Worse health outcomes for PLWH receiving care outside of the Ryan White system • Cultural and language barriers • Difficult-to-Navigate System of Care • Linkage to care post-incarceration • Lack of a protocol for HIV outbreak response

EHE Pillar	Responsible Parties	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
2-Treat 4-Respond	• OCHCA • CBO • SOA, ADAP • Pacific AIDS Education and	• Continue implementing ARTAS to assist PLWH transition between different	• PLWH • PLWH who are not virally suppressed	• Reported CD4/Viral Load labs to surveillance	• Ryan White (HRSA) • Ending the HIV Epidemic (CDC/HRSA) • HOPWA

[42]A Retention in Care indicator was not included in the NHAS; this is an Orange County specific progress indicator. Retained in HIV medical care is defined as the number of persons who had at least two viral load or CD4 results within a two (2) year period with at least three (3) months in-between the first and last result.

	Training Center (PAETC)	insurance networks quickly and help them engage and remain in care • Expansion of Data-to-Care and Outreach Services that help to find individuals that have fallen out of care and assist in linking them back to care • Continued expansion of Medical Retention Services under Case Management along with other levels of case management that assists PLWH remain in care • Continued expansion of centralized eligibility to ensure that every PLWH has access to Ryan White, EHE, and other services for which they are eligible for including medications	• PLWH who are transitioning between systems of care • PLWH who have comorbidities and are not treatment adherent	• Number of individuals linked to care • Number of PLWH who are brought back into care •	

		• Provide care for High Acuity clients who do not qualify for Ryan White and are unable to engage or stay in medical care • Expansion of training opportunities for case managers and other staff on pharmacology and treatment adherence to assist PLWH • Continued opportunities for provider education (i.e., AIDS on the Frontline Conference implemented in collaboration with PAETC) and resources for medical providers on updated treatment guidelines • Use of Linkage to Care strategies to assist PLWH navigate medical			

		groups to ensure access to HIV specialist • Implement Viral Suppression Patient Incentive Program to incentivize PLWH to engage in HIV care, reach and maintain viral suppression, and use case management support services • Implement Jail Viral Load Incentive Program to incentive individuals to link to care upon release from jail. • Implement case manager at community-based provider sites (outside of the Ryan White system of care) with a high volume of patients not virally suppressed			

NHAS Goal 3:	Reduce HIV-Related Health Disparities Health Inequities
2022-2026 Objective 3.2:	By the end of 2026, increase viral suppression among people diagnosed with HIV for the following groups: • Men who have sex with men (MSM) (from 74.9% in 2020 to 84.9% in 2026) • Black MSM (from 66.7% in 2020 to 76.7% in 2026) • Latino MSM (from 71.3% in 2020 to 81.3% in 2026) • Transgender Women in HIV medical care (from 87.1% in 2020 to 75.0% in 2026) • People who inject drugs (PWID) (from 52.8% in 2020 to 62.8% in 2026) • Youth aged 13-24[43] (from 71.1% in 2020 to 81.4% in 2026).
Strategies:	• Engage priority populations through community engagement and needs assessment activities, such as health summits • Social marketing, media, and community mobilization strategies that are culturally appropriate and in languages of targeted groups • Increase capacity to offer trauma informed prevention services to priority populations
Needs/Barriers Addressed:	• Need for support services for priority populations to achieve viral suppression • Worse health outcomes for PLWH receiving care outside of the Ryan White system • Barriers to reaching PWID and limited availability of harm reduction services • Social determinants of health • Stigma • Cultural and language barriers • Difficult-to-navigate systems of care

Pillar	Responsible Parties	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
• 2- Treat	• OCHCA • CBOs	• Implement community engagement and needs assessment activities with priority populations to inform delivery of services, including improvements to HIV care services and identify barriers to care to improve viral suppression	• MSM • Black MSM • Latino MSM • Transgender Women in HIV medical care • PWID	• Number of PLWH that participate in community engagement activities, such as health summits • Provider capacity building and training activities implemented • Viral suppression	• Ryan White (HRSA) • EHE (CDC/HRSA)

[43] Surveillance data available is for youth ages 14-25.

		• Implement health summits for priority populations to increase awareness of health issues and to provide information about community resources available • Implement training and capacity building activities to support delivery of trauma informed care services among service providers to priority populations	• Youth		

(Continued on next page)

NHAS Goal 3:	Reduce HIV-Related Health Disparities and Health Inequities
2022-2026 Objective 3.4:	By the end of 2026, reduce the percentage of persons in Ryan White HIV medical care who are homeless from 4.7% in 2020 to 2.4% in 2026.
Strategies:	• Provide access to programs that assist PLWH with emergency financial assistance for housing needs • Provide on-going housing resources such as transitional housing and linkage to permanent housing • Provide on-going support to individuals with unstable housing • Expand services that bring PLWH that are out of care and living in unstable housing back into care
Needs/Barriers Addressed:	• Social determinants of health • Homelessness • High cost of living

Pillar	Responsible Parties	Activity/Interventions	Target Population	Data Indicators	Potential Funding Resources
2- Treat	• OCHCA • CBOs • City of Anaheim, Anaheim Housing Authority	• Continue to provide emergency financial assistance and/or short-term rental assistance on behalf of PLWH that experience unexpected financial challenges in order to help them stay housed • Provide transitional housing options for PLWH and develop plans for permanent housing • Assist eligible individuals in obtaining permanent housing options • Use of Outreach Services to engage homeless individuals who are out of care	• PLWH that are Homeless • PLWH with unstable housing	• Reported homeless and/or unstable housing in the Housing status section of the ARIES database • Reported homeless based on the Point in Time Homeless Count • Number of homeless individuals in the Homeless Management Information System (HMIS)	• Ryan White (HRSA) • Housing Opportunities for Persons with AIDS (HOPWA) • EHE (HRSA)

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

1. 2022-2026 Integrated Planning Implementation Approach

To support the five(5) key phases of integrated planning to ensure goals and objective are met, the Integrated Plan Committee (IPC) will take the lead on ensuring implementation, monitoring, evaluation, improvement, and reporting and dissemination of the 2022-2026 Integrated Plan. This will be accomplished through collaborating between the Orange County HIV Planning Council (Council) and its subcommittees to ensure input from consumers of HIV services, community partners, and other key stakeholders is considered and addressed. The IPC will also collaborate with the Orange County Health Care Agency (OCHCA) to ensure the necessary infrastructure, procedures, systems and tools are available to accomplish of the 5 phases of integrated planning as follows:

- Infrastructure - To ensure programs and services are implemented in accordance with the Integrated Plan, the IPC will leverage and expand upon existing HIV infrastructure within the OCHCA and in the community. In doing so, OCHCA can effectively optimize services, expand capacity, and facilitate partnerships. This approach will not only facilitate the key phases of integrated planning, but also ensure that this process is responsive to current and emerging needs of people living with HIV (PLWH) and other key stakeholders.
- Procedures - Procedures (new or existing) will guide integrated planning, including ongoing engagement of priority populations, define roles and responsibilities, and support coordination across funding streams. Procedures will be developed or revised with input from IPC and other key stakeholders, as needed.
- Systems and Tools - Data and reporting systems will be utilized to regularly monitor and evaluate progress for Integrated Plan implementation. This includes but is not limited to service utilization data accessed through the ARIES and LEO data systems, surveillance data accessed through internal and state (CalREDIE) data systems, and needs assessment data compiled by the Grant Recipient. This will facilitate decision making for planning purposes and guide improvements and quality improvement efforts.

a. Implementation

Implementation of Orange County's Integrated Plan will be an on-going and collaborative effort between multiple committees and key stakeholders, with IPC taking the lead. The IPC meets monthly to ensure progress is made and includes representation from service providers and administrators across multiple funding streams, including but not limited to CDC (EHE and Prevention), HRSA (EHE and Ryan White Parts A, B, and C), HUD (HOPWA), SAMHSA, and other federal and state funding sources. Furthermore, an annual resource inventory, including an assessment of all funding sources used to support HIV prevention and care services in the jurisdiction is conducted as part of the planning process to ensure the jurisdiction leverages and effectively coordinates funding streams to avoid duplication of services and gaps in the service delivery system.

(Continued on next page)

The process for coordinating partners to meet Integrated Plan goals and objectives includes efforts to engage new partners, PLWH, and people at high risk for HIV. These efforts include community engagement activities directly with PLWH, people at risk for HIV, and/or with community-based organizations through new and existing partnerships that serve these populations. The OCHCA is also leveraging new partnerships developed through efforts such as Equity in OC for engagement in the HIV planning process, and more specifically in integrated planning.

b. **Monitoring**

Monitoring progress of the Integrated Plan will also be a collaborative and on-going effort between multiple committees with IPC taking the lead, as indicated above. In addition, the Priority Setting, Allocations, and Priorities (PSAP) Committee, the HIV Client Advocacy Committee (HCAC), the Quality Management (QM) Committee, and the Planning Council will regularly review data, quality indicators, and strategies associated with the Integrated Plan to ensure goals and objectives are met. The following data will be reviewed throughout the year to determine progress towards the goals of the Integrated Plan:

- January: Overview of IPC Reports
- January: EHE Work Plan
- February: Community STD Screening
- February: Orange County's HIV Testing Progress Report
- March: Early Identification of Individuals with HIV/AIDs (EIIHA) Outcomes, Plan, and Goals
- April: Orange County's epidemiological profile
- April: Orange County's epidemiological profile
- April: Orange County HIV Care Continuum
- April: EHE Work Plan
- May: Quality Management Outcomes
- May: Data from survey results (Client Satisfaction Survey or Client Needs Survey)
- June: Orange County progress toward achieving National HIV/AIDS (NHAS) goals
- June: EHE Performance Outcomes
- July: Client Focus Group outcomes
- July: EHE Work Plan
- August: EIIHA Mid-Year Outcomes
- August: Orange County's HIV Testing Mid-Year Progress Report
- September: Unmet Need Estimate Outcomes

Orange County's monitoring process ensures an ongoing and comprehensive review of HIV programs and services that impact the HIV care continuum as detailed in the Integrated Plan as well as other key planning documents, such as the EHE Plan, EIIHA Plan, and NHAS Goals for Orange County to avoid duplication of effort and gaps in services.

c. **Evaluation**

The process to evaluate progress towards achieving the goals and objectives of the Integrated Plan will be ongoing. Data will be obtained using surveillance data from laboratory reports, program data, as well as other data sources (i.e., EHE AHEAD Dashboard). This data will allow committees to assess performance measures for all funded services in Orange County such as the number of individuals that are newly diagnosed, PLWH who are linked and retained in care, PLWH that are virally suppressed, PrEP coverage, the number of HIV tests conducted, HIV positivity rate, the number of Partner Services Interviews conducted, and the number of self-collected STD tests collected. Committees review this data throughout the year as detailed in the section above. Additionally, the Ryan White Clinical Quality Management (CQM) reviews performance measure outcome reports for services funded through Ryan White and EHE on a quarterly basis. The performance measures are based on quality indicators that align with NHAS strategies, the Integrated Plan, and the HIV Care Continuum. Moreover, additional data will come from Bi-Annual Narrative Reports submitted by service providers which details strengths, barriers, and challenges related to service delivery. As part of the review, the committees will be evaluating implementation strategies, outcomes, and target populations to see if Orange County is on track to reach the goals and objectives outlined in the Integrated Plan by 2026.

d. **Improvement**

The regular review of data as well as ongoing community engagement to solicit community input is integral to the integrated planning process, specifically to inform revisions and improvements to Orange County's Integrated Plan. Data is used to develop appropriate health outcome targets and goals. Furthermore, data is reviewed in conjunction with input from the community to effectively monitor and report successes in improving the health of PLWH or at risk for HIV in Orange County as well as identify opportunities for improvement. This same approach is used to identify and prioritize populations or areas with significant disparities and serves as the backbone for making revisions and improvements to the Integrated Plan. As indicated above, data is shared with committees of the HIV Planning Council (IPC, PSAP, and HCAC). The Ryan White QM committee also utilizes data in its planning for improving health outcomes.

The following is an example of the data indicators and types of community input that will be used to make revisions and improvements to the plan:

- Number and percent of individuals diagnosed with AIDS
- Number and percent of individuals who are currently diagnosed with HIV and AIDS (late testers)
- Number and percent of individuals currently living in Orange County with HIV
- Number and percent of individuals who have been linked to care, retained in care, and virally suppressed
- Data to show trends in the epidemic
- Data to show effectiveness of interventions (i.e., Orange County's HIV Testing Progress Report, EIIHA Outcomes, etc.)

(Continued on next page)

- Data to show health disparities along the HIV Care Continuum
- Comparison of Ryan White service utilization data to HIV Surveillance data to identify strengths/successes in programs and uncover areas for improvement
- Development of the annual HIV Fact Sheet, HIV Care Continuum, and the HIV Surveillance Report (completed every five years)
- Focus group/key-informant interview summary report
- HIV Client Advocacy Committee recommendations
- Community forum/town hall summary report

The Integrated Plan will be a living document that is used as part of the planning process in Orange County that is reviewed quarterly, at minimum and updated, as needed in order to effectively improve the HIV Care Continuum and reach the goals of the National HIV/AIDS Strategy. This process will be led by the IPC with final review and approval from the Council.

e. **Reporting and Dissemination**
Updates on Integrated Plan progress, including implementation, monitoring, evaluation, and improvements, will be reported and disseminated to the Council and its subcommittees (IPC, PSAP, and HCAC) throughout the year as detailed in section b, monitoring, above Additionally, updates on Integrated Plan progress, including quality indicators and epidemiological data, will also be presented during quarterly HIV provider meetings. Other key stakeholders, including PLWH and community partners will also be provided updates on Integrated Plan progress through community meetings and presentations. All documents produced and presentations given that relate Orange County's efforts will be available through the HIV Planning and Coordination website.

f. **Updates to Other Strategic Plans Used to Meet Requirements**
The OCHCA did not use portions of another local strategic plan to satisfy/address Section VI (2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up).

Section VIII: Letters of Concurrence:

1. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)
    a. **See Attachment C**
2. Integrated Planning Body/EHE Planning Body
    a. **See Attachment B**

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

1. **See Attachment D**

Attachment A

HIV Prevention, Care and Treatment Resource Inventory																																									
Funding Source	**Estimated 2022 Budget**	**Known Service Providers***	**Core Medical-related Services**	Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management, including Treatment Adherence Services	Substance Abuse Care	**Supportive Services**	Non-Medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	**HIV Testing and Prevention**
	Dollar Amount																																								
Part A / MAI	$6,721,441 [1]	17th St Clinic, APAIT, LBCC, PLC, RHC, Shanti OC, Various Dental Providers		x			x	x	x		x		x	x	x			x		x	x		x	x		x	x		x										
Part B	$2,295,489 [1]	17th St Clinic, County Jails		x	x			x						x	x			x									x		x										
Part C	$689,024 [1]	17th St Clinic, Various Dental Providers		x			x	x							x			x												x									
Part D	$139,246 [2]	AltaMed		x																							x												
Part F	$226,940 [2]	UCI - AETC																																						
CDC PREVENTION	$1,454,685 [2]	17th St Clinic, APAIT, County Jails, The LGBT Center, RHC																				x																		x
SAMHSA	$807,354 [2]	APAIT														x														x									

Funding Source	Estimated 2022 Budget	Known Service Providers*	Core Medical-related Services	Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management, including Treatment Adherence Services	Substance Abuse Care	Supportive Services	Non-Medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	HIV Testing and Prevention
	Dollar Amount																															
HOPWA	$841,041 [2]	APAIT, RHC													x					x			x								x	
STATE/ LOCAL	$1,624,581 [2]	Numerous providers including non-RW providers			x								x					x			x		x				x					
CDC EHE (Component A and C)	$1,503,239	17th St Clinic, RHC																														x

Funding Source	Estimated 2022 Budget	Known Service Providers*	**Core Medical-related Services**	Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program Treatments	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium and Cost-Sharing Assistance for Low-Income Individuals	Home Health Care	Home and Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management, including Treatment Adherence Services	Substance Abuse Care	**Supportive Services**	Non-Medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home Delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	**HIV Testing and Prevention**
	Dollar Amount																															
HRSA EHE (HRSA 20-078 and HRSA 22-104)	$2,514,084[2]	17th St Clinic, RHC, Shanti OC, Korean Community Services, Inc., North Orange County Regional Health Foundation, St. Jude Neighborhood Health Centers, Nhan Hoa Comprehensive Health Care Center		x									x		x																	x
CARES Act	$60,191[1]	APAIT, RHC																					x									

[1] Amounts listed are funds awarded for FY22.
[2] Amounts listed are the most recent funds available, based on FY21.
*Other providers may have direct funding which the County is not aware of.

Attachment B

Darby Osnaya
Orange County Integrated Plan Committee
Co-Vice Chair

Zixia Wang
Orange County Integrated Plan Committee Co-Vice Chair

P.O. BOX 6009
SANTA ANA, CA 92706-0099
VOICE: (714) 834-8399
FAX: (714) 834-8270
E-Mail: MGarcia@ochca.com

October 19, 2022

Babak Yaghmaei, MPH
Public Health Analyst
U.S. Department of Health & Human Services
Health Resources & Services Administration
HIV/AIDS Bureau
Division of Metropolitan HIV/AIDS Program

Dear Mr. Yaghmaei:

The Integrated Plan Committee (IPC), a committee of the Orange County HIV Planning Council, is the designated Integrated HIV Prevention and Care Plan and Ending the HIV Epidemic (EHE) Steering Committee. IPC was tasked with leading the development, monitoring, and evaluation of the Integrated HIV Prevention and Care Plan and concurs with the following submission of the Orange County Health Care Agency in response to the guidance set forth for health departments and HIV planning groups funded by the Health Resources Services Administration's (HRSA) HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

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

The approach to developing the 2022-2026 Integrated HIV Prevention and Care Plan included a combination of updating the previously submitted plan (2017-2021), integrating sections of Orange County's Ending the HIV Epidemic (EHE) Plan, incorporating feedback from key stakeholders, including HIV Client Advocacy Committee members, community members, including individuals from priority populations, community partners, , and service providers through meetings, surveys, focus groups, and other methods.

The 2017-2021 Integrated HIV Prevention and Care Plan document was used as a foundation for the 2022-2026 Integrated HIV Prevention and Care Plan and most current data was used to update the plan. In addition, Orange County's most current epidemiological profile (2021), NHAS for Orange County, and components of the situational analysis submitted with Orange County's EHE plan were used to develop new material and meet submission requirements.

The signature(s) below confirms the concurrence of IPC with the Integrated HIV Prevention and Care Plan.

Sincerely,

Zixia Wang

Darby Osnaya
Co-Vice Chair
Orange County
Integrated Plan Committee

Zixia Wang
Co-Vice Chair
Orange County
Integrated Plan Committee

Attachment C

John Paquette
Orange County HIV Planning Council
Chair

Fernando Martinez
Orange County HIV Planning Council
Vice Chair

P.O. BOX 6009
SANTA ANA, CA 92706-0099
VOICE: (714) 834-8399
FAX: (714) 834-8270
E-Mail: MGarcia@ochca.com

November 9, 2022

Babak Yaghmaei, MPH
Public Health Analyst
U.S. Department of Health & Human Services
Health Resources & Services Administration
HIV/AIDS Bureau
Division of Metropolitan HIV/AIDS Program

Dear Mr. Yaghmaei:

The Orange County HIV Planning Council (Council) concurs with the following submission by the Orange County Health Care Agency in response to the guidance set forth for health departments and HIV planning groups funded by the HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

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

The Integrated Plan Committee (IPC), a subcommittee of the Council, led the development of the current Integrated HIV Prevention and Care Plan (2022-2026). The Council worked closely with the IPC and provided on-going feedback to ensure the plan was reflective of Orange County HIV prevention and care needs.

The approach to developing the 2022-2026 Integrated HIV Prevention and Care Plan included a combination of updating the previously submitted plan (2017-2021), integrating sections of Orange County's Ending the HIV Epidemic (EHE) Plan, incorporating feedback from key stakeholders, including HIV Client Advocacy Committee members, community members, including individuals from priority populations, community partners, and service providers through meetings, surveys, focus groups, and other methods.

The 2017-2021 Integrated HIV Prevention and Care Plan document was used as a foundation for the 2022-2026 Integrated HIV Prevention and Care Plan and most current data was used to update the plan. In addition, Orange County's most current epidemiological profile (2021), National HIV/AIDS Strategy (NHAS) for Orange County, and components of the situational analysis submitted with Orange County's EHE plan were used to develop new material and meet submission requirements. Lastly, Council had a representative on the California Planning Group (CPG) to ensure the Integrated Plan for 2022-2026 complements the State Office of AIDS 2022-2026 Statewide Integrated Strategic (Ending the Epidemics) Plan.

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

Sincerely,

John Paquette

Chair, Orange County HIV Planning Council

Attachment D

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material	N/A	Page 1	*N/A*
a. Approach	New Material	N/A	Page 1	N/A
b. Documents Submitted to Meet Requirements	New Material	N/A	Page 2	N/A
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material	N/A	Page 2	N/A
a. Entities Involved in Process	New Material	N/A	Pages 2-4	N/A
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	N/A	Page 5	N/A
c. Role of Planning Bodies and Other	New Material	N/A	Pages 5-6	N/A

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Entities				
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material	N/A	Page 6	N/A
e. Engagement of People with HIV – SCSN Requirement	New Material	N/A	Pages 6-7	N/A
f. Priorities	New Material	N/A	Pages 7-10	N/A
g. Updates to Other Strategic Plans Used to Meet Requirements	New Material	N/A	Page 10	N/A
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material	N/A	Pages 10-13	N/A
2. Epidemiologic Snapshot	New Material	N/A	Pages 13-27	N/A
3. HIV Prevention Care and Treatment Resource Inventory	New Material	N/A	Pages 27-29	Attachment A
a. Strengths and Gaps	New Material	N/A	Pages 27-28	N/A
b. Approaches and Partnerships	New Material	N/A	Page 29	N/A
4. Needs Assessment	New Material	N/A	Pages 29-35	N/A
a. Priorities	New Material	N/A	Page 35	N/A

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
b. Actions Taken	New Material	N/A	Pages 36-37	N/A
c. Approach	New Material	N/A	Page 38	N/A
Section IV: Situational Analysis				
1. Situational Analysis	New Material	N/A	Pages 39-55	N/A
a. Priority Populations	New Material	N/A	Pages 39-55	N/A
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	New Material	N/A	Pages 56-70	N/A
a. Updates to Other Strategic Plans used to Meet Requirements	New Material	N/A	Page 56	N/A
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow				

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Up				
1. 2022-2026 Integrated Planning Implementation Approach	New Material	N/A	Page 71	N/A
a. Implementation	New Material	N/A	Pages 71-72	N/A
b. Monitoring	New Material	N/A	Page 72	N/A
c. Evaluation	New Material	N/A	Page 73	N/A
d. Improvement	New Material	N/A	Pages 73-74	N/A
e. Reporting and Dissemination	New Material	N/A	Page 74	N/A
f. Updates to Other Strategic Plans Used to Meet Requirements	New Material	N/A	Page 74	N/A
Section VII: Letters of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	Choose an item.	N/A	N/A	N/A
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or	New Material	N/A	Pages 83-84	Attachment C

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Representative(s)				
3. RWHAP Part B Planning Body Chair or Representative	Choose an item.	N/A	N/A	N/A
4. Integrated Planning Body	New Material	N/A	Pages 80-81	Attachment B
5. EHE Planning Body	New Material	N/A	Pages 80-81	Attachment B