

Office of AIDS FY2009-2010 Budget Planning and Stakeholder Surveys

EXECUTIVE SUMMARY of KEY DECISIONS 8.5.09 (Minor Corrections 8.12.09)

This document describes the Office of AIDS (OA) programmatic and operational plans in the context of the budget for FY2009-2010 which:

- Preserves \$7.65 million general fund for HIV/AIDS surveillance activities
- Eliminates general fund for all testing, prevention, care and support programs
- Reduces ADAP general fund by \$25.5 million and backfills with Special (rebate) Fund to sustain current program

OA's contingency planning began immediately following the Governor's May Revision proposal and has included internal and external input, including surveys that were sent to approximately 850 stakeholders. Survey results are summarized in the document, following this Executive Summary.

SURVEILLANCE

Decisions

1. Eliminate funding to contractors for all special epidemiological studies (FY08-09 level: \$730,374)
 - o All work to complete legislatively mandated reports will be completed in-house (Governor's SB1159 evaluation)
2. Eliminate funding to contract providing epidemiological support from graduate student researchers (FY08-09 level: \$360,199)
3. Redirect Federal funding that has previously supported 1 LHJ-based surveillance coordinator to strengthen surveillance state-wide.
4. Reduce frequency of surveillance reports (posted to the OA Web site) from monthly to quarterly
5. Cancel routine surveillance site visits. OA staff will still be available to complete site visits that are requested by the LHDs or are deemed important based upon OA quality assurance findings.

Epidemiologic Studies/Surveillance

Program/Project Description	FY 2008/09			FY 2009/10		
	GF	FF	TOTAL	GF	FF	TOTAL
<i>Core, Incidence, and Secondary Surveillance Activities</i>						
Active Surveillance contract with LHJs	\$ 7,560,427		\$ 7,560,427	\$ 7,560,427	\$ -	\$ 7,560,427
Enhanced Perinatal Surveillance	\$ 200,000		\$ 200,000	\$ -	\$ -	\$ -
Core Surveillance - coordination of data collection, analysis, and interpretation	\$ 160,199	\$ 131,457	\$ 291,656	\$ -	\$ 130,242	\$ 130,242
HIV Incidence Surveillance - coordination of data collection, analysis, and interpretation		\$ 144,294	\$ 144,294	\$ -	\$ 130,802	\$ 130,802
National HIV Behavioral Surveillance		\$ 369,404	\$ 369,404	\$ -	\$ 369,404	\$ 369,404
Medical Monitoring Project		\$ 649,114	\$ 649,114	\$ -	\$ 649,114	\$ 649,114
<i>Special Epi Studies</i>						
Barriers to Care Study	\$ 80,374		\$ 80,374	\$ -	\$ -	\$ -
SB1159/Pharmacy Sale of Syringes Study (Syringe Discard Trial)	\$ 150,000		\$ 150,000	\$ -	\$ -	\$ -
SYNC (Studies in Youth in Northern California)	\$ 300,000		\$ 300,000	\$ -	\$ -	\$ -
Specialized support epidemiological studies	\$ 150,000		\$ 150,000	\$ -	\$ -	\$ -
<i>Other activities</i>						
ARIES network hosting (data system to support HRSA reporting and QA)	\$ 50,000		\$ 50,000	\$ 50,000	\$ -	\$ 50,000
EHARS network hosting (data system to support Surveillance reporting)				\$ 40,573	\$ -	\$ 40,573
<i>Excess federal authority - no actual grant funds</i>		\$ 283,731	\$ 283,731	\$ -	\$ 298,438	\$ 298,438
Total	\$ 8,651,000	\$ 1,578,000	\$ 10,229,000	\$ 7,651,000	\$ 1,578,000	\$ 9,229,000

SUBTOTAL - EPI AND SURVEILLANCE PORTFOLIO	\$ 8,651,000	\$ 1,578,000	\$ 10,229,000
--	---------------------	---------------------	----------------------

\$ 7,651,000	\$ 1,578,000	\$ 9,229,000
---------------------	---------------------	---------------------

Proportion of FY 2008/09 total

90%

CARE

Available Funding

- Proposed overall support and local assistance = \$3.8 million (11%) and \$29.4 million (89%) respectively
- HRSA Part B Grant funding for local assistance allocations (Part B: approximately \$27 million)
- HRSA Minority AIDS Initiative funding (MAI: approximately \$890,000)
- AIDS Medi-Cal Waiver Program (Fee for Service)
- HUD Housing Opportunities for Persons with AIDS Program (HOPWA; approx \$3.5 million)

Decisions

Continue

1. HOPWA Program will continue to be administered by OA as a stand alone program and will not be included in the Care Program Model at this time.
2. AIDS Medi-Cal Waiver Program will continue to be administered by OA.

Modify

1. OA will eliminate the following *stand-alone* programs, but, to the extent possible using HRSA service categories, *support the types of services they provide* through the “Care Program Model” described below: Early Intervention Program (EIP) and the associated Positive Changes, Bridge Project and Pathways; Therapeutic Monitoring Program (TMP), Case Management Program (CMP), Care Services Program (CSP) and Residential Licensed Facilities Program (RALF).
 - a. OA is in the process of planning for close-out of the 100% General Funded Programs; TMP vouchers will no longer be valid after August 14, 2009.
2. OA will allocate FY 09/10 Part B and MAI funds to be used in a unified Care Program Model, utilizing a Single Allocation Model (SAM)
3. Care Program Model:
 - a. The Care Program Model is based upon HRSA-defined service categories.
 - b. OA will not require local utilization of the HRSA 75/25 requirement for prioritization of services,
 - c. The Care Program Model will include a two tiered approach to service prioritization.
 - a. The Care Program Model prioritizes Outpatient/Ambulatory Medical Care as a Tier One service.
 - b. Tier Two services support access to Tier One care, maintenance in Tier One care, and reduce the risk of treatment failure. To provide the greatest flexibility to local providers, the following HRSA service categories are included in Tier Two of the Care Program Model at this time.
 - c. Potential refinement and development of a third tier will be considered in the future, in collaboration with stakeholders

- | | |
|--|--|
| • Mental Health Services | • Treatment Adherence Counseling |
| • Medical and non-Medical Case Management (no cap) | • Health Insurance Premium and Cost Sharing Assistance |
| • Oral Health Care | • Home and Community Based Health Services |
| • AIDS Pharmaceutical Assistance | |

- Substance Abuse Services – Outpatient and Residential
- Health Education/Risk Reduction
- Home Health Care
- Hospice
- Outreach Services
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation Services
- Psychosocial Support Services
- Medical Nutrition Therapy
- Early Intervention Services
- Referral for Health Care/Supportive Services
- Rehabilitation Services
- Respite Care
- Child Care Services

- d. Eligibility for specific services will be determined at the local level by agency staff
- e. OA is in the process of developing Care Program Model Guidelines to provide contracting agencies with detailed guidance regarding the implementation and administration of the Care Program Model using the SAM. The preliminary Program Guidelines will be made available in written form and on the OA website no later than August 17, 2009.

4. SAM Implementation: SAM is an administratively streamlined model for providing OA's care and support funding, currently limited to HRSA Part B and MAI funds, to local partners by contracting with a single fiscal agent. Due to the specific needs and capacity at the county level, OA anticipates contracting with either the local health department or a community based organization, depending upon which is the most appropriate single fiscal agent in a given jurisdiction.

- a. As soon as this plan receives CDPH approval, OA will begin to implement SAM in those counties or regions that are ready to transition. The following 19 counties have an appropriate single fiscal agent that is a current OA contractor, and have been determined by OA to be able to readily transition to SAM:

- | | | |
|------------|------------|--------------|
| • Imperial | • Plumas | • San Luis |
| • Inyo | (including | Obispo |
| • Kern | Lassen, | • Santa Cruz |
| • Kings | Modoc, | • Solano |
| • Madera | Sierra and | • Tulare |
| • Merced | Siskiyou) | • Ventura |
| • Mariposa | • San | |
| • Mono | Joaquin | |

- b. OA has 39 identified counties that cannot be immediately transitioned to the SAM due to the complex mix of health departments and community based organizations that are direct OA care program contractors or because existing contractors provide services in multi-county regions and the primary contracting county must be designated. OA will begin working with these counties as soon as this plan receives CDPH approval to

develop plans for transitioning counties to the SAM. Final date for transition of these counties or regions to the SAM will be determined by OA and the local contracting agencies. During the transition period, OA will provide an adjusted FY 09/10 funding allocation through existing contract or contracts as determined by OA and the participating agencies.

- Santa Clara
- Fresno
- Humboldt, Del Norte
- Los Angeles EMA (and Long Beach LHJ)
- Mendocino
- Monterey
- San Benito
- Napa
- Oakland TGA (Alameda, Contra Costa)
- Orange County TGA
- San Diego EMA
- San Francisco EMA (Marin, San Francisco, San Mateo)
- Santa Barbara
- Inland Empire TGA (San Bernardino, Riverside)
- Sacramento TGA (Sacramento, Yolo, El Dorado, Alpine, Placer, Nevada)
- Stanislaus (Tuolumne)
- Butte Group (Butte, Colusa, Glenn, Shasta, Sutter, Trinity, Tehama, Yuba)
- Calaveras, Tuolumne, Amador
- Sonoma
- Lake

- c. OA is in the process of finalizing the logistics for implementing SAM, to include the alignment of HRSA and state fiscal years, and anticipates providing preliminary written SAM guidance to local contractors as soon as this plan receives CDPH approval.

5. Care Program Model Funding Allocation Process¹.

OA will allocate **approximately** \$26,800,000 in FY 09/10 HRSA Part B and MAI funding to fiscal agents including health departments and, when appropriate, CBOs. OA will utilize the existing Care Services Program (CSP) formula as the basis for allocating funds and will implement provisions to provide as much equity and stability of funding allocations as possible across all regions of California. The allocations will be provided to contracting agencies and County AIDS Directors as soon as this plan receives CDPH approval.

- a. The allocation formula is based upon the following factors initially developed by the Resource Allocation Committee of the California HIV Planning Group (CHPG) for allocation funding through the Care Services Program:
- Living AIDS cases – prevalence and incidence data
 - Census data
 - Persons per square mile
 - Non-English speaking
 - Persons below poverty level
 - People of color

¹ See Appendix for Care Program Model Allocation Table

- Medi-Cal HIV positive beneficiaries with one or more claims for HIV-specific medications
- ADAP clients

b. The following provisions will be implemented for equity and stability of funding:

No Case Counties:

Step One: The following 1 county, with no reported HIV or AIDS cases and no record of ADAP access, will not receive an allocation of Care Program funding: Alpine

Floor County Allocations:

Step Two: Counties with fewer than six reported HIV and/or AIDS cases and demonstrated low or no utilization of HIV services will receive a floor amount of \$7,500. Many of these counties have already developed a partnership with contiguous counties in developing a regional approach to the delivery of HIV services. OA will assist in supporting the floor counties within these regional partnerships by developing minimal administrative processes and reporting requirements for the floor counties. 7 floor counties are:

Colusa	Modoc	Sierra
Inyo	Mono	Trinity
Mariposa		

Formula Funded Counties:

The remaining 50 counties will receive a formula funding allocation through the Care Program Model formula. The following stabilization measures will be undertaken to adjust the formula funding for distribution of funds throughout all regions of California. Utilization of a 70% cap and 35% hold harmless provision will restrict funding allocations to the range between 35% and 70% of the combined pre-budget-reduction allocation to each county, resulting in county allocations averaging 50% of former allocations. These levels will be reevaluated and adjusted each year with the goal of eliminating the need for both of these provisions while maintaining some level of stability.

Funding Cap:

OA will implement a 70% funding cap, which is a **maximum** funding level placed on each county allocation of Care Program Model funding, set at 70% of the pre-budget-reduction allocation of the combined funds provided through EIP, TMP, Bridge, Positive Changes, CSP, CMP and Pathways.

Hold Harmless Provision:

Counties throughout California received allocations through General Funded programs, such as EIP and CMP, primarily due to the availability of specific General Fund sources targeting people of color, women, rural sites, etc. These counties are now especially hard hit by the elimination of the long-time allocation of state funding. To equalize the funding levels across all regions of the state, OA will implement a hold harmless provision, which is a **minimum** funding level placed on each county allocation of Care Program Model funding at 35% of the pre-budget-reduction allocation of the combined funds provided through EIP, TMP, Bridge,

Positive Changes, CSP, CMP and Pathways.

Step Three: The funds for all counties receiving in excess of 70% of their pre-budget amount are capped at 70%; funds over the 70% level are returned for redistribution to hold counties harmless. The seventeen counties impacted by the funding cap:

Amador	Merced	Sutter
Del Norte	Placer	Tehama
Glenn	San Benito	Tuolumne
Kern	San Francisco	Yolo
Lake	Shasta	Yuba
Lassen	Siskiyou	

Step Four: Application of the 35% hold harmless provision. The following fifteen counties were allocated funds based at 35% of their original allocation from previously funded care programs.

Butte	Monterey	Santa Barbara
Calaveras	Nevada	Santa Cruz
Humboldt	Plumas	Sonoma
Imperial	San Luis Obispo	Stanislaus
Mendocino	San Mateo	Ventura

Step Five: The remaining funds resulting from placing a cap or hold harmless provisions in Step Three and Four are redistributed to the 18 counties below. The following 18 counties' formula amounts were between the established 35% - 70% range:

Alameda	Madera	San Bernardino
Contra Costa	Marin	San Diego
El Dorado	Napa	San Joaquin
Fresno	Orange	Santa Clara
Kings	Riverside	Solano
Los Angeles	Sacramento	Tulare

Leveraging additional care and support resources:

OA is committed to leveraging all available resources to enhance and expand the existing funding available to OA and to the local HIV service agencies and other partners. OA staff will collaborate with the independent, federally-funded Pacific AIDS Education and Training Center (PAETC), the California Chapter of the American Academy of HIV Medicine (AAHIVM) and other partners to help address the resource gaps experienced throughout the state, with special focus in the jurisdictions that were disproportionately impacted by the funding reductions.

6. Reduce CSTEP contract - training for benefits counseling (not treatment education)

Eliminate

1. Eliminate Residential AIDS Licensed Facilities Program (RALF) effective June 30, 2009
2. Eliminate Pacific AIDS Education and Training Center contract
3. Eliminate "Reconnect" pilot contract

Early Intervention					
Program/Project Description	FY 2008/09			FY 2009/10	
	GF	FF	TOTAL		
<i>Local services for persons living with HIV/AIDS</i>					
Early Intervention Programs (medical care)	\$ 7,140,000	\$ 6,880,023	\$ 14,020,023	\$ -	\$ -
<i>Support for local services for persons living with HIV/AIDS</i>					
Treatment Education Training	\$ 210,000		\$ 210,000	\$ -	\$ -
Provider Training, Education, and Support	\$ 83,000	\$ 102,977	\$ 185,977	\$ -	\$ -
Total	\$ 7,433,000	\$ 6,983,000	\$ 14,416,000	\$ -	\$ -

See CPM

Therapeutic Monitoring Program					
Program/Project Description	FY 2008/09			FY 2009/10	
	GF	FF	TOTAL		
<i>Local services for persons living with HIV/AIDS*</i>					
Resistance Testing	\$ 1,230,000		\$ 1,230,000	\$ -	\$ 800,000
Viral Load Testing	\$ 5,350,000		\$ 5,350,000	\$ -	\$ -
<i>Unallocated</i>	\$ 1,274,446		\$ 1,274,446	\$ -	\$ -
<i>Support for local services for persons living with HIV/AIDS</i>					
Fiscal and Laboratory Services	\$ 145,554		\$ 145,554	\$ -	\$ -
Total	\$ 8,000,000	\$ -	\$ 8,000,000	\$ -	\$ 800,000

See CPM

*FY 2009/10 allocation is for vouchers distributed for July 2009

Housing					
Program/Project Description	FY 2008/09			FY 2009/10	
	GF	FF	TOTAL		
<i>Local services for persons living with HIV/AIDS</i>					
RALF Program (bed nights residential care/skilled nursing)	\$ 958,000		\$ 958,000	\$ -	\$ -
Sonoma County Pilot project: Resource Identification	\$ 100,000		\$ 100,000	\$ -	\$ -
Housing Opportunities for Persons with AIDS (HOPWA) Program		\$ 3,540,000	\$ 3,540,000	\$ -	\$ 3,540,000
<i>Support for local services for persons living with HIV/AIDS</i>					
Training for housing providers	\$ 35,000		\$ 35,000	\$ -	\$ -
Total	\$ 1,093,000	\$ 3,540,000	\$ 4,633,000	\$ -	\$ 3,540,000

Home and Community Based Care					
Program/Project Description	FY 2008/09			FY 2009/10	
	GF	FF	TOTAL		
<i>Local services for persons living with HIV/AIDS</i>					
Case Management Program (CMP)	\$ 6,327,000	\$ 5,426,000	\$ 11,753,000	\$ -	\$ -
Total	\$ 6,327,000	\$ 5,426,000	\$ 11,753,000	\$ -	\$ -

See CPM

CARE/HIPP					
Program/Project Description	FY 2008/09			FY 2009/10	
	GF	FF	TOTAL		
Private health insurance premium payments		\$ 1,700,000	\$ 1,700,000	\$ -	\$ 1,700,000
Total	\$ -	\$ 1,700,000	\$ 1,700,000	\$ -	\$ 1,700,000

Care Services					
Program/Project Description	FY 2008/09			FY 2009/10	
	GF	FF	TOTAL		
<i>Local services for persons living with HIV/AIDS</i>					
Medical care and support services contracts with LHJs and CBOs		\$ 14,143,378	\$ 14,143,378	\$ -	\$ -
HRSA allocation for Emergency Communities				\$ 165,082	\$ 165,082
Excess federal budget authority - no actual grant funds		\$ 1,029,622	\$ 1,029,622	\$ -	\$ -
<i>Support for local services for persons living with HIV/AIDS</i>					
ARIES (data system to support HRSA reporting and QA)		\$ 1,015,020	\$ 1,015,020	\$ -	\$ 1,208,000
Benefits Counseling Training	\$ -	\$ -	\$ -	\$ -	\$ 200,000
Statewide Community Planning/Care		\$ 293,980	\$ 293,980	\$ -	\$ 200,000
Total	\$ -	\$ 16,482,000	\$ 16,482,000	\$ -	\$ 1,773,082

See CPM

Care Allocation for Local Health Jurisdictions					
Care Program Model in Local Health Jurisdictions				\$ -	\$ 26,800,000
Total				\$ -	\$ 26,800,000

*Required activity in our HRSA grant that can not be redirected

SUBTOTAL - CARE AND SUPPORT PORTFOLIO	\$ 22,853,000	\$ 34,131,000	\$ 56,984,000	\$ -	\$ 34,613,082
--	----------------------	----------------------	----------------------	-------------	----------------------

Proportion of FY 2008/09 total 61%
 Proportion of FY 2008/09 total, excluding Housing 59%

PREVENTION

Definitions

- “Higher HIV/AIDS burden LHJs” refers to those 17 LHJs that were allocated at least 1% of the total of the combined Education and Prevention (E&P) and Counseling and Testing (C&T) funding distributed by OA in FY 2008-2009. 93% of the total population of reported living cases of AIDS (92.3%) and HIV (94.3%) were reported in these LHJs (as of December, 2008).
- The remaining 44 LHJs, for the purpose of this document are referred to as “lower HIV/AIDS burden LHJs.”

Available Funding

- Proposed overall support and local assistance = \$2.98 million (21%) and \$11.11 million (79%) respectively
- CDC Prevention Grant funding for local assistance allocations and centralized core services (\$9.73 million)

Decisions – Funding of Core/Centralized Services (Note, for each core/centralized service funded, fewer resources will be available for distribution to LHJs and CBOs to provide direct service.)

Continue but reduce funding

1. Continue to provide rapid HIV test kits for higher burden LHJs only, with the exception noted below (estimated cost, \$750,000).
 - a. Testing sites in lower-burden LHJs that currently perform ≥ 100 tests per year and have a positivity rate of $\geq 1\%$ (the historical statewide average) will continue to receive rapid test kits (approximately 10 sites in 8 LHJs)
 - b. OA will pursue strategies to control rapid test kit costs including: provision of technical assistance about billing insurance, consideration of charging using a sliding scale, and eligibility requirements for free testing.
 - c. OA will continue to negotiate test kit pricing agreements, including consideration of additional products (in light of pending legislation that would support greater use of less expensive finger-stick rapid testing should this legislation be enacted).
2. Provide educational materials and condoms to *all* requesting LHJs, bringing distribution in-house and eliminating contract with CA AIDS Clearinghouse (estimated cost \$225,000 for FY 09-10 since OA currently has adequate condom inventory for FY 09-10, then \$300,000 annually)
3. Fund scaled back, flexible, HIV test counselor training (to be developed) and reduce or eliminate funding to contractor UCSF/AHP for these activities (estimated cost, \$350,000).
4. Provide \$1.2 million to STD Control Branch (STDCB) to support Partner Services (PS) in the 17 high burden LHJs². The dollars expended on PS represent approximately 12% of the total local assistance grant dollars and approximately 16.5% of the resources available for prevention interventions at the local level (as opposed to core services). The distribution of dollars to each LHJ and the degree of direct versus supervisory state support is dependent on the current PS infrastructure in each LHJ.

² See Appendix for associated PS funding distribution and program spreadsheet

- a. Although funding LA and SF will reduce PS funds to the 15 other higher burden LHJs an average of 25%, this approach will decrease destabilization of PS activities to the 2 directly funded LHJs.
5. Continue but reduce funding for Telephone Hotline through contractor SFAF (cost, \$200,000).

Subtotal core expenses = \$2.725 million

Continue in house, no funding

6. Bring development and maintenance of HIV CHOICE website in-house and eliminate funding to STDCB/PTC.
7. Program performance data performed by OA staff, requiring no additional resource allocation.
8. Continue development of LEO for Los Angeles and maintenance of LEO overall with existing QA staff including 2 recently hired programmers. Development of LEO for Los Angeles could be delayed due to lack of additional resources from ITSD.

Eliminate

9. Eliminate continuing education training (CET) requirements and eliminate funding to contractor
10. Eliminate funding for ongoing CHRP Research projects. CHRP may decide to continue funding one or more of these studies based upon their progress to date and available CHRP funds.
11. Eliminate specific funding for NIGHT. General Fund is required to receive the Medi-Cal matching funds. Also, HIV positivity rates in NIGHT testing have been lower than the non-Night testing in the 21 NIGHT LHJs (FY 05/06 non-NIGHT 1.2% vs. NIGHT 0.8%, FY 06/07 non-NIGHT 1.3% vs. NIGHT .0.9% and FY 07/08 non-NIGHT 1% vs. NIGHT 0.7%). With OA approval, LHJs with productive NIGHT programs may use their prevention and testing allocation funds for NIGHT activities.
12. Eliminate OA support of Prevention Trainings through PTC, leaving only CDC-funded training options
13. Do not renew recently expired Latino focused HIV capacity building contract (Project Concern International)
14. Eliminate African American focused HIV capacity building contract with On-Track Program Resources
15. Eliminate Syringe related HIV capacity building contract with Harm Reduction Coalition
16. Eliminate SEP contracts. If federal ban is lifted, LHJ allocations may be used to support SEPs.
17. Eliminate Transgender focused capacity building through Transgender Center of Excellence contract
18. Eliminate funding for Men's Wellness Center (Los Angeles)
19. Eliminate funding for rapid research support through UCLA contract
20. Eliminate funding for C&T Opt-Out study and complete in-house

Decisions – Funding Provided to LHJs

1. All interventions outlined in survey will be allowable (described in this report). LHJs will decide how they want to prioritize HCV testing with their allocation. OA will not create tiered system of interventions. However, a refined tiers concept will be considered in the future. Allowable interventions include:

- HIV Testing (with/without counseling)
- Prevention with Positives (PwP) in Care and non-Care settings
- CDC-DEBI and non-DEBI Behavioral Interventions
- Hepatitis C (HCV) Testing
- Syringe Exchange Programs (only if Federal Ban lifted)

2. Adopt the revised allocation formula.

The current formula is:

- 70%: # new HIV infections identified through C&T (3 year period) plus the total number of living AIDS cases
- 15%: # male syphilis, gonorrhea and Chlamydia cases combined (1 year period)
- 7%: # people of color (US Census)
- 8%: # people living below poverty (US Census)

The revised formula is:

- 20%: # new HIV infections identified through C&T (3 year period)
- 20%: # newly reported HIV cases (3 year period)
- 20%: # living AIDS cases
- 7.5%: # male syphilis cases (1 year period)
- 7.5%: # male gonorrhea cases (1 year period)
- 15%: # African Americans (Non-Hispanic) (US Census)
- 5%: # Hispanics(US Census)
- 5%: # people living below poverty (US Census)

3. The proposal to require LHJ to certify (without providing documentation) that a weighted proportion of OA funds had been directed to services for African Americans is strongly supported by OA. LHJs would be certifying that they spend prevention allocation dollars on prevention interventions focused on African Americans (AA) in proportion greater or equal to 2 times the proportion of living AA male HIV/AIDS cases in their jurisdiction.

a. LHJs may request a waiver from OA.

4. Implement Funding Allocation Alternative #2 to maximize resources in the 17 most highly impacted jurisdictions in CA, taking into account the availability of direct CDC funding to LA and SF, while attempting to lessen destabilization to LA and SF that would result if no state CDC funding was allocated³.

b. Under this allocation, only the 17 higher HIV/AIDS burden LHJs would receive funding, thus there is a clear but unavoidable negative impact on the lower burden LHJs.

c. The directly funded LHJs, LA and SF, will be allocated half of their new formula allocation and the remaining half will be redistributed among the remaining 15 higher impact LHJs. Based upon allocation estimates of [approximately](#) \$7 million of CDC funding, the 15 LHJs would be allocated [approximately](#) 46% of their combined C&T and E&P allocation from 2008-09 (range: \$87,500 to \$1.08 million). LA would be allocated 18% of their prior allocation (\$1.2 million) and SF would be allocated 14% of their prior allocation (\$434,300).

³ See Appendix for 2 associated Prevention Allocation Tables

- i. Note that in FY2007-08, CDC directly funded LA approximately \$12 million and SF approximately \$5.8 million. When comparing this allocation to the hypothetical allocation resulting from applying the State allocation formula to the combined total CDC resources provided to the State, LA and SF (\$24.8 million), accounting for 25% overhead for LA and SF to administer their direct funds, LA and SF are still allocated more than they would be if all funds were allocated based upon the State formula only (\$1.5 million and \$1.7 million, respectively)⁴.
- d. The total dollars available for this allocation will depend on the total spent on core services and on redirection of salary and other overhead to program activities. These are described above and are subject to revision after CDPH review.

Education and Prevention Programs						
Program/Project Description	FY 2008/09			FY 2009/10		
	GF	FF	TOTAL	GF	FF	TOTAL
Local services for high risk populations						
Contracts with LHJs for Health Education/Risk Reduction through LHJs and CBOs	\$ 18,016,159	\$ 250,000	\$ 18,266,159	\$ -	\$ -	\$ -
Outreach and Prevention Services within Early Intervention Programs (additional funding is noted in the Early Intervention category below)	\$ 1,219,832	\$ 1,181,478	\$ 2,401,310	\$ -	\$ -	\$ -
Syringe Exchange Programs	\$ 1,175,000		\$ 1,175,000	\$ -	\$ -	\$ -
Los Angeles Men's Wellness Center	\$ 250,000		\$ 250,000	\$ -	\$ -	\$ -
Partner Services		\$ 654,909	\$ 654,909	\$ -	\$ 1,200,000	\$ 1,200,000
Rapid HIV testing in Labor & Delivery		\$ 534,197	\$ 534,197	\$ -	\$ 534,197	\$ 534,197*
Hemophilia Council	\$ 300,000		\$ 300,000	\$ -	\$ -	\$ -
Support for local services for high risk populations						
Technical Assistance - IDU/Syringe Exchange	\$ 200,000		\$ 200,000	\$ -	\$ -	\$ -
Technical Assistance and Capacity Building - LHJs	\$ 600,000		\$ 600,000	\$ -	\$ -	\$ -
Technical Assistance and Capacity Building - Transgender Communities	\$ 200,000	\$ 150,000	\$ 350,000	\$ -	\$ -	\$ -
Technical Assistance and Capacity Building - African American Communities	\$ 100,000	\$ 600,000	\$ 700,000	\$ -	\$ -	\$ -
Technical Assistance and Capacity Building - Latino Communities	\$ 150,000	\$ 200,000	\$ 350,000	\$ -	\$ -	\$ -
Statewide Community Planning/Prevention	\$ 150,000	\$ 160,000	\$ 310,000	\$ -	\$ 150,000	\$ 150,000
Health Education Materials		\$ 1,200,000	\$ 1,200,000	\$ -	\$ 225,000	\$ 225,000
Prevention Intervention Training						
Outreach	\$ 200,000		\$ 200,000	\$ -	\$ -	\$ -
Prevention with Positives		\$ 446,894	\$ 446,894	\$ -	\$ -	\$ -
Men who have Sex with Men (MSM)		\$ 300,000	\$ 300,000	\$ -	\$ -	\$ -
Group Facilitation		\$ 200,000	\$ 200,000	\$ -	\$ -	\$ -
Comprehensive Risk Counseling and Services		\$ 200,000	\$ 200,000	\$ -	\$ -	\$ -
LEO (data systems to support CDC reporting and Quality Assurance/QA)	\$ 775,000		\$ 775,000	\$ -	\$ -	\$ -
Prevention Research and Evaluation	\$ 1,142,009	\$ 338,522	\$ 1,480,531	\$ -	\$ -	\$ -
SYNC (Studies of Youth in Northern CA; qualitative component)	\$ 150,000		\$ 150,000	\$ -	\$ -	\$ -
Total	\$ 24,628,000	\$ 6,416,000	\$ 31,044,000	\$ -	\$ 2,109,197	\$ 2,109,197

HIV Counseling and Testing Programs						
Program/Project Description	FY 2008/09			FY 2009/10		
	GF	FF	TOTAL	GF	FF	TOTAL
Local services for high risk populations						
Contracts with LHJs for C&T through LHJs and CBOs	\$ 5,794,513	\$ 500,000	\$ 6,294,513	\$ -	\$ -	\$ -
HCV Testing Contracts with LHJs	\$ 408,811		\$ 408,811	\$ -	\$ -	\$ -
NIGHT (outreach to engage people in HIV testing) contracts with LHJs	\$ 1,339,000		\$ 1,339,000	\$ -	\$ -	\$ -
Testing in 3 Bay Area Emergency Departments		\$ 702,691	\$ 702,691	\$ -	\$ 702,691	\$ 702,691*
Support for local services for high risk populations						
HIV Rapid test kits and Lab slips to support C&T contracts	\$ 527,575		\$ 527,575	\$ -	\$ 750,000	\$ 750,000
HIV Testing Counselor and Outreach Training						
HIV Counselor Training		\$ 731,309	\$ 731,309	\$ -	\$ 350,000	\$ 350,000
Outreach Training		\$ 300,000	\$ 300,000	\$ -	\$ -	\$ -
C&T "Opt-Out" study	\$ 155,101		\$ 155,101	\$ -	\$ -	\$ -
Centralized activities						
HIV/AIDS Telephone Hotline (for public)		\$ 300,000	\$ 300,000	\$ -	\$ 200,000	\$ 200,000
Total	\$ 8,225,000	\$ 2,534,000	\$ 10,759,000	\$ -	\$ 2,002,691	\$ 2,002,691

Prevention Allocation to Local Health Jurisdictions			
Prevention in Local Health Jurisdictions			\$ - \$ 7,000,000 \$ 7,000,000
SUBTOTAL - PREVENTION PORTFOLIO	\$ 32,853,000	\$ 8,950,000	\$ 41,803,000
			\$ - \$ 11,111,888 \$ 11,111,888

Proportion of FY 2008/09 total

27%

*Required activities in our CDC grants that cannot be reallocated

⁴ See Appendix for 2 associated Prevention Funding Allocation Tables

Table of Contents

Background, Methods and Survey Response Rates	14
Surveillance	16
<i>Background</i>	16
<i>Survey Respondents</i>	16
<i>Key Implications</i>	17
<i>Detailed Survey Findings</i>	18
Care	25
<i>Background</i>	25
<i>Survey Respondents</i>	25
<i>Key Implications and Next Steps</i>	26
<i>Detailed Survey Findings</i>	30
Prevention	43
<i>Background</i>	43
<i>Survey Respondents</i>	43
<i>Key Implications and Next Steps</i>	44
<i>Detailed Survey Findings</i>	47
Appendix	68
<i>Care</i>	68
<i>Prevention</i>	70

I. Background, Methods And Survey Response Rates

In order to solicit input from its partners regarding contingency planning based upon the proposed FY2009-10 Governor's and Conference Committee's budget proposals, the Office of AIDS developed three surveys and conducted them among two groups of partners. The three surveys requested feedback on contingency planning options for: 1) HIV Care programs; 2) Education and Prevention programs; and 3) Surveillance activities.

The surveys were first distributed to the California Conference of Local AIDS Directors (CCLAD); the two independently funded Surveillance Directors (San Francisco and Los Angeles) also receiving the Surveillance survey. The HIV Care and Education and Prevention surveys were e-mailed out to 66 individuals on Monday, June 22, 2009. The Surveillance survey was e-mailed out 68 individuals on Monday, June 29, 2009. The response rates for these "CCLAD Surveys" are:

• HIV Care	35 respondents/66 recipients = ~ 53%
• Education and Prevention	32 respondents/66 recipients = ~ 48%
• Surveillance	28 respondents/68 recipients = ~ 41%

After analyzing the results from the CCLAD surveys, the Care and Education and Prevention surveys were slightly revised and on Thursday, July 2, 2009 e-mailed out to approximately 900 stakeholders to solicit additional input. The Surveillance survey was significantly revised after CCLAD input, and the revised survey was sent out on Monday, July 6, 2009 to the same 900 stakeholders (which also included the recipients of the CCLAD surveys).

In addition to CCLAD, the following stakeholder groups received all surveys:

Office of AIDS contractors
 California HIV Planning Group (CHPG) members
 CHPG MSM Task Force
 CHPG Women’s Task Force
 CHPG Design Team Community Partners
 ADAP Medical Advisory Committee members
 ADAP Coordinators
 Ryan White/Care Planning Council co-chairs
 Prevention Planning Council co-chairs
 Latino Advisory Board
 Transgender Center of Excellence

California African American HIV/AIDS Coalition and regional co-chairs
 HIV/AIDS Surveillance Directors
 California Conference of Local Health Officers/Communicable Disease Committee Chair
 Visioning Change Initiative (VCI) Planning Group
 California Caucus/VCI
 The Alliance
 American Academy of HIV Medicine – California Board
 CHRP Advisory Council
 Other Interested parties

The response rates for the second round of surveys are:

• HIV Care	67 respondents/658 recipients = ~ 10%
• Education and Prevention	81 respondents/658 recipients = ~ 12%
• Surveillance	46 respondents/658 recipients = ~ 7%

Given that some of our stakeholders may only be engaged in one of the survey areas (i.e., an HIV care contractor may not be well-informed about and interested in responding to the Education and Prevention survey), an unduplicated response rate across all six of the surveys was calculated. This unduplicated response rate counts an individual once even if sh/e responded to three of the surveys, and is a better indicator of the level of response OA received about any of its contingency plans. The response rate is an estimate since some of our initial recipients invited others to also complete one or more of the surveys; however, we believe that only a handful, at most, of our respondents fall in this category. Additionally, our contractor distribution list includes two representatives for many of our contracts, a fiscal contact and a program contact. We assumed that, for the most part, the program representative would respond individually, or possibly collaboratively with their fiscal counterpart, but both would not respond separately.

• There were 178 unduplicated respondents across all 6 surveys, with a response rate of ~ 25% (178/724).
--

II. Surveillance and Epidemiological Studies Contingency Planning Surveys

A. Background

The Case Registry and Epidemiological Studies Sections within OA have the responsibility to coordinate and support HIV/AIDS surveillance data collection state wide as well as quality control, interpret, and disseminate HIV/AIDS surveillance data and supplemental surveillance information at the State level. Thus the Case Registry and Epidemiological Studies Sections of OA are here forward referred to as the 'HIV/AIDS surveillance' or 'Surveillance' Sections. The OA Surveillance Sections work closely with the 61 California local health departments (LHDs) to perform data collection, data quality assurance, data interpretation, and dissemination related to HIV/AIDS case reports and associated laboratory results. The Office of AIDS receives General Fund (GF) support for surveillance activities, most of which is distributed to the LHDs to support collection and management of surveillance data at the LHD level prior to sending that data to OA. The other two activities supported by GF surveillance support have been (a) special epidemiological studies and (b) additional analytic support for the Office of AIDS. Recent Special Epidemiological studies include:

- (1) Study of Youth in Northern California (SYNC)- Multi-county research study exploring behaviors and structural factors associated with non-prescription drug use and sexual risk factors for HIV infection (ended July, 2009).
- (2) Surveillance of Perinatal HIV Transmission- Multi-county surveillance of childbirth outcomes in HIV+ women.
- (3) Study of Barriers to HIV+ patients utilizing care services- Multi-county research study to determine individual and structural correlates of HIV+ individuals who do not receive regular health care.
- (4) State-wide evaluation of California legislation permitting limited sale of syringes (Senate Bill 1159) to reduce risk of injection-mediated HIV transmission (ended June, 2009).

Additional analytic support, provided predominantly by graduate student researchers, includes entry, management, and analysis of data from special epidemiological studies, core surveillance, and supplemental surveillance projects.

B. Surveillance Survey Respondents

Overall, there were 76 respondents representing various OA stakeholder groups including:

- CCLAD/Surveillance Directors (n=28)
- Surveillance Coordinators (n=9)
- OA contractors (n=19)
- Advisory bodies (n=7)
- Advocacy groups (n=7)
- Planning council members (n=20)
- ADAP coordinators (n=3)
- OA staff (n=2)
- Other organizations and affiliations (n=10)

Please note that individuals may be counted in more than one affiliation group. Results were stratified by affiliation (for CCLAD and Surveillance Directors combined, OA contractors including Surveillance coordinators, planning council members, advisory bodies, advocacy groups, and all other stakeholders) for questions that were asked in both surveys.

C. Key Implications

OA has developed the following contingency plans regarding surveillance in the case of General Fund reductions. In some cases (#7 and #8 below), changes have already been instituted:

1. Reductions will first be taken from special epidemiological studies (FY08-09 level: \$730,374)
2. If reductions are more than \$730,374, funding to contracts providing epidemiological support from graduate student researchers, LHJ surveillance support from a community health program representative, a statistical consultant, and a database systems analyst will be reduced (FY08-09 level: \$360,199)
3. If reductions are more than \$1,090,573, OA will reduce the surveillance allocations for counties anticipated to have unexpended surveillance allocations in FY2008-09 if they agree they will not need their current level of surveillance allocation in FY09-10 (following individual discussions with these LHDs to determine any level of surveillance funding that is not needed).
4. If further reductions are necessary, a uniform (percentage) reduction will be applied to all LHD surveillance allocations
5. If further reductions are necessary that are likely to stress the local capacity to perform active surveillance, OA will work with laboratories reporting HIV/AIDS-related tests for California cases to implement direct electronic laboratory reporting to OA. This will form a system of dual lab reporting, with labs reporting both to the LHDs (as required by State regulation) and to OA. This will permit OA to unduplicate lab reports in an automated manner and reduce workload for the LHDs.
6. If further reductions are necessary that are likely to stress the local capacity to perform active surveillance, OA will develop a plan for health care provider education to encourage complete case reporting by health care providers and thus limit the resources LHDs allocate to active surveillance. This strategy will utilize electronic mail, internet, and other efficient communication resources.
7. OA has changed the frequency of surveillance reports (posted to the OA Web site) from monthly to quarterly
8. OA has cancelled routine surveillance site visits, though OA staff will still be available to complete site visits that are requested by the LHDs or are deemed important based upon OA quality assurance findings
9. OA will review all functions performed by OA surveillance and epidemiologic studies staff to ensure these are focused on activities that
 - o support LHDs to obtain case reports,
 - o support LHDs to utilize their surveillance data,
 - o ensure completeness and quality of surveillance data State-wide
 - o ensure California surveillance data is certifiable by CDC,
 - o perform analyses required by State mandate, by Federal requirements, and
 - o otherwise inform program/policy decisions.

D. Survey Findings Part I: Local Health Department Surveillance Functions

To understand the impact of potential reductions to LHD surveillance allocations, OA asked the same set of questions under two different funding reduction scenarios. In the first scenario, respondents were asked to assume funding would be reduced as per the Governor’s May Revision Budget Proposal which (elimination of General Fund support for surveillance activities). For the second scenario, respondents were asked to assume funding would be reduced as per the Senate Conference Committee’s proposal (decreased by \$1M; ~10%). Tables 1a/1b and 2a/2b summarize the responses.

Most responding LHDs would not be able to continue active surveillance activities under the Governor’s budget proposal, but most would be able to complete many surveillance activities under the Conference Committee’s proposal (receiving case reports, receiving labs, provider outreach, data entry, local analysis). However, most respondents would not be able to unduplicate incoming cases, investigate lab reports (to determine if related to a case of HIV infection), nor investigate beaches of confidentiality should the funding reductions be applied to the LHD allocations in a significant amount.

Table 1a: Proportion of respondents indicating moderate or substantial difficulty with the listed surveillance functions if General Fund support to HIV/AIDS surveillance is eliminated

CCLAD and Surveillance Directors (n=28)

Surveillance Activity	Moderate/substantial difficulty
Match and un-duplicate laboratory reports of confirmed HIV tests with the LHD’s HIV/AIDS registry database and with HIV/AIDS case reports received from health care providers	100%
Collect, tabulate, and analyze HIV/AIDS surveillance statistics	96%
Report at least weekly to CDPH/OA the number of AIDS cases reported to the LHD	96%
Submit unduplicated HIV cases by patient name to CDPH/OA	93%
Receive HIV case reports from health care providers	89%
Receive reports of CD4+ T-Cell test results from laboratories & determine if related to HIV	86%
Investigate potential breach of confidentiality of HIV-related public health records and report any evidence of an actual breach to CDPH/OA and the appropriate law enforcement agency	82%
Receive laboratory reports of confirmed HIV tests	56%

Table 1b: Proportion of respondents indicating a 60-100% reduction in selected surveillance activities if General Fund support for HIV/AIDS surveillance is eliminated

CCLAD and Surveillance Directors (n=28)

Surveillance Activity	Moderate/substantial difficulty
Conduct outreach to providers to facilitate their case reporting	89%
Local level data analysis and report creation based on HIV/AIDS surveillance data	89%
Conduct active case surveillance with health care providers	86%
Enter case information into the HIV/AIDS reporting system	82%

Table 2a: Proportion of respondents indicating moderate or substantial difficulty with the listed surveillance functions if General Fund support to HIV/AIDS surveillance is reduced by \$1m (theoretical reduction)

CCLAD and Surveillance Directors (n=28)

Surveillance Activity	moderate/substantial difficulty
Match and un-duplicate laboratory reports of confirmed HIV tests with the LHD's HIV/AIDS registry database and with HIV/AIDS case reports received from health care providers	75%
Collect, tabulate, and analyze HIV/AIDS surveillance statistics	96%
Report at least weekly to CDPH/OA the number of AIDS cases reported to the LHD	75%
Submit unduplicated HIV cases by patient name to CDPH/OA	67%
Receive HIV case reports from health care providers	46%
Receive reports of CD4+ T-Cell test results from laboratories & determine if related to HIV	61%
Investigate potential breach of confidentiality of HIV-related public health records and report any evidence of an actual breach to CDPH/OA and the appropriate law enforcement agency	71%
Receive laboratory reports of confirmed HIV tests	32%

Table 2b: Proportion of respondents indicating a 60-100% reduction in selected surveillance activities if General Fund support for HIV/AIDS surveillance is reduced by \$1m (theoretical reduction)

CCLAD and Surveillance Directors (N=28)

Surveillance Activity	60-100% reduction in activity
Conduct outreach to providers to facilitate their case reporting	29%
Local level data analysis and report creation based on HIV/AIDS surveillance data	36%
Conduct active case surveillance with health care providers	29%
Enter case information into the HIV/AIDS reporting system	25%

E. Survey Findings Part II: Increasing Case Reporting by Health Care Providers

Given CCLAD/Surveillance Director survey responses indicating their ability to complete surveillance activities would be substantially reduced with significant funding reductions, OA must encourage health care provider reporting of HIV/AIDS cases. To help develop a plan to sustain high levels of case ascertainment, OA asked stakeholders their support for two methods of provider education to encourage case reporting. These questions were not included in the CCLAD/Surveillance Directors survey as the importance of this information was not recognized when that survey was developed.

Table 3: Proportion of Respondents indicating moderate or strong support for selected methods to encourage case reporting by providers if active surveillance is reduced or eliminated

Office of AIDS Stakeholders (N=46)

Survey Question	OA Contractor (N = 19)	Advisory Bodies (N = 7)	Planning Council Members (N = 20)	Advocacy Groups (N = 7)	All other Stakeholders (N = 24)
General information sent to health care & HIV testing providers through email	83%	83%	75%	75%	52%
Informational Webinars on reporting procedures made available to providers	50%	67%	58%	50%	39%

F. Survey Findings Part III: Potential Funding Reduction Strategies

Maintenance of HIV/AIDS case (core) surveillance activities is most important because core surveillance provides essential information influencing program development, policy, and eligibility for Federal HIV/AIDS funding. Thus, special epidemiological studies and additional analytic support provided by graduate student researchers would be the first and second activities (respectively) to be cut if reductions are enacted.

If additional reductions are needed after those noted above, OA planned to explore the feasibility of reducing surveillance allocations to those LHDs that did not utilize and did not need their present surveillance allocation. Table 4a lists results from the CCLAD/Surveillance Directors survey on this and other reduction approaches under a scenario of \$1M reduction to surveillance while Table 4b summarizes results from the same survey under a scenario of >\$1M reduction to surveillance. Both these scenarios asked respondents to rank the reduction approach based on unspent allocations from 2007/08 and this tied for second rank with 50% of respondents assigning it as the first or second ranked approach. However, subsequent discussion revealed that unspent allocation levels from the 2007/08 fiscal year was not a valid indicator of unneeded allocations due to a long delay in availability of these funds during that year. Thus, OA will consult with LHDs separately to determine if any LHDs have higher allocations than they can expend and thus can be reduced without threatening the quality of surveillance functions.

The CCLAD/Surveillance survey found the highest preference for reductions to LHDs that receive direct Federal surveillance support (see Tables 4a and 4b). However, subsequent discussion and analysis also found this was not a viable method for reduction since the independently funded LHDs receive lower total per case funding (State + Federal) than most other counties and reductions in their GF surveillance support levels could cause a substantial reduction in California case counts since these LHDs account for approximately 50% of cases in the State.

The remaining potential reduction approaches thus were uniform reductions to all LHDs and reductions to the LHDs reporting lower case numbers. CCLAD/Surveillance Directors were asked to rank these reduction approaches under the two reduction scenarios (Tables 4a and 4b) and Other Stakeholders were asked to rank them as well (Table 4c). The uniform reduction approach ranked highest each time.

Table 4a: Proportion of respondents ranking the following strategies as #1 or #2 (out of 5) assuming a reduction of \$1M to General Fund support for surveillance (theoretical reduction)

CCLAD and Surveillance Directors (N=28)

Reduction Approach	First or second priority (out of 5)
Reduce 15% to LHDs receiving direct federal surveillance funding	59%
Reduce LHDs that did not spend their surveillance funding in full during FY 2007/08	50%
Reduce surveillance awards to all LHDs by a uniform percentage	50%
Eliminate funding to LHDs that have reported a lower proportion of cases in the State	21%

Table 4b: Proportion of respondents ranking potential reduction strategies as #1 or #2 assuming the a reduction of >\$1M to General Fund support for surveillance (theoretical reduction)

CCLAD and Surveillance Directors (N=28)

Reduction Approach	
Reduce 15% to LHDs receiving direct federal surveillance funding	59%
Reduce LHDs that did not spend their surveillance funding in full during FY 2007/08	55%
Reduce surveillance awards to all LHDs by a uniform percentage	48%
Eliminate funding to LHDs that have reported a lower proportion of cases in the State	28%

Table 4c: Proportion of respondents ranking the following strategies as first* priority if General Fund support for HIV/AIDS surveillance is reduced by \$1m (theoretical reduction)

CCLAD, Surveillance Directors, and Stakeholders (N=76)

Survey Question	All: CCLAD, Surveillance Directors & Stakeholders (N=76)	CCLAD and Surveillance Directors (N=28)	OA Contractors (N=16)	Advisory Bodies (N=7)	Regional Planning Council Members (N=9)	Advocacy Groups (N=5)	All other Stakeholders (N = 25)
Reduce uniform percentage	49%	50%	44%	20%	22%	33%	48%
Eliminate funding to LHDs that have reported a lower proportion of cases	21%	21%	31%	60%	56%	33%	20%

* Because CCLAD survey ranked 5 options and Stakeholders survey ranked only 3, ranks 1 and 2 were included for the CCLAD/Surveillance Directors survey

G. Survey Findings Part IV. Prioritization of OA Services

OA functions include support to LHDs to obtain case reports, maintenance of the HIV/AIDS case reporting data warehouse, ensuring completeness and quality of surveillance data, ensuring surveillance data is certifiable by CDC, performing data analysis and interpretation and informing program and policy decisions. OA asked respondents in both surveys to classify support activities as to their relative importance (Tables 5a and 5b). A shorter list of activities was included in the Stakeholder survey (Table 5b) as most of the longer list is only relevant to LHDs. Responses indicate many of the services provided by OA are perceived as ‘important’ or ‘very important’ by a minority of respondents. These results confirmed the pre-survey assumptions of OA and have contributed to changes to surveillance services and plans for further evaluation to focus surveillance activities.

Table 5a: Proportion of respondents indicating the selected OA services to be important or very important

CCLAD and Surveillance Directors only (N=28)

OA Services	
Technical support for processing and management of electronic HIV/AIDS case data	68%
Producing Quarterly Quality Assurance Reports and distributing to LHDs	50%
Production of the monthly HIV/AIDS surveillance report and posting to the OA Web site	50%
Completing tables and line listings on request using the Statewide HIV/AIDS surveillance database	41%
Telephone support to field all LHD inquiries 8 – 5 Monday through Friday	36%
Monthly HIV/AIDS Surveillance Newsletters	11%
Non-routine site visits by OA staff as requested by the LHD or as needed by OA	7%
Routine annual site visits by a surveillance coordinator to provide technical assistance and capacity building	7%

Table 5b: Proportion of respondents indicating the selected OA services to be important or very important

CCLAD, Surveillance Directors, and Stakeholders (N=76)

Survey Question	All: CCLAD, Surveillance Directors & Stakeholders (N=76)	CCLAD and Surveillance Directors (N=28)	OA Contractor (N=16)	Advisory Bodies (N= 6)	Regional Planning Council Members (N=9)	Advocacy Groups (N=3)	All other Stakeholders (N=25)
Complete tables & line listings on request	56%	41%	69%	80%	56%	67%	70%
Monthly HIV/AIDS surveillance report	53%	50%	50%	40%	44%	33%	56%

III. Care Survey

A. Background

To address the need for sustainable HIV care and support service delivery during times of financial instability, OA drafted a proposed Care Program Model (CPM) for the provision of key OA-funded HIV services in California. The proposed Care Program Model would be supported by a proposed Single Allocation Model (SAM), which is a flexible model that ultimately provides one funding stream through one contract that supports primary HIV medical care, support services that support care access, and services that reduce the risk of treatment failure. OA, recognizing that counties, local health jurisdictions, or geographic regions may have differing HIV care/support service needs and resources, proposes to implement both the Care Program Model and SAM in a manner that allows maximum flexibility and creativity at the local level.

The proposed Care Program Model and SAM are designed to meet the primary goals of OA:

- To minimize new HIV infections
- To maximize the number of people with HIV infection who access appropriate care, treatment, support and prevention services

Additional objectives were considered in crafting both the Care Program Model and SAM, and include the following:

- Implementation of a model that is less administratively burdensome. The model proposes a single allocation that merges all remaining funding into one contract with one primary grantee per county/local health jurisdiction.
- Implement a model that supports leveraging and integrating other resources by encouraging the most appropriate use of OA resources within the context of non-OA resources available in the community.
- Places a priority on the provision of primary HIV medical care and treatment to all eligible clients.
- Provide services that ensure access and ongoing engagement in HIV medical care, particularly in communities of color and other traditionally underserved communities.
- Provides appropriate services or interventions for those with high risk for HIV transmission and/or treatment failure.

B. Care Survey Respondents

Overall, there were 102 respondents representing various OA stakeholder groups including:

- CCLAD (n=38)
- OA contractors (n=40)
- Advisory bodies (n=10)
- Advocacy groups (n=5)
- Planning council members (n=21)
- ADAP coordinators (n=7)
- Other organizations and affiliations (n=22)

There are two tables under each heading, labeled “a” and “b.” The “a” tables display responses from both care surveys, with combined results for all respondents in the first “All” column. The remaining columns separate out responses by different groups of respondents for comparison purposes. The second all OA stakeholders were grouped into the following affiliation categories: OA Contractors, Advisory Bodies, Regional Planning Council Members and Advocacy Groups. Individuals may be counted in more than one affiliation group. The “b” tables display results from all the CCLAD respondents only, stratified by EMA, TGA, and non-EMA/TGA. EMA counties are San Francisco, Los Angeles (including Long Beach and Pasadena local health jurisdictions), and San Diego. TGA counties are Sacramento, Sonoma, Alameda (including Berkeley)/Contra Costa, Santa Clara, Orange, and San Bernardino/Riverside. The EMA and TGA counties receive a direct allocation of RWCA Part A funding that helps address the higher need for HIV care, treatment and support services in these regions of the state. Approximately 92% of the clients with HIV/AIDS access ADAP in EMA or TGA counties. Responses of “N/A” were excluded from the analysis. Rating questions with Strongly Agree and Agree response categories were combined into one Agree category.

C. Key Implications

Development of the Care Program Model:

1. Respondents were generally in favor of development of a Care Program Model. The Care Program Model will be based upon HRSA-defined service categories.
2. OA will not require local utilization of the HRSA 75/25 requirement for prioritization of services
3. To provide the greatest level of flexibility, the Care Program Model will initially include a limited two tiered approach to service prioritization.
 - a. Refinement of tiers will be considered in the future
 - b. The Care Program Model will prioritize Outpatient/Ambulatory Medical Care as a Tier One service.
 - c. Tier Two services are directly linked to access to Tier One care, maintenance in Tier One care, or addressing service needs related to treatment failure. To provide the greatest flexibility to local providers, the following HRSA service categories are included in Tier Two of the Care Program Model at this time. In the future, OA may work with stakeholders to create a more refined three tiered system:
 - Mental Health Services
 - Medical Case Management (no cap)
 - Oral Health Care
 - AIDS Pharmaceutical Assistance

- Treatment Adherence Counseling
- Health Insurance Premium and Cost Sharing Assistance
- Home and Community Based Health Services
- Substance Abuse Services – Outpatient
- Health Education/Risk Reduction
- Home Health Care
- Hospice
- Outreach Services (outreach to care)
- Case Management
- Emergency Financial Assistance
- Food Bank/Home-Delivered Meals
- Housing Services
- Legal Services
- Linguistic Services
- Medical Transportation Services
- Psychosocial Support Services
- Medical Nutrition Therapy
- Early Intervention Services
- Referral for Health Care/Supportive Services
- Rehabilitation Services
- Respite Care
- Substance Abuse Services - Residential
- Child Care Services

4. Eligibility for specific allowable services will be determined at the local level by agency staff
5. OA is in the process of developing Care Program Model Guidelines to provide contracting agencies with detailed guidance regarding the implementation and administration of the Care Program Model using the SAM. The preliminary Program Guidelines will be made available in written form and on the OA website no later than August 17, 2009.
6. OA will develop allocation methodologies that provide for the following:
 - a. an equitable distribution of scarce HIV care resources throughout all regions of California
 - b. allocation strategies to support stabilization of funding through the early transition to the proposed Care Program Model and SAM, including a hold harmless provision, funding cap and funding floor

7. OA will reallocate HRSA Part B and MAI funding to fiscal agents including county health departments or HIV service agencies utilizing the existing Care Services Program formula as the basis for reallocating funds. OA will implement provisions to provide equity and stability of funding allocations across all regions of California.

The allocations will be provided to contracting agencies and County AIDS Directors as soon as this plan receives CDPH approval (no earlier than August 5, 2009).

The Care Program Model formula is based upon the following factors initially developed by the Resource Allocation Committee of the California HIV Planning Group for allocation funding through the Care Services Program:

Living AIDS cases – prevalence and incidence data

Census data

- Persons per square mile

- Non-English speaking

- Persons below poverty level

- People of color

HIV service utilization data –

- Medi-Cal HIV positive beneficiaries with one or more claims for HIV-specific medications

- ADAP clients

OA will make no or a minimal allocation of funds to counties with no reported cases of HIV or AIDS, or counties with few cases of HIV/AIDS and minimal HIV service utilization. OA anticipates that these counties will not receive a funding allocation until they meet the criteria for inclusion in the floor or formula process.

Counties with fewer than six reported HIV and/or AIDS cases and demonstrated low or no utilization of HIV services will receive a floor amount. Many of these counties have already developed a partnership with contiguous counties in developing a regional approach to the delivery of HIV services. OA will assist in supporting the floor counties within these regional partnerships by developing minimal administrative processes and reporting requirements for the floor counties. OA anticipates that these counties will remain at the existing floor funding level until they individually meet the criteria for inclusion in the formula process.

OA will implement the following stabilization measures:

Funding Cap:

OA will implement a funding cap, which is a **maximum** funding level placed on each county allocation of Care Program Model funding. OA has decided to implement a funding cap set at 70% of the pre-budget-reduction allocation of the combined funds provided through EIP, TMP, Bridge, Positive Changes, CSP, CMP and Pathways.

Hold Harmless Provision:

Counties throughout California received program allocations through General Funded programs, such as EIP and CMP, primarily due to the availability of specific funding sources for people of color, women, rural sites, etc. These counties are now especially impacted by the elimination of the long-time allocation of state funding. To equalize the funding levels across all regions of the state, OA will implement a hold harmless provision, which is a **minimum** funding level placed on each county allocation of Care Program Model funding.

OA will implement the hold harmless at 35%, which provides no less than 35% of the pre-budget-reduction allocation of the combined funds provided through EIP, TMP, Bridge, Positive Changes, CSP, CMP and Pathways. The 35% hold harmless, when used in conjunction with a floor and a 70% cap on funding, was found to equalize the funding levels and funding reductions across all regions.

8. Leveraging additional resources:

Staff will collaborate with the independent, federally-funded Pacific AIDS Education and Training Center (PAETC), the California Chapter of the American Academy of HIV Medicine (AAHIVM) and other partners to help address the resource gaps experienced throughout the state, with special focus in the jurisdictions that were disproportionately impacted by the funding reductions.

D. Care Survey Findings Part 1: Care Program Model

Respondents were presented with an overview of the tiered approach to prioritizing the provision of HIV care, treatment, prevention and support services and asked questions specific to their views of the tiered service model. *A process for prioritization of services, such as through implementation of a tiered process, was generally supported by survey respondents. Periodic screening and assessment processes to be used for prioritizing or determining the provision of services in Tiers Two and Three was also generally supported.*

Table 1a: Overall Questions Regarding the Proposed Care Program Model for CCLAD and Stakeholders

Survey Question	All N = 88	CCLAD N = 35	OA Contractor N = 35	Advisory Bodies N = 8	Planning Council Members N = 19	Advocacy Groups N = 4
	% Yes	% Yes	% Yes	% Yes	% Yes	% Yes
Screening & assessment for services in Tier Two & Three	90	94	91	88	95	100
Support 3-tiered service model	72	83	74	50	68	50
Support criteria - Tier Three	71	71	74	88	84	100
Support for criteria - Tier Two	68	80	63	63	79	75
Support prioritization of HRSA service categories	68	74	71	38	79	75

Table 1b: EMA, TGA, and non-EMA/TGA for CCLAD only

Survey Question	All CCLAD N=35	EMA N=7	TGA N=8	Non-EMA/TGA N=20
	% Yes	% Yes	% Yes	% Yes
Screening & assessment for services in Tier Two & Three	94	100	75	100
Support 3-tiered service delivery model	83	71	88	85
Support criteria - Tier Two	80	71	75	85
Support prioritization of HRSA service categories	74	86	75	70
Support criteria - Tier Three	71	71	63	75

E. Care Survey Findings Part 2: Tier One Services

Table 2a: Tier One of Proposed Care Program Model for CCLAD and Stakeholders – Administration’s Proposal

Survey Question	All (CCLAD & Stakeholder) N = 87	CCLAD Survey N = 35	OA Contractor N = 34	Advisory Bodies N = 8	Regional Planning Council Members N = 19	Advocacy Groups N = 4
	% Agree	% Agree	% Agree	% Agree	% Agree	% Agree
Outpatient/Ambulatory Medical Care as Tier One service	91	91	97	88	90	100

Table 2b: EMA, TGA, and non-EMA/TGA for CCLAD only – Administration’s Proposal

Survey Question	All (CCLAD only) N=35	EMA N=7	TGA N=8	Non-EMA/TGA N=20
	% Agree	% Agree	% Agree	% Agree
Outpatient/Ambulatory Medical Care as Tier One service	91	100	100	85

F. Care Survey Findings Part 3: Tier Two Services

Tier Two service categories include all designated HRSA core medical services, except for Outpatient/Ambulatory Medical Care (in Tier One). Also in Tier Two, OA has proposed prioritization of three HRSA support services: Treatment Adherence/Counseling, Outreach, and Health Education/Risk Reduction. These three support service categories were prioritized as Tier Two services to address the needs of the clients at high risk for transmission of HIV, becoming lost to care, or treatment failure. Respondents were generally in support of using care funding for this purpose.

Medical Case Management, Treatment Adherence Counseling, Oral Health Care, Health Insurance Premium Payment Assistance, AIDS Pharmaceutical Assistance and Health Education/Risk Reduction Services are supported by respondents and therefore will be included in Tier 2.

Table 3a: Tier Two of Proposed Care Program Model for CCLAD and Stakeholders – Administration’s Proposal

Survey Question	All (CCLAD & Stakeholder) N = 85*	CCLAD Survey N = 34*	OA Contractor N = 34*	Advisory Bodies N = 7	Regional Planning Council Members N = 19*	Advocacy Groups N = 4
	% Yes	% Yes	% Yes	% Yes	% Yes	% Yes
Mental Health	89	94	85	100	95	100
Medical Case Management	88	91	91	100	94	100
Oral Health Care	84	88	88	71	95	75
AIDS Pharmaceutical Assistance	82	79	85	86	84	75
Treatment Adherence Counseling	77	88	74	86	79	100
Health Insurance Premium & Cost Sharing Assistance	74	79	77	71	83	100
Home & Community- Based Health Services	74	74	79	86	94	75
Substance Abuse Service-Outpatient	74	74	74	100	90	100
Health Education/Risk Reduction	69	79	68	57	67	75
Home Health Care	68	71	71	57	89	75
Hospice	62	56	71	57	78	75
Outreach	61	68	65	57	67	50
Medical Nutrition Therapy	58	63	62	43	68	75

* This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

Table 3b: EMA, TGA, and non-EMA/TGA for CCLAD only – Administration’s Proposal

Survey Question	All (CCLAD only) N=34	EMA N=7	TGA N=7	Non-EMA/TGA N=20*
	% Yes	% Yes	% Yes	% Yes
Mental Health	94	100	100	90
Medical Case Management	91	86	86	95
Treatment Adherence Counseling	88	86	86	90
Oral Health Care	88	100	100	79
Health Insurance Premium & Cost Sharing Assistance	79	57	86	85
AIDS Pharmaceutical Assistance	79	86	71	80
Health Education/Risk Reduction	79	86	86	75
Home & Community-Based Health Services	74	86	71	70
Home Health Care	71	86	71	65
Substance Abuse Service-Outpatient	74	71	86	70
Outreach	68	100	57	60
Medical Nutrition Therapy	63	50	71	63
Hospice	56	71	57	50

* This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

NARRATIVE RESPONSES – summary:

- Comments from CCLAD (N=21) showed some support for prioritizing the following service categories by moving from Tier Two to Tier One: Medical Case Management (8 comments), AIDS Pharmaceutical Assistance (5 comments), Outreach (3), Health Education/Risk Reduction (2) and Treatment Adherence (2). Mentioned once were Linguistic Services, Home Health Services and Oral Health Care,
- Other Stakeholders (N=40) comments reflected some support for moving the following service categories to Tier One: Medical Case Management and Mental Health (12 comments each), Oral Health and Pharmaceutical Assistance (8 comments each), Treatment Adherence (7), Substance Abuse Services (6), Health Education/Risk Reduction (4), Home and Community Based Health Services and Health Insurance Premium and Cost Sharing Assistance (3 each), Case Management (2). Also mentioned once were Outreach and Hospice. One respondent said all services should be moved from Tier Two to Tier One, and one respondent said all should be moved except for Outreach.

- CCLAD (N=17) respondents showed some support for moving some Tier Two Services to Tier Three, as follows: Hospice and Substance Abuse Services (5 comments each), Outreach and Home and Community Based Care (4 comments each), Mental Health, Home Health, and Medical Nutrition (3 comments each). Health Education and Risk reduction received 2 comments. Receiving one comment each were Treatment Adherence, Oral Health Care, Case Management and Medical Case Management. Three respondents said all services in Tier II should be moved to Tier III.
- Other Stakeholder respondents (N=29) showed some support for moving some Tier Two Services to Tier Three as follows: Hospice (8), Outreach and Medical Nutrition Therapy (5 each), Oral Health Care, Home Health Care and Substance Abuse (3 each), Health Education/Risk Reduction (2), Mental Health, Medical Case Management, Treatment Adherence and Health Insurance Premium and Cost Sharing Assistance (1 each). Two respondents said all services in Tier II should be moved to Tier III.

G. Care Survey Findings Part 4: Tier Three Services

Tier Three was established as a tier of HRSA support service categories that may be of lower priority to certain clients, but are critical to those who are assessed as having a high need for support services to facilitate access to medical care and treatment. Tier Three includes all HRSA support services except for the three that are in Tier Two.

Table 4a: Tier Three of Proposed Care Program Model for CCLAD and Stakeholders – Administration’s Proposal

Survey Question	All N = 80*	CCLAD Survey All N = 33*	OA Contractor N = 32*	Advisory Bodies N = 7*	Planning Council Members N = 17*	Advocacy Groups N = 4*
	% Yes	% Yes	% Yes	% Yes	% Yes	% Yes
Housing Services	80	88	81	86	82	50
Case Management	76	85	77	67	75	75
Psychosocial Support	76	82	77	71	69	100
Medical Transportation	75	73	81	67	75	50
Referral for Health Care/Supportive Services	74	76	80	80	79	67
Emergency Financial Assistance	73	69	87	67	88	100
Substance Abuse Services-Residential	68	67	66	100	82	75

Survey Question	All N = 80*	CCLAD Survey All N = 33*	OA Contractor N = 32*	Advisory Bodies N = 7*	Planning Council Members N = 17*	Advocacy Groups N = 4*
	% Yes	% Yes	% Yes	% Yes	% Yes	% Yes
Food Bank/Home Delivered Meals	65	73	72	57	59	0
Linguistic Services	63	73	65	50	60	50
Legal Services	60	64	68	50	73	50
Rehabilitation	59	64	67	83	67	50
Child Care Services	58	61	65	50	60	67
Respite Care	53	58	65	67	53	50

* This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

Table 4b: EMA, TGA, and non-EMA/TGA for CCLAD only – Administration’s Proposal

Survey Question	All CCLAD N=33	EMA N=7	TGA N=7	Non-EMA/TGA N=19*
	% Yes	% Yes	% Yes	% Yes
Case Management	85	86	86	84
Housing Services	88	100	86	84
Psychosocial Support	82	86	86	79
Linguistic Services	73	86	86	63
Referral for Health Care/Supportive Services	76	71	86	74
Medical Transportation	73	86	43	79
Food Bank/Home Delivered Meals	73	71	71	74
Substance Abuse Services-Residential	67	86	71	58
Emergency Financial Assistance	69	86	71	61
Legal Services	64	71	86	53
Rehabilitation	64	71	86	52
Child Care Services	61	57	86	53
Respite Care	58	43	86	53

* This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

NARRATIVE RESPONSES - Summary

All respondents were asked if they would move any Tier Three services to either Tier One or Tier Two. Responses were quite varied, and no clear patterns emerged.

Non-CCLAD Stakeholders respondents' comments suggested moving services in a variety of ways.

- Suggestions to move Tier Three services to Tier One included: Medical Transportation (3 comments), Case Management (2 comments), and one comment each for Referrals to Health Care/Supportive Services, Rehabilitation, and Linguistic Services.
- Suggestions to move Tier Three services to Tier Two included: Case Management (6 comments), Housing Services (4 comments), Substance Abuse Services – Residential (3), Food Bank/Home Delivered Meals (2), and one comment each for Linguistic Services, Emergency Financial Assistance, Psychosocial Services, and Medical Transportation.
- Some suggested moving Tier Three categories but did not specify where the service should be moved to: Housing Services (3 comments), Medical Transportation (3), Food Bank/Home Delivered Meals (3), and one comment each for Case Management, Psychosocial Support, and Linguistic Services.

CCLAD respondents' comments also suggested moving services in a variety of ways.

- Suggestions to move Tier Three services to Tier Two included: Medical Transportation (3 comments), Housing Services (2), and one comment each for Case Management, Linguistic Services, Psychosocial Support, Food Bank/Home Delivered Meals, Emergency Financial Assistance, and Substance Abuse Services – Residential.
- Some suggested moving Tier III services categories but did not specify where to move them: Medical Transportation (3 comments), Linguistic Services (2), and one comment each for Case Management, Food Bank/Home Delivered Meals, Housing Services, and Substance Abuse Services – Residential.
- Four respondents specifically replied to not change any service categories from Tier Three to One or Two.

General Comments Regarding Service Tiers

- Overall, there was support for maintaining some form of Medical Case Management and ensuring that Mental Health and Substance Abuse Services are kept at high priority. In addition, comments reflected concern about clients failing to receive supportive services necessary to keep them in care if a tiered system is rigidly enforced. While there was general agreement that primary medical care must receive first priority, respondents pointed out that lack of mental health services, in particular, would prevent clients from accessing and receiving medical care.

Another general trend is that rural regions will want assurance that the model can be flexible enough to support their particular HIV service needs.

- **Implementation Uncertainty:** Overall comments, concerns, and suggestions for the tiered model of service prioritization were primarily linked to uncertainties in the approach to determining in which tier a client will access services, who is authorized to make the determination, and how this information is tracked. Comments related to this matter included solutions that resulted in changing service categories among tiers, as opposed to other options such as not using tiers, etc. Comments also included recommendations to collapse three tiers into two tiers.
- **Case Management:** Two questions were specific to the use of funds to support case management services, with respondents asked if they were supportive of caps on medical or non-medical case management services. Respondents were mixed in their responses, but many respondents were clearly in favor of NOT placing limitations on case management services and allowing local flexibility in determining the need for caps or ceilings on funding for case management services of any kind.

IMPLICATIONS

Respondents were supportive of a tiered process for prioritization and provision of HIV services, but voiced concern regarding the approach to determining client eligibility for services in each tier, asking that OA provide the highest level of flexibility possible. OA should use a tiered prioritization process and provide a structure that allows for flexibility and local control over the provision of services.

Regionalized Services

Respondents were asked if there was interest in providing some specialized services, e.g., mental health or substance use treatment in a care setting, in-home care, outreach services, etc., on a regional basis. Of the CCLAD respondents (N=31), only 25.8% answered yes, with 54.8% answering not sure. This response was similar to the other stakeholders (N=47) with 31.9% answering yes and 44.7% answering not sure.

H. Care Survey Findings Part 5: Proposed Implementation of a Single Allocation Model (SAM)

Table 5a: Proposed Single Allocation Model (SAM) for CCLAD and Stakeholders

Survey Question	All N = 77*	CCLAD N = 32*	OA Contractor N = 31*	Advisory Bodies N = 7	Planning Council Members N = 17*	Advocacy Groups N = 3
	% Yes	% Yes	% Yes	% Yes	% Yes	% Yes
Support for SAM in county using MOU & State fiscal year.	60	72	52	57	56	67
Support for use of SAM in health department, local health jurisdiction or service area	55	80	39	57	53	33
Support for SAM contracting limited to county health departments and/or local health jurisdictions.	46	65	30	43	38	100

* This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

Table 5b: EMA, TGA, and non-EMA/TGA for CCLAD only

Survey Question	All CCLAD N=32*	EMA N=7	TGA N=7	Non-EMA/TGA N=18*
	% Yes	% Yes	% Yes	% Yes
Support for SAM in county using MOU & State fiscal year.	72	71	86	80
Support for use of SAM in health department, local health jurisdiction or service area	80	71	100	67
Support for SAM contracting limited to county health departments and/or local health jurisdictions.	65	57	8	59

NARRATIVE RESPONSES:

There was a generally high level of support for this concept from CCLAD members, with common concerns about the specifics around implementation. Comments from all stakeholder respondents reflected varied concerns from across all regions on California. An EMA representative stated “In our EMA not all potential providers are qualified to provide the

services”. A rural area respondent expressed the concern that “Eliminating CBOs from direct contracting with the state will cause problems in our rural northern California counties”. Still another survey taker stated “given the complexities of our EMA, we are unsure if this would affect the grass roots organizations”. A Planning Council member expressed concerns “that the criteria on allocation of funds is not defined-too many unknowns to agree with this concept”.

While there is support for the SAM model among CCLAD members, respondent comments include concerns regarding the lack of capacity for county governments, especially those in rural communities, to adequately administer HIV/AIDS services under a single contract. The respondents, particularly OA Contractors, noted that small county agencies, including health departments, are “stretched to the limit” and indicated that this may be a long process that will result in long delays and loss of services, with CBOs having to close their doors before the process could be completed.

Comments from respondents also reflected the need for flexibility in using alternative contractual relationships with community based organizations as the primary contractor for a county. Examples were provided of county health departments’ lack of willingness or expertise to accept the responsibility for provision of HIV services, creating a reliance on local CBOs to provide administrative oversight as primary contracting agencies. Respondents currently in a multi-county/regional model for the provision of HIV services were supportive of continuation of that model in their region.

Respondents also voiced concerns regarding the administrative expenses associated with a multiply-layered service delivery model, as each contracting and subcontracting agency carves out an administrative fee from the allocation.

IMPLICATIONS: There is a fairly high level of support from CCLAD, and cautious support in the comments from CCLAD and other stakeholders, for a SAM with adequate flexibility to allow the agreement to be with a county health department/LHJ or a CBO with the capabilities and experience to provide necessary HRSA authorized HIV/AIDS services. SAM should be structured to provide adequate flexibility to account for regionalization of services, use of CBOs as primary fiscal agent, and address capacity issues at the county health department/LHJs.

OA will identify counties and regions that cannot be immediately transitioned to the SAM due to the many issues that may prohibit successful transition, such as the existence of multiple contracting agencies, regional contractual relationships, or counties in which the county health department is not able or does not have the capacity to accept or administer a Care contract with OA. Jurisdictions may also not be immediately ready to transition to SAM due to the complex mix of county health departments and community based organizations that are direct OA care program contractors. Additionally, many counties may experience barriers because the existing contractors provide services in multi-county regions and the primary contracting county must be designated. OA will work with these counties to develop plans for transitioning counties to the SAM. Final date for transition of these counties or regions to the SAM will be jointly determined by OA and the local contracting agencies. To address service needs during the transition period, OA will develop a process for providing an adjusted FY 09/10 funding allocation through existing contract or contracts as determined by OA and the participating county agencies.

I. Care Survey Findings Part 6: Eligible Use of Funds

Option 1: Minimum of 75% allocated to HRSA-defined Core Medical Services and a maximum of 25% allocated to HRSA-defined Supportive Services.

Option 2: Utilize HRSA service categories with no 75%-25% restriction.

Table 6a: Eligible Use of Funds for CCLAD and Stakeholders – Administration’s Proposal

Survey Question	All N = 75	CCLAD N = 31	OA Contractor N = 30	Advisory Bodies N = 7	\Planning Council Members N = 17	Advocacy Groups N = 3
	%	%	%	%	%	%
Option 2	61	68	53	43	53	67
Option 1	27	16	33	57	47	33

Table 6b: EMA, TGA, and non-EMA/TGA for CCLAD only – Administration’s Proposal

Survey Question	All (CCLAD only) N=31	EMA N=7	TGA N=7	Non-EMA/TGA N=17
	%	%	%	%
Option 2	68	57	57	76
Option 1	16	43	29	0

J. Care Survey Findings Part 7: Funding Allocation Methodology

Option 1: Reduce current allocations to counties/LHJs by a flat percentage which reflects the cuts associated with the Administration's Proposal. The percentage reduction would be applied to counties/LHJs for all care programs and services funded by OA from all sources, including state and federal.

Option 2: Allocate funds based upon the percentage of ADAP-only clients in your county. ("ADAP-only" does not include ADAP clients with Medi-Cal, private insurance, or Medicare.) If a county/LHJ has 12% of the statewide ADAP-only clients, then that county/LHJ would receive 12% of the available funding. The rationale for this option is that care fund allocations would follow clients who need public services and have no other resources, consistent with ADAP eligibility criteria. (The rationale explanation is new and was not included in the CCLAD survey.)

Option 3: Update the existing CSP formula to include HIV cases, modifying the floor and maintaining some level of hold harmless. Allocate funds utilizing the updated CSP formula.

Table 7a: Level of Agreement among the Three Proposed Allocation Options – Administration’s Proposal

Survey Question	All N = 71*	CCLAD N = 31*	OA Contractor N = 28*	Advisory Bodies N = 7	Planning Council Members N = 16*	Advocacy Groups N = 4
	% Support	% Support	% Support	% Support	% Support	% Support
Option 3	57	55	46	57	67	50
Option 1	49	48	52	57	50	25
Option 2	24	17	28	29	20	50

*This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

Table 7b: EMA, TGA, and non-EMA/TGA for CCLAD only – Administration’s Proposal

Survey Question	All (CCLAD only) N=31*	EMA N=7	TGA N=7*	Non-EMA/TGA N=17*
	% Support	% Support	% Support	% Support
Option 3	55	71	72	41
Option 1	48	29	33	63
Option 2	17	14	33	13

*This is the number of people in this group that responded to this set of questions. The number in this column varies slightly from one question to another.

NARRATIVE RESPONSES:

- Although CCLAD and planning council members favored Option 3 which was to use a modified version of the CSP formula to allocate funds, the OA contractors slightly favored the use of Option 1 (flat reductions).
- Respondents showed strong support for using data for county of residence if ADAP is utilized as the primary factor in funding allocation formula
- The use of a funding floor and a hold harmless provision was strongly favored by the respondents.
- The majority of the respondents indicated that their responses would not differ under the Conference Committee Proposal.

IMPLICATIONS: OA will implement allocation strategies, such as funding floor, cap, or a hold harmless provision, to support stabilization of funding through the proposed Care Program Model and SAM.

K. Care Survey Findings Part 8: Transition Period

NARRATIVE RESPONSES:

Respondents were asked for their input on the amount of time needed to adequately transition to the proposed Care Program Model and SAM. Respondents were supportive of a longer transition period to allow for implementation, but voiced concern that a longer transition period for a process might result in funding shortfalls as the remaining funds are redistributed in FY 09/10.

IMPLICATIONS: OA acknowledges the concerns voiced by respondents and will implement the Care Program Model and SAM in a manner that mitigates the adverse impact to the provision of client services.

IV. HIV Education and Prevention Survey

A. Background

To address the need for sustainable HIV education and prevention service delivery during times of financial instability, OA has developed a set of contingency proposals that includes prevention activities funded by OA Education & Prevention and Counseling & Testing funds. These proposals were developed to maintain the maximum HIV prevention efforts with reduced funds and to maximize flexibility and minimize administrative burden for OA contractors.

These prevention activity areas include:

- Core Services
- CHRP Research
- PTC Trainings
- Rapid Test Kits
- Counselor Training/NIGHT
- Partner Services
- Tiered Activities
- Other OA Services
- HIV/AIDS Disparities Among African Americans
- Funding Allocations/Funding Formula
- Identifying Savings Under the Conference Committee Proposal

B. Prevention Survey Respondents

This document summarizes findings from an initial survey of California Council of Local AIDS Directors (CCLAD) and a second survey of all Office of AIDS (OA) stakeholders. Overall, there were 113 respondents representing various OA stakeholder groups including:

- CCLAD (n=35)
- OA contractors (n=43)
- Advisory bodies (n=22)
- Advocacy groups (n=5)
- Regional planning council members (n=23)
- HIV/AIDS Surveillance Directors (n=4)
- ADAP coordinators (n=6)
- Other organizations or affiliations (n=20)

When examining the ensuing tables, note that there are two tables under each heading, labeled “a” and “b”. The “a” tables represent the combining of both surveys. The results in these tables combined responses from the initial CCLAD survey with the other stakeholder responses. Also, results were stratified by affiliation for CCLAD, OA contractors, advisory bodies, regional planning council members, and advocacy groups. Please note that individuals may be counted in more than one affiliation group. The “b” tables display results from only the CCLAD respondents (n=35). The results in these tables were stratified by higher HIV/AIDS burden LHJs (n=15) and lower HIV/AIDS burden LHJs (n=20). Higher HIV/AIDS burden refers to those LHJs that in FY 2008-2009 were allocated at least 1% of the total of the combined E&P

and C&T funding distributed by OA. There were 17 LHJs that received 1% or greater; the remaining 44, for the purpose of this document are referred to as lower HIV/AIDS burden LHJs.

While taking the survey, respondents could skip questions or mark “N/A” for questions that did not apply to them. Therefore, responses of “N/A” were excluded from the analysis. Rating scale questions with “Important” and “Very important” response categories were combined into one “Important” category.

C. Key Implications and Next Steps

PREVENTION

Definitions

- “Higher HIV/AIDS burden LHJs” refers to those 17 LHJs that were allocated at least 1% of the total of the combined Education and Prevention (E&P) and Counseling and Testing (C&T) funding distributed by OA in FY 2008-2009. 93% of the total population of reported living cases of AIDS (92.3%) and HIV (94.3%) were reported in these LHJs.
- The remaining 44 LHJs, for the purpose of this document are referred to as “lower HIV/AIDS burden LHJs.”

Available Funding

- Proposed overall support and local assistance = **\$2.98 million (21%) and \$11.11 million (79%)** respectively
- CDC Prevention Grant **funding for local assistance allocations and centralized core services (\$9.73 million)**

Decisions – Funding of Core/Centralized Services (Note, for each core/centralized service funded, fewer resources will be available for distribution to LHJs and CBOs to provide direct service.)

Continue but reduce funding

21. Continue to provide rapid HIV test kits for higher burden LHJs only, with the exception noted below (estimated cost, **\$750,000**).
 - a. Testing sites in lower-burden LHJs that currently perform ≥ 100 tests per year and have a positivity rate of $\geq 1\%$ (the historical statewide average) will continue to receive rapid test kits (approximately 10 sites in 8 LHJs)
 - b. OA will pursue strategies to control rapid test kit costs including: provision of technical assistance about billing insurance, consideration of charging using a sliding scale, and eligibility requirements for free testing.
 - c. OA will continue to negotiate test kit pricing agreements, including consideration of additional products (in light of pending legislation that would support greater use of less expensive finger-stick rapid testing should this legislation be enacted).

22. Provide educational materials and condoms to *all* requesting LHJs, bringing distribution in-house and eliminating contract with CA AIDS Clearinghouse (estimated cost **\$225,000** for FY 09-10 since OA currently has adequate condom inventory for FY 09-10, then \$300,000 annually)
23. Fund scaled back, flexible, HIV test counselor training (to be developed) and reduce or eliminate funding to contractor UCSF/AHP for these activities (estimated cost, **\$350,000**).
24. Provide **\$1.2 million** to STD Control Branch (STDCB) to support Partner Services (PS) in the 17 high burden LHJs⁵. The dollars expended on PS represent approximately 12% of the total local assistance grant dollars and approximately 16.5% of the resources available for prevention interventions at the local level (as opposed to core services). The distribution of dollars to each LHJ and the degree of direct versus supervisory state support is dependent on the current PS infrastructure in each LHJ.
 - a. Although funding LA and SF will reduce PS funds to the 15 other higher burden LHJs an average of 25%, this approach will decrease destabilization of PS activities to the 2 directly funded LHJs.
25. Continue but reduce funding for Telephone Hotline through contractor SFAF (cost, **\$200,000**).

Subtotal core expenses = \$2.725 million

Continue in house, no funding

26. Bring development and maintenance of HIV CHOICE website in-house and eliminate funding to STDCB/PTC.
27. Program performance data performed by OA staff, requiring no additional resource allocation.

Eliminate

28. Eliminate continuing education training (CET) requirements and eliminate funding to contractor
29. Eliminate funding for ongoing CHRP Research projects. CHRP may decide to continue funding one or more of these studies based upon their progress to date and available CHRP funds.
30. Eliminate specific funding for NIGHT. General Fund is required to receive the Medi-Cal matching funds. Also, HIV positivity rates in NIGHT testing have been lower than the non-Night testing in the 21 NIGHT LHJs (FY 05/06 non-NIGHT 1.2% vs. NIGHT 0.8%, FY 06/07 non-NIGHT 1.3% vs. NIGHT .0.9% and FY 07/08 non-NIGHT 1% vs. NIGHT 0.7%). With OA approval, LHJs with productive NIGHT programs may use their prevention and testing allocation funds for NIGHT activities.
31. Eliminate OA support of Prevention Trainings through PTC, leaving only CDC-funded training options
32. Do not renew recently expired Latino focused HIV capacity building contract (Project Concern International)
33. Eliminate African American focused HIV capacity building contract with On-Track Program Resources
34. Eliminate Syringe related HIV capacity building contract with Harm Reduction Coalition
35. Eliminate SEP contracts. If federal ban is lifted, LHJ allocations may be used to support SEPs
36. Eliminate Transgender focused capacity building through Transgender Center of Excellence contract

⁵ See Appendix for associated PS funding distribution and program spreadsheet

- 37. Eliminate funding for Men’s Wellness Center (Los Angeles)
- 38. Eliminate funding for rapid research support through UCLA contract
- 39. Eliminate funding for C&T Opt-Out study and complete in-house

Decisions – Funding Provided to LHJs

- 5. All interventions outlined in survey will be allowable (described in this report). LHJs will decide how they want to prioritize HCV testing with their allocation. OA will not create tiered system of interventions.
- 6. Adopt the revised allocation formula (described in this report).
- 7. The proposal to require LHJ to certify (without providing documentation) that a weighted proportion of OA funds had been directed to services for African Americans is strongly supported by OA.
 - a. LHJs may request a waiver from OA.
- 8. Implement Funding Allocation Alternative #2 to maximize resources in the 17 most highly impacted jurisdictions in CA, taking into account the availability of direct CDC funding to LA and SF, while attempting to lessen destabilization to LA and SF that would result if no state CDC funding was allocated ⁶.
 - b. Under this allocation, only the 17 higher HIV/AIDS burden LHJs would receive funding, thus there is a clear but unavoidable negative impact on the lower burden LHJs.
 - c. The directly funded LHJs, LA and SF, will be allocated half of their new formula allocation and the remaining half will be redistributed among the remaining 15 higher impact LHJs. Based upon allocation estimates of \$7 million of CDC funding, the 15 LHJs would be allocated 46% of their combined C&T and E&P allocation from 2008-09 (range: \$87,500 to \$1.08 million). LA would be allocated 18% of their prior allocation (\$1.2 million) and SF would be allocated 14% of their prior allocation (\$434,300).
 - i. Note that in FY2007-08, CDC directly funded LA approximately \$12 million and SF approximately \$5.8 million. When comparing this allocation to the hypothetical allocation resulting from applying the State allocation formula to the combined total CDC resources provided to the State, LA and SF (\$24.8 million), accounting for 25% overhead for LA and SF to administer their direct funds, LA and SF are still allocated more than they would be if all funds were allocated based upon the State formula only (\$1.5 million and \$1.7 million, respectively)⁷.
 - d. The total dollars available for this allocation will depend on the total spent on core services and on redirection of salary and other overhead to program activities. These are described above and are subject to revision after CDPH review.

For all tables that follow, the percentages reflect all those responses of “important” & “very important” (except on questions asking for “agree” or “disagree”). Additionally, N = the number of people in that group that responded to that set of questions. The number in that column varies slightly from one question to another.

⁶ See Appendix for associated spreadsheet

⁷ See Appendix for associated spreadsheet

D. Education and Prevention Survey Findings⁸ Part 1: Core Services

Table 1a. Administration Proposal: Importance of Maintaining Core Services Provided by OA

Core Services	All N = 101	CCLAD N = 34	OA Contractor N = 36	Advisory Bodies N = 17	Planning Council Members N = 21	Advocacy Groups N = 5
	%	%	%	%	%	%
Rapid test kits	83	88	75	71	86	60
C&T training	65	61	68	59	71	50
Prevention training	44	35	36	35	37	60
Condom distribution	37	35	25	41	25	0
CA education materials	35	35	25	24	37	50
Capacity building assistance	32	17	27	56	32	50
Client referral resources	28	18	19	29	29	25
Technical assistance	24	9	24	29	15	33

Table 1b. CCLAD Survey Responses--Administration Proposal: Importance of Maintaining Core Services Provided by OA

Core Services	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	%	%	%
Rapid test kits	88	86	90
C&T training	61	64	58
CA education materials	35	43	35
Prevention training	35	21	30
Condom distribution	35	36	45
Client referral resources	17	7	25
Capacity building assistance	18	14	19
Technical assistance	9	14	6

⁸ All red areas in tables are areas where OA has taken a specific action

Table 2a. Conference Committee Proposal: Importance of Maintaining Core Services Provided by OA

Core Services	All N = 97	CCLAD N = 34	OA Contractor N = 34	Advisory Bodies N = 17	Planning Council Members N = 20	Advocacy Groups N = 4
	%	%	%	%	%	%
Rapid test kits	87	94	81	81	85	66
C&T training	62	58	64	53	60	75
Condom distribution	43	47	41	41	31	25
CA education materials	41	46	32	47	40	50
Prevention training	40	42	33	35	26	33
Client referral resources	32	15	29	35	25	50
Technical assistance	29	21	20	31	24	50
Capacity building assistance	28	17	22	53	6	50

Table 2b. CCLAD Survey Responses--Conference Committee Proposal: Importance of Maintaining Core Services Provided by OA

Core Services	All CCLAD only N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	%	%	%
Rapid test kits	94	86	100
C&T training	58	64	53
CA education materials	47	29	58
Condom distribution	46	28	60
Prevention training	42	43	42
Technical assistance	15	21	21
Client referral resources	21	7	21
Capacity building assistance	17	15	18

NARRATIVE RESPONSES:

General:

HIV rapid test kits and HIV C/T training received the most “important” and “very important” responses under both budget proposals. The services receiving the least support including capacity building assistance and TA; however, Advisory Group respondents placed higher value on capacity building and TA. 3 respondents from one LHJ supported funding only those OA positions needed for program administration.

Training:

HIV-counseling and testing training is deemed most valuable. There is support for web-based training, providing training funds for local training instead of statewide trainings, and reducing the number of training days for Basic I and II or eliminating Basic II.

Technical Assistance:

Several respondents indicated support for TA in managing agencies and programs with diminishing resources: maintaining infrastructure, organizational mergers, restructuring services to target high-risk clients, improving service delivery, and integrating prevention and care. Respondents indicated a need for TA for OA-funded activities.

Capacity Building:

There is interest in building capacity to provide services to special populations, particularly transgendered individuals. Other areas include PwP and harm reduction.

IMPLICATIONS:

There appears to be consensus across all survey categories that rapid test kits and C&T training are the most highly valued followed by a grouping of 3 others: Prevention training, condom distribution and CA educational materials. Amongst CCLAD participants, lower burden LHJs placed a high value on educational materials and condoms. These two resources are a cost effective way to provide a minimum level of resources to LHJs that would otherwise not receive direct funding. OA will bring educational materials and condom distribution in-house costing out at approximately \$225,000 for FY 08/09 since OA has adequate condom inventory for this FY. Thereafter \$300,000 will be needed to fund these activities.

CHRP Research

Table 3a. Maintenance of California HIV/AIDS Research Program (CHRP) Behavioral Intervention Research Project

	All N = 93	CCLAD N = 34	OA Contractor N = 29	Advisory Bodies N = 15	Planning Council Members N = 21	Advocacy Groups N = 4
	% agree	% agree	% agree	% agree	% agree	% agree
Discontinue funding	62	65	72	60	52	100

Table 3b. CCLAD Survey Responses-- Maintenance of California HIV/AIDS Research Program (CHRP) Behavioral Intervention Research Project

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Discontinue funding	65	64	65

NARRATIVE RESPONSES:

Many respondents felt that the cost to complete the study outweighed the benefits of its findings. The cost associated with the study could be better utilized by providing more services to individuals in need. Two years of data will provide a significant amount of information. Others felt that closing down the research would be a mistake given the investment made to date and the fact that research is important to determine where our resources should be targeted.

IMPLICATIONS:

Per CHRP, the Latino and AA male studies were designed to produce CDC level data that could advance them to DEBIs; the AA women’s study was designed to be more formative in nature. In terms of progress, the Latino male study is furthest along and on target to achieve its goals (\$260,685 due for 09/10). The AA male study has had recruitment difficulties and is not on target to achieve its goals (\$231,028 due for 09/10). The AA women’s study was delayed by human subjects approval (\$85,095 due for 09/10, but may not need funds to complete study).

OA will not continue funding CHRP Research projects. CHRP may decide to continue AA women’s study if additional funds are not necessary. CHRP may wish to consider continuing funding of Latino male study because it is currently on target to achieve its goals. CHRP has non-OA resources.

PTC Trainings

Table 4a. Administration Proposal: Importance of Maintaining PTC trainings

PTC Training	All N = 97	CCLAD N = 34	OA Contractor N = 33	Advisory Bodies N = 16	Planning Council Members N = 20	Advocacy Groups N = 4
	%	%	%	%	%	%
Men who Have Sex with Men	54	44	56	75	70	100
Prevention with Positives	53	50	46	69	55	75
CRCS	42	35	41	44	45	75
HIV Medical Provider	31	32	24	31	32	0
Continuing Education	29	12	26	33	32	0
Group Facilitation	14	9	7	25	15	0

Table 4b. CCLAD Survey Responses--Administration Proposal: Importance of Maintaining PTC trainings

PTC Training	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	%	%	%
Prevention with Positives	44	64	40
Men who Have Sex with Men	50	50	40
CRCS	35	29	40
HIV Medical Provider	32	29	35
Continuing Education	12	14	10
Group Facilitation	9	0	15

Table 5a. Conference Committee Proposal: Importance of Maintaining PTC trainings

PTC Training	All N = 93	CCLAD N = 34	OA Contractor N = 32	Advisory Bodies N = 16	Planning Council Members N = 19	Advocacy Groups N = 4
	%	%	%	%	%	%
Men who Have Sex with Men	63	56	65	73	72	100
Prevention with Positives	63	61	63	69	63	75
CRCS	57	55	53	47	58	67
HIV Medical Provider	43	44	33	44	39	0
Continuing Education	41	24	40	38	41	0
Group Facilitation	19	18	10	25	11	0

Table 5b. CCLAD Survey Responses--Conference Committee Proposal: Importance of Maintaining PTC trainings

PTC Training	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	%	%	%
Prevention with Positives	56	64	58
Men who Have Sex with Men	61	57	55
CRCS	55	50	58
HIV Medical Provider	44	36	50
Continuing Education	24	29	21
Group Facilitation	18	14	21

NARRATIVE RESPONSES:

PTC trainings for men who have sex with men (MSM) and Prevention with Positives (PwP) were found to be the most important under both budget proposals. Those who ranked PwP and MSM high explained that they did so because MSM still have the highest infection rates. Respondents who ranked Group Facilitation, CETs and medical provider training low suggested that there were other sources for such trainings. Several suggestions to have the curricula written as CET modules that can be presented by local health departments, and suggestions were made to eliminate CET requirements entirely.

Other comments

- Trainings should be local, designed as CETs
- Web-based, distance learning, brief, effective training
- Any mandate should have training attached

- Eliminate training
- OA should look at what training participants say about the trainings

IMPLICATIONS:

Support for training in the context of severely diminished resources was not particularly strong. In general, CCLAD members found training to be a lower priority than all other stakeholders (higher burden CCLAD members rated training a higher priority than lower burden CCLAD members). Support for training was highest amongst Advisory Bodies, Regional Planning Council Members, and Advocacy Groups.

Next steps: Trainings provided by PTC will not be funded because of limited funding. OA will attempt to identify additional non-OA funded training resources and make that information available.

Rapid Test Kits

Table 6a. Rapid Test Kit Funding Options

	All N = 86*	CCLAD N = 34	OA Contractor N = 25	Advisory Bodies N = 14	Planning Council Members N = 19	Advocacy Groups N = 4
	% agree	% agree	% agree	% agree	% agree	% agree
LHJs assume 100% cost	41	30	40	50	68	50
LHJs assume 50% cost	50	47	56	69	65	50

Table 6b. CCLAD Survey Responses--Rapid Test Kit Funding Options

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
LHJs assume 100% cost	30	36	25
LHJs assume 50% cost	47	43	50

- Support for both options was similar; however, slightly more stakeholders supported option #2.

NARRATIVE RESPONSES:

Option #1:

Most felt LHJs could not afford this option. Small LHJs felt that it would be detrimental to their program. Some thought that small LHJs should receive test kits at a lower cost while other felt that we should meet halfway and charge \$5.00 per

test kit. LHJs felt that they would need support in entering into an agreement with the test kit manufacturer. In contrast, some respondents also felt that by having LHJs order their own rapid test kits, they may be more prudent in their ordering and monitoring the test kits.

Option #2:

Several respondents felt that LHJs need to be more accountable for testing services. Many respondents felt that OA should give them the money and then they would save on resources by streamlining the process of ordering test kits. Concern was expressed that if LHJs are charged for the test kits, some LHJs may reduce the amount of testing that they perform. Some indicated that: funding for testing and test kits should be at the local level so that resources can better be monitored; triaging clients would be important and services should only be offered to high risk clients; they would need support from OA to decline testing for individuals that don't indicate that they are at risk.

IMPLICATIONS:

Majority would like OA to continue to provide test kits. LHJs stated they did not have the funds, ability to contract, or staff to be able to do this on their own. Comments included desire for help in prioritizing use of RT kits, and for TA re. billing insurance for testing. Decision made for OA to continue to provide test kits; under Administration Proposal, costs would come out of LHJ allocations. OA will continue to provide rapid HIV test kits for higher burden LHJs only, with the exception noted below (estimated cost, \$750,000).

- a. Testing sites in lower-burden LHJs that currently perform ≥ 100 tests per year and have a positive rate of $\geq 1\%$ will continue to receive rapid test kits (approximately 10 sites)
- b. OA will pursue strategies to control rapid test kit costs including: provision of technical assistance about billing insurance, consideration of charging using a sliding scale, and eligibility requirements for free testing.
- c. OA will pursue potential better test kit pricing agreements (in light of pending legislation that would support greater use of less expensive finger-stick rapid testing should this legislation be enacted).

Counselor Training

Table 7a. Proposal to Change Counselor Training Requirements

	All N = 85	CCLAD N = 34	OA Contractor N = 29	Advisory Bodies N = 13	Planning Council Members N = 18	Advocacy Groups N = 3
	% agree	% agree	% agree	% agree	% agree	% agree
Administration Proposal, no required counselor training & certification	51	59	41	31	50	67
Conference Committee Proposal, no required counselor training; invest in optional training	52	64	35	31	44	67

Table 7b. CCLAD Survey Responses-- Proposal to Change Counselor Training Requirements

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Administration Proposal, no required counselor training & certification	59	50	65
Conference Committee Proposal, no required counselor training; invest in optional training	64	62	65

NARRATIVE RESPONSES:

Counselor Training:

While a large number of respondents supported this concept, almost half did not support the OA proposal to no longer require HIV test counselor training and certification. Local options for training by the LHJ, web-based programs and mentoring programs were all suggested. Comments included that training is critical but does NOT need to be provided by the State. Some mentioned that Basic I is essential. Some respondents expressed concern over quality of counseling if no longer required. One respondent mentioned that training is legally mandated. "People need training to do their jobs, and the state has an enormous stake in ensuring that the test counselors are doing high quality counseling."

Eliminating Counselor Training Requirement:

Approximately one-third of respondents did not favor this plan. Several respondents suggested eliminating the Basic II and CET requirements, and keeping Basic I and PCRS. One respondent suggested separating the counseling and testing components of the training, which may allow more flexibility for everyone. On the question of recommended funding, answers ranged from 0-20, with dollar amounts ranging from \$500K to \$1 million. Many respondents said they were unable to calculate the cost of training.

IMPLICATIONS:

Based on the centralized activities prioritization and the C&T counseling specific questions it appears that participants want a counselor training system that is less time intensive and retains/requires basic training and eliminates or makes optional CETs that are available online. Many respondents value quality standardized training standards. Suggestions include charging a fee for training, utilizing a TOT model, establishing a trainer cadre regionally (OA had this system some years back).

Next steps: A streamlined HIV Counselor training program will be funded through existing contractor at a cost of approximately \$350,000. OA will work with interested stakeholders to develop a flexible, high quality, scaled-down training system.

NIGHT

Table 8a. Maintenance of the NIGHT Outreach Program

	All N = 77*	CCLAD N = 34	OA Contractor N = 21	Advisory Bodies N = 16	Planning Council Members N = 18	Advocacy Groups N = 3
	% agree	% agree	% agree	% agree	% agree	% agree
Administration Proposal, continue NIGHT	74	68	71	93	78	100
Conference Committee, continue NIGHT	90	91	90	92	90	100

Table 8b. CCLAD Survey Responses-- Maintenance of the NIGHT Outreach Program

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Administration Proposal, continue NIGHT	68	71	65

Conference Committee, continue NIGHT	91	93	90
--------------------------------------	----	----	----

IMPLICATIONS:

Since General Fund is required to receive the Medi-Cal matching funds (not explained in the survey), OA will eliminate specific funding for NIGHT. Note that HIV positivity rates in NIGHT testing have been lower than the non-Night testing in the 21 NIGHT LHJs (FY 05/06 non-NIGHT 1.2% vs. NIGHT 0.8%, FY 06/07 non-NIGHT 1.3% vs. NIGHT .0.9% and FY 07/08 non-NIGHT 1% vs. NIGHT 0.7%). With OA approval, LHJs with productive NIGHT programs may use their prevention and testing allocation funds for NIGHT activities.

Partner Services

Table 9a. Funding for Partner Services in Highly Impacted LHJs

	All N = 73	CCLAD N = 33	OA Contractor N = 22	Advisory Bodies N = 16	Planning Council Members N = 16	Advocacy Groups N = 3
	% agree	% agree	% agree	% agree	% agree	% agree
10% Investment Model	44	33	52	60	60	33
15% Investment Model	56	67	48	69	40	67
15% Funding Directly to LHJs	45	42	55	27	56	33

Table 9b. CCLAD Survey Responses--Funding for Partner Services in Highly Impacted LHJs

	All CCLAD N = 33	Higher Burden LHJs N = 14	Lower Burden LHJs N = 19
	% agree	% agree	% agree
10% Investment Model	33	21	42
15% Investment Model	67	79	58
15% Funding Directly to LHJs	42	50	37

NARRATIVE RESPONSES:

Some respondents believe a strong, centralized PS system run by STD Control Branch is the most effective. Others believe that good agencies should already be doing this effectively as a part of comprehensive prevention services.

Several comments mentioned duplication of services. Some concern about the accuracy of PS reporting by providers across the state.

IMPLICATIONS:

15% Investment model was most favored across almost all groups. Estimated cost is \$1.2 million. Although a funding model that includes LA/SF would reduce funds to the 15 other higher burden LHJs an average of 25%, it decreases destabilization to the 2 directly funded LHJs. For each of the 17 higher burden LHJs, there is an approximate 15% investment for Partner Services (PS) from the combined C & T and E/P allocation. The distribution of the funds to support PS within each LHJ is dependent on their current PS infrastructure, with CDPH STD Control Branch providing more support and less funding for those LHJs with less infrastructure as follows: 1) LHJs with fully developed and integrated HIV/STD Disease Intervention Specialist (DIS) teams will receive 100% of their funding allocation for PS; 2) LHJs with trained DIS but needing direct DIS support from the STD Control Branch will receive 50% of their funding allocation for PS; 50% of the funding will be allocated to STD Control Branch; 3) LHJs with trained DIS but needing some supervisory State DIS support will receive 80% of the funding allocated for PS; 20% of the funding will be allocated to STD Control Branch. (See funding Table in Appendix.)

Utilizing this allocation formula, six LHJs receive 100% of the funding allocated for PS; three LHJs receive 50%, and three LHJs receive 80%. For five LHJs with no infrastructure in place for PS, 100% of the allocation goes to STD Control Branch to provide direct services to that LHJ. Of the total amount of funding for PS, 63% is distributed to LHJs and 37% is allocated to STD Control Branch. Provide \$1.2 million to STD control branch to support Partner Services in all 17 high burden LHJs.

Tiered Activities

Table 10a. Prioritization of Prevention Activities using a Tiered System

	All N = 87	CCLAD N = 34	OA Contractor N = 29	Advisory Bodies N = 15	Planning Council Members N = 19	Advocacy Groups N = 4
	% agree	% agree	% agree	% agree	% agree	% agree
Tier 1						
Testing (no required counseling)	70	71	59	73	94	75
SEP	73	65	73	100	90	100
DEBIs	63	62	57	79	60	100
PwP in care settings	81	82	76	93	84	75
Tier 2						
PwP in non-care settings	49	64	32	50	37	50
HCV testing	70	70	72	77	68	75
Non-DEBIs	57	70	39	42	44	75
Counseling with Testing	53	56	44	54	56	0

Table 10b. CCLAD Survey Responses--Prioritization of Prevention Activities using a Tiered System

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Tier 1			
Testing (no required counseling)	71	71	70
SEP	65	79	55
DEBIs	62	50	70
PwP in care settings	82	93	75
Tier 2			
PwP in non-care settings	64	64	63
HCV testing	70	86	58
Non-DEBIs	70	57	79
Counseling with Testing	56	43	65

NARRATIVE RESPONSES:

Testing without counseling, Testing with counseling:

Most commentators wanted to ensure that all high-risk testers were counseled. A few felt it should be optional. One respondent felt that counseling and testing have become institutionalized over the last many years; it is hard to think of these activities separated, or one without the other. Others noted that in some settings (e.g. medical settings), it makes sense to de-link these activities, but there should be at a minimum referrals for risk reduction counseling for high risk patients, if not available on site.

Syringe Exchange Programs:

Most respondents agreed that SEPs should be a Tier One activity. Four of the 13 commentators wanted harm reduction funds for IDUs, in addition or instead of funding for SEPs, expressing concern that they would be left out of a funding opportunity because SEPs were not permitted in their jurisdiction.

DEBIs for High-Risk Negatives:

Most commentators did not support limiting interventions to DEBIs, which were described as expensive and inflexible. Many comments expressed support for “homegrown” interventions.

Prevention with Positives in Care Settings:

Most respondents believe that PwP should be a Tier One activity. Comments included: PwP is the ethical responsibility of any care provider, and there are other funding streams which can support it.

Prevention with Positives in Non-Care Settings:

Most respondents felt this should be a Tier One activity. One respondent suggested that this should be the responsibility of the STD Control Branch, and that STD prevention efforts should be much more visible.

HCV Testing:

Of the respondents who did not agree that HCV testing should be Tier Two, thirteen felt it should be Tier One, seven felt it should not be funded at all.

IMPLICATIONS:

After further analysis at OA, the “Tiers” approach appears not to be feasible to implement quickly; HCV testing appears to be the only activity that appropriately would fit in a second tier. Thus, all interventions types will be allowable at this time. Consideration of prioritization of interventions through tiers may be considered at a later date, in consultation with stakeholders. Additional assistance to some LHJs will be needed to help them determine those behavioral intervention activities are most effective for a given population.

Next steps: HIV CHOICE website will be brought in-house to OA for additional development and maintenance to assist funded LHJs in selecting appropriate prevention interventions.

Other OA Services

Table 11a. Funding and Prioritization of Additional OA Services

	All N = 81	CCLAD N = 34	OA Contractor N = 27	Advisory Bodies N = 15	Planning Council Members N = 17	Advocacy Groups N = 4
	% agree	% agree	% agree	% agree	% agree	% agree
Administration Proposal, support needs assessment, TA, capacity building	24	21	11	36	25.0	0
Conference Committee Proposal, support needs assessment, TA, capacity building	41	44	31	39	33	0
Administration Proposal, provide CBO data	75	65	83	93	88	100
Conference Committee Proposal, provide CBO data	77	65	83	93	88	100

Table 11b. CCLAD Survey Responses-- Funding and Prioritization of Additional OA Services

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Administration Proposal, support needs assessment, TA, capacity building	21	36	10
Conference Committee Proposal, support needs assessment, TA, capacity building	44	64	30
Administration Proposal, provide CBO data	65	86	50
Conference Committee Proposal, provide CBO data	65	86	50

- There is little overall support in favor of OA funding needs assessments, trainings, TA or capacity building
- The majority of stakeholders agree that OA should provide data on performance of specific CBOs.

IMPLICATIONS:

Broad consensus that needs assessment with associated TA and capacity building was not favored. However, it is not clear if this question was well articulated. Equally broad consensus that data would be helpful.

Next steps: Develop a plan to implement the provision of CBO data to LHJs. Continue to consider what types of TA would be helpful, as a lower priority.

African American Disparities

Table 12a. Proposal to Address HIV/AIDS Disparities among African Americans

	All N = 84	CCLAD N = 33	OA Contractor N = 25	Advisory Bodies N = 14	Planning Council Members N = 18	Advocacy Groups N = 5
	% agree	% agree	% agree	% agree	% agree	% agree
required funding for AAs	51	39	60	73	67	80

Table 12b. CCLAD Survey Responses--Proposal to Address HIV/AIDS Disparities among African Americans

	All CCLAD N = 33	Higher Burden LHJs N = 14	Lower Burden LHJs N = 19
	% agree	% agree	% agree
required funding for AAs	39	57	26

- A small majority of stakeholders support the proposal to require LHJs to focus a proportion of funding on African American populations.
- CCLAD members least favored this requirement, especially those from lower burden LHJs.

NARRATIVE RESPONSES:

Several responses favored letting local jurisdictions make the decisions related to AA spending, and expressed the view that fewer dollars should result in increased local control over those dollars. Several responses were concerned that this requirement would come at the expense of other groups at risk (primarily Latino). One respondent suggested it would be difficult to track interventions by race if your work reaches or targets other groups as well.

IMPLICATIONS:

There is also strong support for this concept within OA, although we recognize that this proposal was not highly supported by survey respondents.

Next steps: The proposal to require LHJ to certify (without providing documentation) that a weighted proportion of OA funds had been directed to services for African Americans will be implemented, at a lower weight (2 times instead of 2.5 times). LHJs may request a waiver from OA.

Funding Allocations

Table 13a. Proposed Funding Allocations

	All N = 84	CCLAD N = 34	OA Contractor N = 28	Advisory Bodies N = 15	Planning Council Members N = 18	Advocacy Groups N = 5
	% agree	% agree	% agree	% agree	% agree	% agree
Support Alternative #1	38	24	42	47	50	80
Support Alternative #2	30	30	19	33	27	20
Support Alternative #3	59	53	65	57	69	20
Funds for unfunded LHJs	44	53	36	29	31	50
Fund only LHJs with highest HIV/AIDS burden ` This question was not included in the initial CCLAD survey	70	0	71	93	82	100
Prefer proposed allocation formula to historic formula	68	62	82	92	93	100
Apply alternate formula to E&P and C&T funding	68	56	77	92	93	75
1 allocation for E&P and C&T funding	77	85	72	93	75	75
MOU would work for LHJ	91	97	88	100	100	100
Conference Committee Proposal, support OA exploring alternative funding allocations	75	88	63	67	71	50

Table 13b. CCLAD Survey Responses--Proposed Funding Allocations

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Support Alternative #1	24	21	25
Support Alternative #2	30	14	40
Support Alternative #3	53	71	40
Funds for unfunded LHJs	53	50	55
Fund only LHJs with highest HIV/AIDS burden ~ This question was not included in the initial CCLAD survey, thus only responses from the three CCLAD members who completed the second stakeholder survey are included	0	-	0
Prefer proposed allocation formula to historic formula	62	79	50
Apply alternate formula to E&P and C&T funding	56	71	45
1 allocation for E&P and C&T funding	85	86	85
MOU would work for LHJ	97	100	95
Conference Committee Proposal, support OA exploring alternative funding allocations	88	79	95

- Stakeholders showed the greatest support for alternative #3 of the funding scenarios.

NARRATIVE RESPONSES:

Allocation Options:

Option #1

Most respondents did not favor this option. Many of the felt that the directly funded LHJs should not receive funding under this option, as one-third funding for the rest was too low to sustain programming.

Option #2

Most respondents did not favor this option. Several stated that LA and SF have resources other LHJs do not.

Option #3

Many respondents did not favor this option. One response was fairly representative of the comments in this section, “The large LHJs have a larger share of the cases and impact and should not have their total awards removed to maintain funding in the other LHJs.”

Set-aside Funds for Unfunded LHJs:

Over half of the respondents did not favor this option. One comment elaborated, “On the surface, not sure if this would be the best use of resources. How would ‘urgent HIV prevention issues’ be defined?”

Agreement With Plan to Fund only LHJs with High HIV Burden (Question not asked in the CCLAD only survey)

Almost three-quarters agreed with this approach. One respondent suggested that they needed clarification of the term “highest burden” with a documented cutoff point for funding. Most others commented that the smaller counties still had need, and expressed concern that their HIV rates would increase. “If you eliminate our funding, does this mean our clients don’t count? Should we recommend to them that they move to LA or SF to get their care?”

Proposed Formula vs. Historic Formula

Most respondents prefer the proposed allocation formula over the historic formula. Among those who do not prefer it, some mentioned that their county would lose funding under the new formula. One suggested it was a good idea to remove Chlamydia and syphilis, as these don’t follow the new HIV infection pattern. One suggested the new formula should be vetted by the CHPG. Another respondent suggested that the new formula under-represents Latinos and Caucasians. Similar responses were given to the question of whether or not respondents supported the plan to apply the alternate formula to both E&P and C&T funding.

Combining E&P and C&T Funding

Approximately one-quarter of respondents did not favor this plan. One respondent commented, “I am concerned that most funds would go to testing, whether that is most effective or not. To ensure that prevention services go to high-risk negatives, separate funding helps.” Another was concerned that “block grants” can more easily be cut.

IMPLICATIONS:

Allocations - A very small majority of respondents favored Option #3. It should be noted that in the CCLAD only survey, the question related to support for funding only the higher burden LHJs was not asked; as a result, many lower burden LHJs expressed their lack of support of this issue (reflected in narrative comments) – this question was added to the Stakeholders survey to address this concern. 71% of higher burden LHJs supported Option #3 in the CCLAD only survey. However, OA will implement Option #2 to decrease destabilization to the 2 directly funded LHJs. The set aside option was clearly not favored and should not be implemented. All other issues had good support and no additional steps are needed.

Next steps: Implement Funding Allocation Alternative #2 to maximize resources in the 17 most highly impacted jurisdictions in CA, taking into account the availability of direct CDC funding to LA and SF, while attempting to lessen destabilization to LA and SF that would result if no state CDC funding was allocated⁹.

⁹ See Appendix for associated Prevention Allocation Table

Under this allocation, only the 17 higher HIV/AIDS burden LHJs would receive funding, thus there is a clear but unavoidable negative impact on the lower burden LHJs.

The directly funded LHJs, LA and SF, will be allocated half of their new formula allocation and the remaining half will be redistributed among the remaining 15 higher impact LHJs. Based upon allocation estimates of \$7 million of CDC funding, the 15 LHJs would be allocated on average 46% of their combined C&T and E&P allocation from 2008-09 (range: \$87,500 to \$1.08 million). LA would be allocated 18% of their prior allocation (\$1.2 million) and SF would be allocated 14% of their prior allocation (\$434,300).

Note that in FY2007-08, CDC directly funded LA approximately \$12 million and SF approximately \$5.8 million. When comparing this allocation to the hypothetical allocation resulting from applying the State allocation formula to the combined total CDC resources provided to the State, LA and SF (\$24.8 million), accounting for 25% overhead for LA and SF to administer their direct funds, LA and SF are still allocated more than they would be if all funds were allocated based upon the State formula only (\$1.5 million and \$1.7 million more, respectively)¹⁰.

Savings

Table 14a. Conference Committee Proposal: Identify Savings of \$2.2 Million for E&P and C&T Activities

	All N = 84*	CCLAD N = 34	OA Contractor N = 27	Advisory Bodies N = 14	Planning Council Members N = 17	Advocacy Groups N = 3
	% agree	% agree	% agree	% agree	% agree	% agree
Conference Committee Proposal, support savings options	93	97	93	92	94	100
Support savings as a reduction to LHJ allocations	18	15	15	36	18	33

¹⁰ See Appendix for associated spreadsheet

Table 14b. CCLAD Survey Responses--Conference Committee Proposal: Identify Savings of \$2.2 Million for E&P and C&T Activities

	All CCLAD N = 34	Higher Burden LHJs N = 14	Lower Burden LHJs N = 20
	% agree	% agree	% agree
Conference Committee Proposal, support savings options	97	93	100
Support savings as a reduction to LHJ allocations	15	0	25

IMPLICATIONS:

This option is no longer relevant.

OTHER NARRATIVE RESPONSES:

General Approach to Planning:

- Don't use budget cuts as the primary tool for policy. "Policy may need to bend in the wind of insufficient funding, but the principles on which we build our programs should change only when data and insight suggest that there are better ways to do things."
- Think about what are the best cuts to make based on the idea of these being temporary: once you dismantle a program, it can be impossible to start again.

CDC Directly Funded LHJs:

- SF and LA cannot necessarily "absorb a hit" because they are directly funded: that is not a sensible way to make allocation decisions.
- Encourage locals to apply for direct CDC funds—CA is underrepresented among those agencies, which receive federal funds.

Resource Management:

- Better contract monitoring and feedback is needed to prevent LHJs from using resources in schools and drug treatment settings, where other funding streams should pay for that.
- We need to start mainstreaming HIV/AIDS testing and prevention in jurisdictions with small numbers. Standalone services for a particular risk group may not work any more.

APPENDIX

Care Allocation Table

CARE Formula-based Allocation (Cap at 70%)

: TGA counties
 : EMA counties

Local Health Jurisdiction	EIP	CMP	TMP	CSP	TOTAL (EIP+CMP+TMP +CSP)	Formula-based Allocation	Total Funding Decrease	Formula allocation as % of TOTAL
Alameda	\$1,328,225	\$654,611	\$170,545	\$596,515	\$2,749,896	\$1,190,123	-\$1,559,773	43.3
Alpine	\$0	\$0	\$0	\$15,000	\$15,000	\$0	-\$15,000	0.0
Amador	\$0	\$0	\$0	\$37,902	\$37,902	\$26,531	-\$11,371	70.0
Butte	\$324,913	\$180,496	\$6,540	\$55,427	\$567,376	\$198,582	-\$368,794	35.0
Calaveras	\$0	\$90,248	\$0	\$32,876	\$123,124	\$43,093	-\$80,031	35.0
Colusa	\$0	\$0	\$0	\$15,000	\$15,000	\$7,500	-\$7,500	50.0
Contra Costa	\$330,175	\$216,595	\$0	\$211,102	\$757,872	\$385,314	-\$372,558	50.8
Del Norte	\$0	\$0	\$0	\$31,420	\$31,420	\$21,994	-\$9,426	70.0
El Dorado	\$0	\$0	\$0	\$77,990	\$77,990	\$45,197	-\$32,793	58.0
Fresno	\$341,363	\$306,843	\$113,120	\$272,852	\$1,034,178	\$443,003	-\$591,175	42.8
Glenn	\$0	\$0	\$0	\$37,717	\$37,717	\$26,402	-\$11,315	70.0
Humboldt	\$285,065	\$153,421	\$18,640	\$66,130	\$523,256	\$183,140	-\$340,116	35.0
Imperial	\$222,675	\$90,248	\$8,140	\$53,703	\$374,766	\$131,168	-\$243,598	35.0
Inyo	\$0	\$0	\$400	\$70,058	\$70,458	\$7,500	-\$62,958	10.6
Kern	\$175,830	\$189,521	\$93,320	\$294,475	\$753,146	\$527,202	-\$225,944	70.0
Kings	\$67,660	\$45,123	\$4,390	\$53,243	\$170,416	\$72,643	-\$97,773	42.6
Lake	\$0	\$0	\$0	\$49,458	\$49,458	\$34,621	-\$14,837	70.0
Lassen	\$0	\$0	\$0	\$30,865	\$30,865	\$21,606	-\$9,260	70.0
Los Angeles	\$2,925,473	\$3,067,885	\$3,756,470	\$4,649,470	\$14,399,298	\$9,578,960	-\$4,820,338	66.5
Madera	\$81,983	\$0	\$4,920	\$57,055	\$143,958	\$66,583	-\$77,375	46.3
Marin	\$0	\$126,347	\$9,600	\$84,165	\$220,112	\$146,552	-\$73,560	66.6
Mariposa	\$0	\$0	\$0	\$29,850	\$29,850	\$7,500	-\$22,350	25.1
Mendocino	\$0	\$153,422	\$0	\$64,256	\$217,678	\$76,187	-\$141,491	35.0
Merced	\$0	\$0	\$600	\$74,412	\$75,012	\$52,508	-\$22,504	70.0
Modoc	\$0	\$0	\$0	\$15,000	\$15,000	\$7,500	-\$7,500	50.0
Mono	\$0	\$0	\$0	\$15,000	\$15,000	\$7,500	-\$7,500	50.0
Monterey	\$463,925	\$171,471	\$40,515	\$142,772	\$818,683	\$286,539	-\$532,144	35.0
Napa	\$0	\$90,248	\$3,110	\$33,601	\$126,959	\$70,917	-\$56,042	55.9
Nevada	\$0	\$99,273	\$0	\$64,056	\$163,329	\$57,165	-\$106,164	35.0
Orange	\$1,005,699	\$595,636	\$549,050	\$691,486	\$2,841,871	\$1,437,389	-\$1,404,482	50.6

Local Health Jurisdiction	EIP	CMP	TMP	CSP	TOTAL (EIP+CMP+TMP +CSP)	Formula-based Allocation	Total Funding Decrease	Formula allocation as % of TOTAL
Placer	\$0	\$0	\$11,350	\$59,850	\$71,200	\$49,840	-\$21,360	70.0
Plumas	\$90,688	\$90,248	\$1,635	\$31,420	\$213,991	\$74,897	-\$139,094	35.0
Riverside	\$604,405	\$676,859	\$105,615	\$609,636	\$1,996,515	\$1,157,791	-\$838,724	58.0
Sacramento	\$814,958	\$379,041	\$181,170	\$420,932	\$1,796,101	\$767,792	-\$1,028,309	42.7
San Benito	\$0	\$0	\$3,070	\$32,419	\$35,489	\$24,842	-\$10,647	70.0
San Bernardino	\$775,453	\$0	\$169,450	\$391,993	\$1,336,896	\$896,265	-\$440,631	67.0
San Diego	\$1,542,213	\$1,128,099	\$960,505	\$1,100,743	\$4,731,560	\$2,076,311	-\$2,655,249	43.9
San Francisco	\$1,321,125	\$828,182	\$758,170	\$1,389,851	\$4,297,328	\$3,008,130	-\$1,289,198	70.0
San Joaquin	\$306,200	\$288,793	\$77,950	\$159,538	\$832,481	\$322,726	-\$509,755	38.8
San Luis Obispo	\$86,525	\$135,372	\$0	\$87,517	\$309,414	\$108,295	-\$201,119	35.0
San Mateo	\$553,925	\$207,570	\$59,335	\$131,112	\$951,942	\$333,180	-\$618,762	35.0
Santa Barbara	\$448,150	\$388,066	\$106,715	\$105,216	\$1,048,147	\$366,851	-\$681,296	35.0
Santa Clara	\$759,530	\$280,200	\$110,340	\$390,225	\$1,540,295	\$782,378	-\$757,917	50.8
Santa Cruz	\$275,760	\$171,471	\$24,270	\$86,572	\$558,073	\$195,326	-\$362,747	35.0
Shasta	\$0	\$0	\$0	\$63,498	\$63,498	\$44,449	-\$19,049	70.0
Sierra	\$0	\$0	\$1,235	\$15,000	\$16,235	\$7,500	-\$8,735	46.2
Siskiyou	\$0	\$0	\$0	\$30,922	\$30,922	\$21,645	-\$9,277	70.0
Solano	\$0	\$207,570	\$7,175	\$144,575	\$359,320	\$230,864	-\$128,456	64.3
Sonoma	\$687,795	\$153,421	\$53,650	\$210,606	\$1,105,472	\$386,915	-\$718,557	35.0
Stanislaus	\$196,455	\$243,669	\$14,970	\$121,733	\$576,827	\$201,889	-\$374,938	35.0
Sutter	\$0	\$0	\$0	\$29,850	\$29,850	\$20,895	-\$8,955	70.0
Tehama	\$0	\$0	\$0	\$35,714	\$35,714	\$25,000	-\$10,714	70.0
Trinity	\$0	\$0	\$0	\$29,850	\$29,850	\$7,500	-\$22,350	25.1
Tulare	\$69,620	\$81,223	\$19,660	\$136,361	\$306,864	\$138,072	-\$168,792	45.0
Tuolumne	\$0	\$0	\$2,515	\$40,532	\$43,047	\$30,133	-\$12,914	70.0
Ventura	\$415,545	\$261,719	\$79,480	\$127,438	\$884,182	\$309,464	-\$574,718	35.0
Yolo	\$0	\$0	\$0	\$41,765	\$41,765	\$29,236	-\$12,530	70.0
Yuba	\$0	\$0	\$0	\$29,850	\$29,850	\$20,895	-\$8,955	70.0
Total	\$16,501,333	\$11,752,891	\$7,527,620	\$13,977,574	\$49,759,418	\$26,800,000	-22,959,418	50.1

Prevention - Partner Services Allocation and Program Structure Table

OA Alternative #2

LHJ	Pre-PS LHJ Allocation/ "Alternative 2"	PS Funding (15%)	PS Allocation and Programming			
			LHJ w/Integrated HIV/STD DIS Teams (No State Support)	LHJ w/Trained DIS +Direct State DIS Support (50% to LHJ; 50% STDCB)	LHJ w/Trained DIS + Supervisory State DIS Support (80% to LHJ; 20% STDCB)	State Safety Net + Direct DIS + Supervisory Support (STDCB)
Alameda	\$579,715	\$86,957	\$0	\$0	\$69,565.80	\$17,391
Contra Costa	\$220,242	\$33,036	\$33,036	\$0	\$0	\$0
Fresno	\$235,812	\$35,372	\$0	\$0	\$0	\$35,372
Kern	\$245,212	\$36,782	\$0	\$0	\$0	\$36,782
Long Beach	\$450,075	\$67,511	\$0	\$0	\$0	\$67,511
Los Angeles	\$1,402,570	\$210,386	\$210,386	\$0	\$0	\$0
Orange	\$748,518	\$112,278	\$0	\$56,139	\$0	\$56,139
Riverside	\$559,149	\$83,872	\$0	\$0	\$67,098	\$16,774
Sacramento	\$380,157	\$57,024	\$0	\$28,512	\$0	\$28,512
San Bernardino	\$433,071	\$64,961	\$0	\$0	\$51,969	\$12,992
San Diego	\$1,204,711	\$180,707	\$0	\$0	\$144,565	\$36,141
San Francisco	\$524,238	\$78,636	\$78,636	\$0	\$0	\$0
San Joaquin	\$157,768	\$23,665	\$23,665	\$0	\$0	\$0
San Mateo	\$178,510	\$26,777	\$26,777	\$0	\$0	\$0
Santa Clara	\$400,854	\$60,128	\$0	\$0	\$0	\$60,128
Solano	\$140,955	\$21,143	\$21,143	\$0	\$0	\$0
Sonoma	\$138,443	\$20,766	\$0	\$0	\$0	\$20,766
Total	\$8,000,000	\$1,200,000	\$393,643	\$84,651	\$333,198	\$388,509

Funds to specific LHJ to support local integrated HIV/STD PS team

Funds to state DIS regional offices to support regional HIV/STD team

The portion of this funding that is used to support local PS activities will be allocated to the LHD with their overall prevention allocation.

Prevention – LHJ Allocation Example from Surveys, Adjusted for \$7 instead of \$8 Million

(\$7 million is likely to be the available resource based on core service decisions, however final amounts will depend upon final determination of total resources available for LHJ allocation)

Please note that the comparison of FY2009-10 funding to FY2008-09 funding only takes into consideration the base E&P and C&T funding in FY2008-09. It does not include HCV testing funds, NIGHT funds, or “augmentation” funds.

Allocation of Formula-Based Funding, Current vs. Alternatives (LHJs that received 1% or more in 2008/09)

Formula:
$$\text{County\$} = \left(\frac{a}{A} * 0.20 + \frac{b}{B} * 0.20 + \frac{c}{C} * 0.20 + D * 0.075 + E * 0.075 + F * 0.15 + G * 0.05 + H * 0.05 \right) * \text{State\$}$$

a = number of new HIV infections identified through C & T in the county
 A = number of new HIV infections identified through C & T in California
 b = number of newly reported HIV cases in the county
 B = number of newly reported HIV cases in California
 c = number of living AIDS cases in the county
 C = number of living AIDS cases in California

D = % of state total syphilis in men
 E = % of state total GC in men
 F = % of state total African Americans
 G = % of state total Hispanics
 H = % of state total people living below federal poverty line
 In red: Average % of funding LHJs receive compared to current funding
 *: LHJs that received separate funding

Local Health Jurisdiction	2008/09	2009/10											
	E/P formula & C/T base allocation	Alternative #1				Alternative #2				Alternative #3			
		LHJs with funding=>1%	Change (\$)	CHG (%)	% of prior fund	50% for LA&SF	Change (\$)	CHG (%)	% of prior fund	Exclude LA&SF	Change (\$)	CHG (%)	% of prior fund
Alameda	\$1,118,310	\$407,620	(710,690)	(64)	36	\$591,860	(526,450)	(47)	53	\$770,589	(347,721)	(31)	69
Alpine	\$1,102												
Amador	\$14,011												
Berkeley	\$316,742												
Butte	\$103,527												
Calaveras	\$9,762												
Colusa	\$2,149												
Contra Costa	\$425,426	\$140,351	(285,075)	(67)	33	\$203,788	(221,638)	(52)	48	\$262,656	(162,770)	(38)	62
Del Norte	\$7,614												
El Dorado	\$21,659												
Fresno	\$437,253	\$141,212	(296,041)	(68)	32	\$205,038	(232,215)	(53)	47	\$261,863	(175,390)	(40)	60
Glenn	\$5,657												
Humboldt	\$90,267												
Imperial	\$77,540												
Inyo	\$2,675												

Local Health Jurisdiction	2008/09	2009/10											
	E/P formula & C/T base allocation	Alternative #1				Alternative #2				Alternative #3			
		LHJs with funding=>1%	Change (\$)	CHG (%)	% of prior fund	50% for LA&SF	Change (\$)	CHG (%)	% of prior fund	Exclude LA&SF	Change (\$)	CHG (%)	% of prior fund
Kern	\$535,857	\$137,771	(398,086)	(74)	26	\$200,042	(335,815)	(63)	37	\$261,589	(274,268)	(51)	49
Kings	\$62,707												
Lake	\$28,147												
Lassen	\$10,197												
Long Beach	\$801,144	\$259,672	(541,472)	(68)	32	\$377,041	(424,103)	(53)	47	\$503,469	(297,675)	(37)	63
* Los Angeles	\$6,938,897	\$2,454,843	(4,484,054)	(65)	35	\$1,227,421	(5,711,476)	(82)	18				
Madera	\$50,203												
Marin	\$226,710												
Mariposa	\$2,446												
Mendocino	\$52,788												
Merced	\$69,913												
Modoc	\$1,085												
Mono	\$5,959												
Monterey	\$162,594												
Napa	\$34,200												
Nevada	\$31,392												
Orange	\$1,414,296	\$408,458	(1,005,838)	(71)	29	\$593,077	(821,219)	(58)	42	\$782,492	(631,804)	(45)	55
Pasadena	\$138,247												
Placer	\$48,395												
Plumas	\$4,851												
Riverside	\$962,650	\$338,829	(623,821)	(65)	35	\$491,976	(470,674)	(49)	51	\$647,563	(315,087)	(33)	67
Sacramento	\$681,117	\$230,131	(450,986)	(66)	34	\$334,148	(346,969)	(51)	49	\$431,906	(249,211)	(37)	63
San Benito	\$10,318												
San Bernardino	\$719,800	\$299,114	(420,686)	(58)	42	\$434,311	(285,489)	(40)	60	\$557,645	(162,155)	(23)	77
San Diego	\$2,157,161	\$745,718	(1,411,443)	(65)	35	\$1,082,775	(1,074,386)	(50)	50	\$1,440,753	(716,408)	(33)	67
* San Francisco	\$3,011,998	\$868,649	(2,143,349)	(71)	29	\$434,324	(2,577,674)	(86)	14				
San Joaquin	\$310,154	\$98,431	(211,723)	(68)	32	\$142,921	(167,233)	(54)	46	\$184,287	(125,867)	(41)	59
San Luis Obispo	\$134,938												
San Mateo	\$350,565	\$94,722	(255,843)	(73)	27	\$137,535	(213,030)	(61)	39	\$182,910	(167,655)	(48)	52
Santa Barbara	\$229,483												
Santa Clara	\$724,427	\$233,421	(491,006)	(68)	32	\$338,925	(385,502)	(53)	47	\$445,515	(278,912)	(39)	61
Santa Cruz	\$151,539												
Shasta	\$63,038												
Sierra	\$193												
Siskiyou	\$18,272												

Local Health Jurisdiction	2008/09	2009/10											
	E/P formula & C/T base allocation	Alternative #1				Alternative #2				Alternative #3			
		LHJs with funding=>1%	Change (\$)	CHG (%)	% of prior fund	50% for LA&SF	Change (\$)	CHG (%)	% of prior fund	Exclude LA&SF	Change (\$)	CHG (%)	% of prior fund
Solano	\$213,324	\$80,776	(132,548)	(62)	38	\$117,286	(96,038)	(45)	55	\$151,300	(62,024)	(29)	71
Sonoma	\$384,397	\$60,283	(324,114)	(84)	16	\$87,530	(296,867)	(77)	23	\$115,464	(268,933)	(70)	30
Stanislaus	\$235,344												
Sutter	\$25,591												
Tehama	\$12,344												
Trinity	\$1,574												
Tulare	\$135,610												
Tuolumne	\$18,009												
Ventura	\$192,530												
Yolo	\$83,461												
Yuba	\$24,334												
Total	\$24,105,893	\$7,000,001			32	\$7,000,000			46	\$7,000,001			60

* 46% excluding LA and SF

Prevention – Impact of Alternative #2 Allocation Decision: *Hypothetical* Allocation Example
 (based upon \$7 million available for allocation)

Allocation of Formula-Based Funding, Alternative #2 vs. State Plus 100% Direct-Funding

Local Health Jurisdiction	Actual Allocation	Hypothetical Allocation	Difference (A)-(B)
	Alternative #2 (A)	Formula applied to sum of state and 100% of direct funding (B)	
Alameda Alpine Amador Berkeley Butte	\$591,860	\$1,444,139	-\$852,279
Calaveras Colusa Contra Costa Del Norte El Dorado	\$203,788	\$497,245	-\$293,457
Fresno Glenn Humboldt Imperial Inyo	\$205,038	\$500,294	-\$295,256
Kern Kings Lake Lassen Long Beach	\$200,042 \$377,041	\$488,102 \$919,980	-\$288,060 -\$542,939
* Los Angeles Madera Marin Mariposa Mendocino	\$10,227,421	\$8,697,157	\$1,530,264
Merced Modoc Mono Monterey Napa			

* Allocation for SF and LA in Alternative #2 includes formula-based state funding and 75% of direct federal funding.

Local Health Jurisdiction	Actual Allocation	Hypothetical Allocation	Difference (A)-(B)
	Alternative #2 (A)	Formula applied to sum of state and 100% of direct funding (B)	
Nevada Orange Pasadena Placer Plumas	\$593,077	\$1,447,107	-\$854,030
Riverside Sacramento San Benito San Bernardino San Diego	\$491,976 \$334,148 \$434,311 \$1,082,775	\$1,200,425 \$815,321 \$1,059,718 \$2,641,972	-\$708,449 -\$481,173 -\$625,407 -\$1,559,197
* San Francisco San Joaquin San Luis Obispo San Mateo Santa Barbara	\$4,784,324 \$142,921 \$137,535	\$3,077,500 \$348,728 \$335,587	\$1,706,824 -\$205,807 -\$198,052
Santa Clara Santa Cruz Shasta Sierra Siskiyou	\$338,925	\$826,977	-\$488,052
Solano Sonoma Stanislaus Sutter Tehama	\$117,286 \$87,530	\$286,176 \$213,574	-\$168,890 -\$126,044
Trinity Tulare Tuolumne Ventura Yolo Yuba			
Total	\$20,350,000	\$24,800,002	

