

California Department of Public Health
Center for Infectious Diseases
Office of AIDS
HIV Prevention and Expanded Testing
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2012 Application

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Category A: HIV Prevention Programs for Health Departments

A. Background and Need: Data referenced in this section represent information from our statewide 2009 Epidemiologic Profile Update. Los Angeles (the Metropolitan Statistical Area [MSA] with at least 30% of those living with HIV), the San Francisco MSA, and the rest of California itself will now constitute three distinct and independent Centers for Disease Control and Prevention (CDC) HIV Prevention project areas. This change will allow the California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) to better target resources to jurisdictions within the California Project Area (CPA) that represent both ongoing and emergent areas of need in order to yield a major statewide impact on the HIV epidemic. The data presented in the following section reflects all of California, not just the CPA.

California AIDS cases account for 15.1 percent of the nearly one million AIDS cases among adults and adolescents reported in the United States since the beginning of the epidemic. From 1983 to 2009 there have been a total of 222,277 persons diagnosed with HIV disease and reported to OA's surveillance system. Of these cumulative cases, 124,584 (56%) were presumed to be living with HIV disease at the end of 2009, and 121,619 of those were presumed to be living in California according to recent residence information.

Among the 124,584 individuals living with HIV disease and reported to CDPH, 43,504 cases (35%) were classified as HIV cases and 81,080 cases (65%) were classified as AIDS cases. In 2009, there were 6,377 persons newly diagnosed with HIV disease in California and reported to CDPH. The number of people newly diagnosed with HIV disease in California from 2000 to 2009 has fluctuated from year to year, but overall remained level. The number of individuals living with HIV disease has increased at a steady rate (average 9.5% increase per year) due to

relatively steady new infection rates coupled with successful care and treatment strategies for people living with HIV disease.

California's epidemic differs from the national epidemic in terms of race/ethnicity, gender and mode of exposure. The overwhelming majority (71% in 2009) of new diagnoses continue to be attributed to men who have sex with men (MSM). Nationally, blacks make up the largest number of new HIV/AIDS cases while in California it is Hispanics. National figures also show that women constitute almost a third of new cases annually. In California that figure is less than 15%. Likewise, national data indicate that heterosexual transmission is responsible for almost one third of new cases, a figure double that of California's heterosexual transmission percentage.

Males represent the overwhelming majority of persons living with HIV disease (83%) in California as well as those newly diagnosed in 2009 (87%). The rates of both new diagnoses and persons living with HIV were seven times greater among males than females. Hispanics constitute the largest racial/ethnic group newly diagnosed with HIV disease in 2009 (2,454 versus 2,052 whites and 1,452 blacks). Hispanics made up 38.7% of all newly diagnosed HIV disease cases in 2009, a greater proportion than the 31.4% all living cases. Newly diagnosed Hispanics were significantly more likely to be simultaneously diagnosed with AIDS than other races, highlighting the need to address known barriers to testing and care such as language, stigma, and health literacy. Although the newly diagnosed HIV disease rate is higher than whites (17.3 versus 12.5), it is still significantly lower than blacks (63.7). Hispanic transgender individuals account for almost 40% (n=342) of the transgender population living with HIV disease.

HIV disease continues to disproportionately impact African Americans in California. The rate of newly diagnosed HIV disease cases in 2009 was five times greater among blacks than whites. Among males, the rate of HIV disease diagnosis was 4.5 times that of white males. This disparity was markedly greater among black females whose rate of HIV disease diagnosis was 14 times that of their white female counterparts. While black females represented only six percent of California's female population, black females accounted for more than a third (35%) of new female HIV diagnoses in 2009. Black transgender individuals make up 35.3% (n=305) of the transgender population living with HIV disease. In terms of age, blacks made up 44% of all newly diagnosed youth aged 13 to 19 years compared to 22% of all other age groups.

Among all groups, the age at initial diagnoses has shifted significantly since 2000. The proportion of newly diagnosed cases in the 20-29 age group has increased significantly, while the proportion of 30-39 year olds has significantly decreased. The difference may be attributed to an increase in testing among younger individuals or due to a true increase in the number of new infections at a younger age.

While the largest proportion of cumulative cases diagnosed have been in the 30-39 age group, the largest proportion of persons living with HIV disease are 40-49 year olds. Over three-quarters (77%) of all individuals living with HIV disease at the end of 2009 were over 40 years of age. A greater proportion of older age groups (40+) are concurrently diagnosed with AIDS (46% versus 29%), indicating more late testing among these older age groups.

Injection drug use is the second most frequently reported risk behavior among people diagnosed with HIV and AIDS in California. HIV positivity is greatest among injection drug users (IDUs) identifying as transgender, African American, and reporting more than one race. The majority of IDUs at publicly funded HIV Counseling Testing Referral Services (CTRS) sites reported "sometimes or always" sharing needles (61.5% in 2005), and male-to-male sexual contact was

reported by 11.4% of all IDUs and 45.6% of HIV-positive IDUs. While IDUs make up only approximately 14% of the total cumulative and living HIV cases in California and 19% of the cumulative and living AIDS cases in California, on average, 30% of all deaths among persons living with HIV/AIDS are among IDUs.

Within the CPA, although no individual city has more than 30% of the living HIV cases, Alameda County, the Central Valley and the Southern regions have shown a significant increase in proportion of newly diagnosed cases across time. OA has mapped 2009 newly diagnosed cases by rate per 100,000, which highlights areas with likely higher HIV transmission rates, particularly Alameda County in the San Francisco East Bay, Madera and Kern counties in the Central Valley, and San Diego and Imperial Counties, which share their southern border with Mexico.

California's rich diversity is one of its greatest assets, but social and cultural inequities and geographical and structural barriers also exist. The array of behaviors, social determinants, and contexts affecting HIV risk includes mental health problems, substance use disorders, language and cultural barriers, immigration status, health belief systems, incarceration, stigma, the impact of health conditions that may co-occur with HIV, domestic violence, poverty, lack of access to transportation, and limited access to HIV testing, prevention services, healthcare and HIV treatment. California's prevention programs have long recognized the fact that in order to be effective, interventions must be tailored to meet the needs of specific locales and populations. For each jurisdiction, the potential influence of some or all of the factors mentioned above may be different and differently weighted, when considered along with individuals' race, age and sexual and gender identity.

California prevention efforts are still significantly impacted by the devastating budget cuts that, as of July 2009, culminated in the loss of all State funds for HIV testing and prevention

activities. This represented approximately 80% of previous prevention activity funding, with the bulk of these dollars provided to local health jurisdictions (LHJs) for direct services. None of these funds have been restored and the cuts have necessitated significant structural changes at both the local and state level. Despite staff reductions however, OA sustains expertise in HIV prevention interventions (behavioral and structural), HIV testing in both medical and non-medical settings, perinatal HIV prevention, syringe service programming, Partner Services (PS), health communication and care/prevention services integration. Multiple staff have more than 25 years' experience working in HIV/AIDS. Areas of developing levels of expertise include biomedical prevention interventions and prevention with positive programs. OA plans to work with our capacity building partners to address additional internal training needs in these areas.

We sustain close partnership with local health department staff which oversee the delivery of HIV prevention programs throughout California, and jointly assist community-based organizations providing HIV prevention programs. The use of our online program monitoring system, Local Evaluation Online (LEO), provides the capacity to report on all program activities. In addition, OA is developing a process to link prevention information from LEO with other information systems at OA, including the Enhanced HIV/AIDS Reporting System (eHARS), (which contains HIV surveillance data) and the AIDS Regional Information and Evaluation System (ARIES), the reporting system utilized by Ryan White (RW) Part B recipients.

OA convenes the Community Planning Group (CPG), a cadre of community leaders from throughout the state who provide critical input and increase our capacity for ongoing planning and integration of prevention and care services. In addition, our Advisory Network allows us a means to communicate with more than 365 contacts throughout the state. These stakeholders are

available to provide community input and feedback critical to our planning and program and policy development.

B. Program Description – Overview: OA will be providing local assistance funding to 19 California LHJs of the newly designated CPA which represent the highest burden of HIV outside of San Francisco and Los Angeles, both of which are directly funded by CDC and will no longer be directly funded by OA. These 19 LHJs represent 95.08% of living HIV/AIDS cases in the CPA. The remaining 40 LHJs will not receive local assistance funding by OA for HIV prevention activities, however they can access educational materials, sterile injection supplies and condoms from OA.

In making its funding allocations and contracting with Prevention-funded LHJs, OA will use a two-tiered system of prioritized activities (**see Appendix M**). LHJs must use their funding allocation to provide services designated as Tier I. Only after they are providing all services in Tier I, using whatever resources are available to the LHJ, may they use their OA funding to provide services in Tier II. These tiers represent OA's priorities in HIV prevention, and correspond closely to the Required and Recommended services identified by CDC in the current Funding Opportunity Announcement (FOA).

In prioritizing and requiring some activities, OA is participating in the significant shifts represented by both the National HIV/AIDS Strategy (NHAS) and this FOA's approaches to HIV prevention. Many of these changes have already been undertaken by OA; others will be initiated under this grant. OA anticipates offering a considerable amount of technical assistance (TA) to the 19 LHJs in order to build capacity to achieve the goals of the FOA. Funded activities will include:

HIV Testing – OA will fund screening in both healthcare and non-healthcare settings, and Linkage to Care (LTC) will be a critical component of OA’s detection efforts. OA will continue to fund LHJs to provide HIV testing in non-healthcare settings but will assist LHJs to improve efforts to target testing to individuals at highest risk of HIV. OA will also aim to increase routine opt-out testing in healthcare settings both by encouraging collaboration between LHJs and healthcare providers and by providing substantial TA to major healthcare providers in routinizing HIV testing. Reimbursement for HIV testing will be pursued in both healthcare and non-healthcare settings, and LHJs will be required to assign a lead staff person to coordinate efforts related to the opportunities and challenges presented by healthcare reform. Collaboration with state agencies which are funded to provide HIV testing in these settings, including the Department of Alcohol and Drug Programs (ADP) and the Office of Family Planning will be intensified.

Comprehensive Prevention with Positives (PWP) – OA is reinvigorating its focus on PWP. LHJs will be required to fund linkage to and retention/re-engagement in care, assessment of prevention needs for HIV-positive persons in care and non-care settings, linkage to other medical and social services, behavioral interventions in medical and non-medical settings (especially targeting adherence to antiretroviral therapy), and PS in multiple settings. OA will operate a Prevention/Care workgroup to take on the tasks associated with prevention and care integration, and will assign a staff lead on healthcare reform for OA’s Prevention Branch. Recent legislative changes will allow health officers in LHJs to use surveillance data to determine lapses in care for HIV-positive individuals, and OA policy work will concentrate in this area. Healthcare reform represents another critical area of focused policy work for OA; a third initiative involves

collaborating with state partners on effective use of the funds dispersed by ADP and dedicated to services in drug and alcohol treatment settings.

Primary prevention – OA will prioritize three centralized programs: condom distribution and education materials through the California AIDS Clearinghouse (CAC) and a syringe supply bank, also through the CAC. The condom distribution program will be revised to target distribution to venues such as bathhouses, bars and clubs and syringe exchange programs which serve high risk individuals. Education materials will be made available to all LHJs in the CPA. OA will continue to support local funding of syringe services programs as well as local and state policy efforts to expand access to sterile syringes. Behavioral interventions for high-risk HIV-negative individuals are classified as Tier II activities, which means that may be funded by LHJs which have completed all Tier I activities. Social marketing activities are also categorized as Tier II activities. Hepatitis C virus (HCV) testing is classified as a Tier II activity, however LHJs will not be required to complete all Tier I activities prior to implementing a HCV testing program.

B1. Program Description – Required Activities

HIV Testing in Healthcare Settings: OA has been funded since 2007 by CDC’s PS07-768 and PS 10-10138 to provide HIV testing in healthcare settings (HCSs). Lessons learned in those settings will be used to expand routine, opt-out HIV testing to all appropriate healthcare settings in order to fully implement CDC’s 2006 HIV testing recommendations in the CPA. OA will assign two HIV Testing in HCSs Specialists (Testing Specialists) to address structural barriers to HIV testing in HCSs, as well as provide direct training and TA to interested HCSs. Testing Specialists will collaborate in providing training and TA through partnering with Pacific AIDS Education and Training Center (PAETC), California HIV/Sexually Transmitted Diseases (STD) Prevention Training Center (PTC), California Primary Care Association (CPCA), California

Medical Association, and the Health Resources and Services Administration (HRSA) Region IX in order to encourage HIV testing in all HCSs. It is expected that the Testing Specialists will address the following structural issues and training needs:

Selection of HCSs for HIV Testing – OA will provide training and TA to any HCS in the CPA that is interested in implementing HIV testing to the extent that the local epidemiology is compelling and OA resources permit. However, OA will focus its efforts to recruit and work with HCSs in the 19 LHJs identified by OA as having the highest HIV prevalence. Several HCSs in these LHJs have already expressed interest in HIV testing. For example, a hospital expressed interest in implementing HIV testing during OA’s 10-10138 Request for Application process. OA did not fund that application but will offer training and TA to that facility. Similarly, an LHJ expressed interest in applying for OA’s PS10-10138, but found the data collection requirements beyond their capacity. If possible, OA will assist them in implementing HIV testing in their HCSs without the burden of Category B data reporting.

Consent Procedures – California law allows for routine, opt-out HIV screening as described in CDC’s 2006 HIV testing guidelines. Patients must be informed that they may be screened for HIV during their health care visit, but that they have the right to decline HIV screening. This information can be provided in written or oral form and can be included in the general consent for treatment. They must also be provided information about the test, informed that treatment options are available, and advised that a person who tests HIV negative should continue to be routinely screened. OA is aware that some HCSs have not eliminated the written consent procedure for HIV testing, and will work with these sites to change these protocols.

Additionally, OA is encouraging HCSs to modify their general consent forms to include information about HIV testing, as well as allow LTC staff who may not be employed by the HCS

to contact patients who test HIV positive. If an HCS uses rapid HIV testing, the newly modified general consent will allow follow-up with the patient for HIV confirmation test results in the event the patient misses his or her results appointment.

Selection of HIV Test Technology – HCSs often confuse routine HIV testing with rapid HIV testing. OA provides TA to assist HCSs in selecting the HIV testing technologies that best meet the clinical and patient needs. For example, often it is assumed that rapid, point-of-contact (POC) HIV testing is best for emergency departments (EDs). However, many busy EDs are not in the position to provide the staff and space needed for test processing in the ED. These same EDs often have high-volume specimen analyzers in their hospital labs that can provide HIV screening more cost-effectively, in some cases with a turnaround time of two to six hours. Community Health Centers (CHCs) and other continuity care providers are also likely to be better served using conventional HIV testing, given their ongoing relationships with their patients and ability to simply add another test to routine blood draws.

Disclosure of HIV Negative Test Results – OA will assist HCSs in determining the most efficient ways to provide HIV negative test results to their patients. HCSs can be reluctant to implement routine HIV testing out of concern that they must provide post-test counseling and HIV negative results in person. In fact, HCSs may provide HIV negative test results orally or in writing. OA has had success in coaching EDs to provide HIV negative test results on discharge papers, and CHCs can also include HIV test results in other medical test correspondence with their patients.

Disclosure of HIV Positive Test Results – Medical providers are sometimes reluctant to implement HIV testing in their practice settings, expressing concern about delivering HIV positive test results. Some medical providers believe that HIV positive result disclosure requires

special skills or training. OA and our partners at PTC and PAETC provide extensive training to all medical providers in order to increase their comfort levels in delivering these results. OA also provides assistance with follow-up care for patients. This support allows providers to feel more comfortable delivering results because they have experts to whom they can refer the patients for HIV care.

LTC and PS – LTC is the most important component of the testing program and can be the most difficult for HCSs to implement. OA will assist HCSs with initiating and strengthening relationships with existing LTC resources in their communities such as RW Part B and Minority AIDS Initiative (MAI) funded outreach workers, and Early Identification of Individuals with HIV/AIDS (EIIHA) or Testing and LTC Plus (TLC+) activities. In addition, changes to general consent forms that allow patient follow-up to ensure LTC will assist HCSs to verify that their HIV-diagnosed patients are receiving appropriate HIV care. It is unlikely that HCSs will provide PS elicitation. However, OA will train HCS staff to refer to PS available in their LHJ as appropriate.

Reimbursement –While California law requires that private insurance companies reimburse for HIV testing regardless of diagnosis, Medi-Cal (California’s Medicaid program) and Medicare are not required to reimburse for routine screening in all populations. For most hospitals in California, Medi-Cal and Medicare together are the largest percentage of their insurance reimbursement. HCSs are reluctant to routinize an activity for which they cannot be sure they will be reimbursed. Resolving this dilemma will be the highest priority of the Testing Specialists. Medicare has stated it will reimburse for routine HIV testing in high prevalence jurisdictions, however they have not yet clearly defined the conditions for reimbursement. OA will work with Medicare to obtain a fuller definition of high prevalence jurisdiction. Similarly, Medi-Cal will

reimburse for some International Statistical Classification of Diseases and Related Health Problems codes that may allow for routine screening. OA expects that working with our current Expanded Testing Project grantees will provide us with the knowledge we need to provide TA to other HCSs in the CPA.

Collaboration with Statewide Organizations – OA has begun working with the CPCA, the member organization for Federally Qualified Health Centers and look-alikes, and the California Medical Association. Both organizations are willing to work with OA to increase their membership’s awareness of routine HIV testing. The Testing Specialists will work to determine how to use these organizations’ resources to the best advantage to accomplish the goal of increasing HIV testing in CHCs and private medical practices.

STD, Hepatitis and Tuberculosis (TB) Screening Incorporated Into HIV Screening

Programs – In the second year of PS12-1201, OA will encourage venues that have successful implementation and reimbursement of routine HIV screening to explore the possibility of adding screening for STDs, Hepatitis and TB. We will strongly encourage this for venues that use blood specimens collected for HIV screening and use high-volume analyzer technology that can run several blood-based screening tests, such as syphilis and hepatitis B and C, on one specimen. This expansion will not be implemented until OA and HCSs are sure they will receive third-party reimbursement for these screenings.

HIV Testing in Non-Healthcare Settings: In the next five years, OA will work closely with funded LHJs to implement strategies to increase HIV testing which targets specified high risk populations in non-healthcare settings, and will increase collaborations at the state level with agencies such as the Office of Family Planning and ADP, which are federally funded to provide HIV testing in such settings within the CPA. OA will continue to support non-healthcare settings

through funded LHJs by providing rapid HIV test kits and external controls, lab slips, HIV testing forms and HIV Counselor Training (which includes training on OraQuick Advance Rapid HIV test, universal precautions and finger stick testing procedures).

OA anticipates that the increased focus on testing targeted to high-risk populations called for by this funding announcement and the NHAS will lead to revision of our approach to funding LHJs for targeted HIV testing in non-healthcare settings. In addition to public health clinics and sites, LHJs subcontract with other community based organizations (CBOs) to perform HIV counseling and testing activities throughout their jurisdictions. OA has conducted preliminary data review of testing efforts made within 14 of the 17 currently funded LHJs and found significant room for improvement in targeting testing activities to high risk individuals and reducing the number of testing sites with low positivity rates. Stakeholder buy-in and TA will be included in change efforts. See **Appendix N** for specific goals and objectives related to HIV testing in non-healthcare settings.

Selection of Non-Healthcare Settings for HIV Testing – The LEO database allows OA and LHJs to generate testing indicator reports that are site-specific and facilitate prioritization of high-positivity test sites over lower positivity test sites. These reports provide LHJs with information about the degree to which they currently conduct high risk versus low-risk testing, and help them to adjust their efforts to better target their testing programs. Selected sites must increase by at least ten percent the number of newly identified HIV-positive tests annually. OA anticipates funding fewer testing sites as testing becomes further focused on higher-risk populations.

Consent Procedures – California has long-established laws regarding HIV consent for all persons testing in non-healthcare settings. General, informed and specific consent are all

covered under current law. LHJs funded to provide testing in non-healthcare settings must obtain written consent. OA will incorporate any changes in testing approaches as needed based on possible legislative changes to consent requirements in our revised HIV Counselor Training curriculum.

Utilization of Additional Rapid Test Technologies – OA will review other rapid testing technologies and assess the feasibility of adopting these technologies into our testing initiatives if such adoption proves to be cost effective. OA has implemented a finger stick training certification for all HIV counselors in funded LHJs, and plans to train HIV/HCV test counselors to administer the OraQuick rapid HCV test if and when pending legislation is signed to allow nonmedical HIV test counselors to administer a Clinical Laboratory Improvement Amendments (CLIA)-waived HCV test. OA will continue to fund conventional HCV testing in LHJs which deem such testing a priority for their population.

Disclosure of HIV Test Results – Current state testing protocol requires that a client who tests preliminarily positive will receive their preliminary result. At that point a specimen is obtained for confirmatory testing or the client is referred to HIV medical services. This protocol is included in the consent form that each client signs prior to testing.

LTC – See Comprehensive PWP below.

Reimbursement – In the first year of the program, OA will assess the capacity of its funded LHJs to screen clients for appropriate public and private health insurance. Information gained from the assessment will assist OA in developing a training and TA program to help LHJs and funded CBOs to establish procedures to assess clients for alternate means of payment. This program will be phased in over successive years of the contract as local capacity grows.

Quality Assurance for HIV Testing Efforts: CLIA-waived laboratories conducting POC rapid HIV tests are required to submit written quality assurance plans which are reviewed by OA Testing Specialist for comprehensiveness and compliance with state and federal requirements. California statute requires CLIA-waived test kit operators to meet specific standards, some more stringent than federal requirements. For example, test kit operators must either be medical personnel providing direct patient care or HIV counselors who have successfully completed the OA rapid HIV test kit training. The OA training includes a proficiency exam using five samples from an independent proficiency panel. In addition, test kit operators are required to complete an annual competency assessment to maintain their certification for testing client samples.

Compliance with these standards and requirements are monitored using data entered into the LEO system and also via TA contacts and in-person site visits. Specifically, data are collected for monitoring test kit operation including processing time and temperature ranges, trainings and competency assessments completed by test kit operators, and result delivery rates and time frames, as well as other quality assurance measures. TA contacts with providers occur routinely, prompted either by requests from the provider or by data submitted that requires follow-up. In-person site visits occur as either a routine part of program monitoring or in order to provide more intensive TA.

Conventional testing, including confirmatory testing, is provided by California-licensed public health laboratories, which are required to meet additional, more stringent requirements beyond those required federally. These laboratories are monitored and overseen by the California Laboratory Field Services Division of CDPH to ensure compliance with both state and federal requirements, including participation in routine performance evaluations.

B2. Comprehensive PWP: To provide more effective oversight for LTC, treatment, and prevention services, retention/re-engagement in care and referral and linkage to other medical and social services for HIV-positive persons, OA will convene a Linkage to/Retention in Care Workgroup that spans OA's Prevention, Surveillance, and Care branches. The purpose of the workgroup will be to ensure maximum coordination, effective data reporting, and minimum duplication of effort between OA-funded care and prevention programs that focus on linkage, engagement, and retention in care and ancillary services. In order to fully realize the vision of the NHAS, and to decrease duplication of effort and ensure maximum impact of linkage to and retention in care interventions, OA will require funded LHJs to demonstrate active collaboration and coordination with care sites involved in these activities. Areas of collaboration may include activities taking place within the context of RW Part C (Early Intervention) programs, and/or activities such as TLC+, the Antiretroviral Treatment (ART) Access Study (ARTAS), RW Part A and Part B, EIIHA programs, or MAI.

All jurisdictions funded through this FOA receive OA-administered RW funding. The 2009 RW Act included an unfunded mandate to increase the number of HIV-positive individuals unaware of their HIV status who are tested, linked to and retained in care and ancillary support services. RW initiatives such as EIIHA were developed to support this requirement and align with the NHAS. EIIHA's scope is defined by HRSA as "identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV-positive individuals into care" (EIIHA and EIS Administrative Overview, RW Part A, June 2011)

Both RW Part A and Part B application guidance establish EIIHA as a priority and require grantees to describe the strategy, plan, and data reporting associated with ensuring that

individuals who are unaware of their HIV-positive status are identified, informed of their status, referred into care, and linked into care.

Fifteen of the 19 jurisdictions to be funded under this FOA also receive RW Part B MAI funding through OA. The MAI increases total RW Part B funding, and is a targeted initiative meant to improve HIV-related health outcomes and reduce HIV-related disparities among racial and ethnic minority groups.

LHJs utilize MAI funds to conduct culturally tailored outreach and/or treatment education to HIV-positive minority populations who know their status but have never been in HIV medical care, who have been lost to HIV medical care, or who are of unknown HIV status and assessed as at high risk for being HIV-positive. A focus of MAI outreach is to identify and remove barriers that prevent access to HIV medical care and assist clients in establishing ongoing engagement in HIV medical care. MAI treatment education includes providing basic information to MAI clients about HIV treatment, treatment adherence, communication with medical and other service providers, how to manage medication side effects, and how to understand laboratory results.

In considering the array of comprehensive PWP elements outlined in this FOA, each LHJ will determine its innovative and collaborative activities based on local needs and priorities. Collaboration may incorporate a number of activities ranging from supporting positions that expand EIIHA or MAI interventions, to assisting care sites in delivery of provider-delivered behavioral interventions, to activities aimed at strengthening communication, data reporting, monitoring and outcome evaluation across local prevention and care referral and service networks. Through LHJ leadership and local community planning, funds to support these activities will be coordinated to achieve maximum benefit and minimum duplication of services.

To facilitate the process for tracking linkage activities and outcomes, OA will strengthen the crosslinking and data sharing capacity between LEO and ARIES, the reporting system utilized by RW Part B recipients. In addition, OA will enhance ARIES to allow reporting of services for persons unaware of their HIV status for whom providers may lack the complete information currently required for client registration in ARIES.

OA anticipates that LHJs will need TA and training to expand or implement PWP approaches that require active care/prevention integration. Resources available include OA specialist staff and training offered through the PTC, PAETC, and the California Statewide Education and Training Program (CSTEP). Current trainings available that support the goals of this FOA include treatment education, treatment adherence, benefits counseling, PS, and support for medical providers in delivering brief behavioral prevention interventions to HIV-positive persons. Prevention and care staff will collaborate with federally-funded (PTC and PAETC) and OA-contracted CSTEP training partners to develop and present provider training as needs emerge and to the extent that OA prioritizes these resources.

Partner Services: OA is continuing to partner with the STD Control Branch to support development, implementation and evaluation of PS activities in the funded LHJs. The STD Control Branch will provide a varying level of support to each LHJ based on current PS infrastructure and local needs. The funded LHJs are responsible for implementation of HIV PS, including delivery of PS activities (offer, elicitation, notification), development of local policies and procedures, and coordination with public and private providers to initiate PS activities. The surveillance-based model to initiate PS is not in place in California because of legal barriers. California implements a venue-based model for PS, with offer and elicitation in HIV testing, Care and STD treatment venues at the POC, and referral to trained PS field staff to conduct

partner notification. It is a standard practice to provide LTC for newly identified HIV-positive persons and referral for care for those previously identified but not currently engaged in medical care. Variables to capture outcomes regarding LTC have been added to the PS forms and databases. During this grant cycle, OA will evaluate LTC outcomes, identifying successful models to share best practices for PS program enhancements.

A recent PS needs assessment of LHJs identified needs for: 1) performance measures for PS within each venue type (testing, prevention, care, STD co-infection), 2) template contract language and policy/procedural documents, 3) staff training on partner elicitation and forms completion, and 4) hands-on assistance in program development at the local level. OA and STD Control Branch will use the needs assessment results to prioritize LHJ TA. Three to four LHJs will be identified for more intense state support. Initial TA will focus on those LHJs with the greatest HIV incidence, existing local infrastructure, and existing provider and community interest. The STD Control Branch has assigned manager consultants to work onsite with two of the high priority LHJs (Riverside and San Diego) to support the development of tools, collaborations and systems to build local capacity for PS within the health department and key community providers. Plans to provide onsite manager consultants to additional LHJs are underway. OA and the STD Control Branch will address other locally specific training and capacity building needs through individualized, focused TA. Partnership with non-health department providers is an essential component of current venue-based PS model. In some LHJs (e.g. San Diego, Sacramento) key CBOs providing HIV testing and care services have robust PS programs, conducting offer and elicitation onsite and referring partners to the LHJ for follow-up/notification. These models will be highlighted in a PS Program Development Workshop for LHJs, providing peer-to-peer insight on facilitators to these effective programs (e.g., contractual

language, internal PS champion, forms training, etc.). These workshops will be delivered via webinar format in order to reduce costs and alleviate travel constraints experienced by many LHJs. Surveillance data will be utilized to identify the priority CBOs and other private medical treatment providers (i.e. high volume HIV test providers, high census HIV care providers) to which to expand PS activity. OA and STD Control Branch staff will provide TA to LHJs with provider visitation and systems development.

Perinatal Services: California promotes early, routine HIV testing for pregnant women in accordance with CDC recommendations. California law requires that all pregnant women be tested for HIV as soon as possible after a pregnancy is diagnosed unless the woman declines testing. In addition, the law states that women who present to labor and delivery with an unknown HIV status must receive HIV testing using a rapid method unless the woman declines. OA also provides training and TA as requested to the Maternal, Child and Adolescent Health (MCAH) Section and their providers regarding HIV testing for pregnant women, providing HIV positive test results and implementing rapid HIV testing in labor and delivery (RTLTD).

California has reached the CDC's definition of elimination for mother-to-child HIV transmissions of less than one transmission per 100,000 births. California averages approximately 550,000 births per year. Thirty percent of those births occur in Los Angeles and San Francisco. In the remaining 70% (~385,000), California averages two mother-to-child transmissions per year. Eighty-seven percent of live births in California were in a hospital known to have RTLTD. Therefore, we are not in a position to use resources for activities such as Fetal and Infant Mortality Review-HIV Prevention Methodology. However, OA will continue to encourage the early detection of pregnant women with HIV and the availability of RTLTD. Current law requires that pregnant women be tested as early as possible in their pregnancy or

during labor and delivery if her HIV status is unknown unless the woman refuses. We will continue to work with MCAH as requested to provide training and TA regarding HIV testing of pregnant women, referring HIV-positive women to care and implementing RTL. In addition, as OA implements HIV testing in other clinical settings such as community health centers and hospitals we will be able to informally monitor the continuation of HIV testing in prenatal care and labor and delivery settings.

Risk Reduction for HIV-Positive Persons: OA will work with HIV medical providers and clinics to support routine risk screening and provide risk reduction interventions for HIV-positive persons at risk of transmitting HIV. In the first year of funding, we will ask LHJs to select at least one clinic receiving RW funding through OA with which to collaborate. Appropriate partners for collaboration are clinics that have large HIV-positive patient populations, especially with a significant number of MSM, IDU and/or African American HIV-positive patients, or where there are a significant number of patients without viral load suppression, with sexually transmitted infections (STIs), or with active mental health and substance abuse issues. LHJs will encourage the use of simple screening tools to assess behavioral activities that are known to transmit HIV or increase risk behaviors, as well as mental health status. One such tool is the Substance Abuse and Mental Illness Symptoms Screener (SAMISS), which has been validated for use in HIV care settings and which is currently included as an assessment tool in our ARIES data system. In addition, LHJs will encourage referral to risk reduction intervention in situations which may include:

- Patients with sexual/injection partner(s) of negative or unknown HIV status;
- Patients who do not achieve undetectable viral load;
- Patients diagnosed with a new STI; and

- Patients transitioning in relationship status from partnered to single or single to partnered.

Sites selected by LHJs will be expected to initiate programs determined to be effective at addressing behavioral risks in clinical settings or to develop simple referral process between the HIV medical providers and PWP programs. In collaboration with OA's training partners PTC and PAETC, we will provide health care providers and CBOs with the training needed to successfully choose and implement science-based interventions. Trainings for interventions such as Partnership for Health, SMART Couples, Project HEART and OPTIONS/OPCIONES are available and will be expected to be completed prior to initiating the interventions.

Alternatively, sites can develop an efficient referral process to community PWP staff who can deliver risk reduction programs to patients at risk of transmitting HIV. In addition to implementing a risk reduction intervention or creating a referral system to a community PWP program, sites will be expected to demonstrate active referral capacity with services to respond to mental health, substance use and domestic violence resources for their clients.

Increasing collaborative relationships between health care providers, PWP prevention program staff, medical case managers and agencies providing mental health, substance use and domestic violence prevention services will also be expected. OA will assist in this collaboration. For example, client STD information as well as the SAMISS screening tool are in the ARIES client database, which can be used by medical case managers in assessing potential need for risk reduction support and encouraging clients to speak with their health care providers or PWP prevention staff. Funded sites will be required to submit documentation of collaborative activities and document referrals to the various collaborative agencies throughout the funding period.

Behavioral Interventions for HIV-Positive Persons: OA provides a set of 29 PWP behavioral interventions including four medication adherence interventions that range from CDC-designated “Best Evidence” through those that show promise on the choiceHIV website, an online resource for planning educational and prevention activities based on scientific evidence of efficacy. OA will request OA-funded behavioral interventions be accessible to all HIV-positive persons throughout the LHJ irrespective of where they receive their HIV medical care. Any person out of health care will also be eligible for and encouraged to participate in the interventions.

Providers will be expected to assist out-of-care individuals, to access HIV health care.

Integrated Hepatitis, TB and STD Screening, and PS: OA will work with HIV care providers and the CDPH/STD Control Branch to encourage the use of current CDC and HRSA standards of care that call for annual asymptomatic screening for chlamydia, gonorrhea and syphilis for HIV-infected persons including more frequent screening for those at high risk of STD acquisition. Given the strong biological and behavioral links between STD and HIV transmission, and evidence that both ulcerative and non-ulcerative STDs can increase risk of transmission, adherence to STD screening recommendations can help reduce overall HIV transmission. Clinical standards for HIV care call for initial and ongoing screening for STDs, hepatitis immunization and TB screening. All state funded medical case managers monitor these screening activities for patients enrolled in that program, and record the information in ARIES (Alameda County does not currently use ARIES, but OA will be working with them to set up a system whereby they can import their data into ARIES). Community PWP programs monitor this information with participants in behavioral interventions as well. Health education/risk reduction (HE/RR), counseling and testing, and ARIES data collection forms document STD and Hepatitis diagnosis and immunizations. OA will modify all forms to include date of most recent

STD and TB screenings and last clinic visit to add sentinel opportunity and to support clients to maintain standard health care recommendations.

Use of CD4 and Viral Load Results for Public Health Purposes: Routine reporting of CD4 and viral load results is required of all California health care providers and laboratories. This information is maintained in OA's eHARS database. Work is actively being done to ensure this information can be utilized in addressing community viral load (CVL) and as appropriate to ensure patient linkages to and retention in care (see Policy Initiatives below). OA's Surveillance and Research Sections will work with the Prevention and Care program staff and LHJs to consider current and future interventions to monitor and lower CVL.

In 2010 California passed legislation that allows state and local health departments to use HIV/AIDS surveillance data collected by OA to contact an HIV-positive person or his/her HIV care provider for the purpose of offering assistance with the coordination of care and treatment services. OA will work to develop a pilot sentinel system which will alert LTC staff when patient CD4 and viral load reports are not submitted during a period of 12 months. Staff may then follow up with the client or provider to see if they are "out of care" and assist in their reconnection to HIV medical care.

Support for the Provision of ART: OA will continue to require all funded medical case management programs to document clients' use of ART in the ARIES client monitoring system, and to assist clients in speaking with their healthcare provider about ART. OA has the capacity to review data in the eHARS surveillance system and the ARIES client monitoring system to identify clients who may not be utilizing ART but for whom ART may be beneficial (e.g., those with high viral loads or low CD4 counts) and as we are able, this information will be used to support access to ART for all HIV-infected patients. In LHJs where medication adherence is

identified as a significant challenge, selecting a medication adherence intervention will be encouraged and assistance will be provided to ensure adherence interventions are accessible to all appropriate people living with HIV.

OA will work collaboratively with the California PTC and PAETC to ensure HIV healthcare providers have access to current treatment guidelines, access to clinical consultation (the national AIDS Education Training Center hosts a “warmline” for clinical consultation), and that regular continuing medical education trainings are available and accessible. Through RW funding, OA will continue its support of CSTEP to offer free training and regular updates on treatment, as well as training on adherence and benefits to HIV providers, including case managers, benefits counselors, treatment advocates and educators, nurses, mental health counselors, peer advocates and other professionals who work with people living with HIV/AIDS on HIV disease and its treatment. These trainings are designed to increase providers’ ability to promote the use of ART and to assist clients in actively participating in their ongoing HIV care. OA will inform HIV health care providers about all OA-funded and non-OA funded training opportunities through its online Advisory Network.

OA also works continuously to ensure the AIDS Drug Assistance Program (ADAP) leverages as many resources as possible to ensure ongoing access to ART for individuals whose annual adjusted gross income is less than \$50,000, are 18 years or older and are California residents.

Support for LTC: OA will develop a Division-wide prevention, surveillance, and care workgroup to coordinate efforts, avoid duplication of effort, and maximize resource utilization. All funded LHJs will be required to submit documentation describing active collaboration and coordination of care sites with RW, EIIHA, MAI, and/or TLC+ activities in their jurisdiction.

As allowed, the OA surveillance, care and prevention database systems will be enhanced to cross-link information to ensure all HIV-positive clients are utilizing health care per clinical standards and accessing risk reduction services necessary to minimize new infections.

Quality Assurance and Adherence to Guidelines: OA contract language requires services to be delivered in culturally and linguistically appropriate manners. OA strives for broad cultural representation within our staff and has identified bilingual staff members, including a designated translator for the Division. To ensure that services are culturally and linguistically appropriate to clients throughout our large geographic area, OA contracts with the LHJs rather than attempting to provide services from a central office. As the new programs are developed, LHJs will document how they deliver their services in culturally and linguistically appropriate manners to their population.

OA management actively works with CDC and the State to ensure all services are consistent with guidelines and recommendations. These guidelines and recommendations are communicated to our contractors through multiple methods, including working closely with the California Conference of Local AIDS Directors (CCLAD), ongoing communication between OA staff and LHJ coordinators, distributing all critical information about guidelines and recommendations directly to our contractors and through our Advisory Network, stakeholder teleconferences and maintaining essential information on our website. Monitoring to ensure programs are compliant with CDC and state/local guidelines and recommendations is a key responsibility of OA staff during all site visits.

B3. Condom Distribution: The CAC assists in reducing the spread of HIV infection in California by developing and providing appropriate, culturally sensitive HIV/AIDS/STD educational materials, free of charge, to LHJs, CBOs and other programs and agencies in

California that conduct structural, individual and group-level HIV/AIDS/STD risk-reduction interventions. Condom distribution is an essential component of the program. From 2004 through 2008, CAC's condom program distributed an average of 770,000 total condoms annually to California's 61 LHJs. The condoms were sent in bulk, once a year, to the LHJs, and the LHJs distributed the condoms to their respective clinics and CBOs. The number of condoms each LHJ received per year was determined by the number of HIV tests they performed in the previous year. No restrictions were placed on specific populations for distribution. From 2009 to 2011, CAC's condom program distributed 1,000,000 total condoms annually not only to LHJs, but directly to CBOs and other HIV/AIDS programs and agencies in California as well. Condoms were ordered on an "as-needed" basis with no limit as to the number of times each entity could place an order. Again, no restrictions were placed on specific populations for condom distribution; however, each agency was required to identify the specific target population among which condoms were to be distributed.

In response to the NHAS, OA will revise its condom distribution and promotion strategy to more precisely target HIV-positive individuals and those people at highest risk of acquiring HIV. An assessment of condom orders that were submitted from October 2009 through August 2011 will be conducted through the use of various statistical software and mapping techniques (e.g. SAS, ArcGIS) in order to identify agencies and/or geographic areas with condom distributions to high-risk populations. Using this information and collaborating with each of OA's funded LHJs, venues within each LHJ can be accurately identified in communities where HIV is most prevalent (e.g. clinics, hospitals, lesbian/gay/bi-sexual/transgender centers, CBOs, syringe exchange programs [SEPs], bathhouses, bars, clubs, etc.).

Each LHJ will recruit these identified high-risk venues for condom distribution and provide their respective OA operations advisor with a contact list of all participating venues. These venues will be able to order condoms directly from OA via the CAC Materials Catalog, downloadable from OA's website. OA operations advisors will also provide TA to their respective LHJ and the participating venues within that LHJ should they require it.

Participating venues will order condoms on an "as-needed" basis to ensure that condoms are not stockpiled. Minimum orders will be 1,000 condoms with a maximum order of 12,000. Should a venue need more than 12,000 condoms for a special event, this request would be subject to the approval of OA prior to shipping. Venues may order condoms as many times as necessary per year, as long as their previous order is expected to be completely depleted prior to receiving the next shipment. These venues will also be able to order and distribute other materials available in the CAC Materials Catalog.

Non-funded LHJs or venues within a non-funded LHJ in the CPA, will be able to order condoms from OA on a "request-only" basis. OA will review each of these requests to ensure that condoms are distributed to HIV-positive individuals and those people at highest risk of acquiring HIV infection only. Venues in Los Angeles (excluding Long Beach) and San Francisco counties that had previously ordered condoms from OA will be referred to the condom distribution programs in their respective county.

The condom distribution will be accompanied by the development of a condom marketing campaign. Using resources developed by other jurisdictions to the extent possible to limit the need to invest additional resources, posters and palm cards will be developed and tailored to specific high-risk populations (e.g. MSM, Latino/a, African American, etc.), promoting increased condom awareness, condom usage and improved sexual health. These

informative materials will be shipped with each initial condom order, and consequently, per request should a venue require more.

OA's service referral line will also be available to provide callers with information as to locations in the funded LHJs where free condoms are distributed.

Routine evaluation of the condom-order data will enable OA to generate quarterly reports on condom distribution numbers. These reports will help to identify areas in each LHJ frequented by HIV-positive people and people at risk for acquiring HIV infection, and to assist in areas where LHJs can expand their venue recruiting for condom distribution.

B4. Policy Initiatives: During 2010-2011 OA developed three key policy initiatives that are critical to OA's HIV prevention work and will be supported and expanded under this grant.

These are: 1) encouraging state and local coordination of the HIV Early Intervention Services (EIS) funds disbursed by ADP as part of the HIV Set-Aside portion of the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) addressing legislative, policy and procedural barriers to using HIV surveillance data to assist in identifying HIV-positive individuals not receiving HIV care and linking them into needed services; and 3) leading a collaborative statewide process to explore and define the HIV-related issues, resources and unanswered questions associated with healthcare reform in the 2014 context of the Affordable Care Act (ACA).

Substance Abuse and Mental Health Services Administration (SAMHSA) HIV Set-Aside Funds Initiative: SAMHSA requires states that are designated as having a higher burden of HIV to spend five percent of their SAPT grant on HIV EIS at substance abuse treatment sites. In California, five percent of the total SAPT block grant amounts to approximately \$12.5 million that is allocated to county Alcohol and Other Drug (AOD) departments for HIV EIS. ADP

distributes these funds statewide according to a formula which allocates a higher proportion of funding to counties which have a higher burden of HIV, with a minimum allocation of \$7,500 to counties with low HIV seroprevalence.

As part of its ongoing work to increase the impact of the state's strategic use of federal funds provided to state grantees to detect and prevent HIV, OA has identified several key challenges in the effective use of these funds as they are currently allocated, targeted and employed. Neither SAMHSA nor ADP requires data reporting on the use of the funds, thus making it difficult to determine at the state level whether or not they are effectively targeted to individuals at high risk of acquiring or transmitting HIV. ADP does not collect data on the HIV status of drug treatment program participants, which represents a barrier to being able to provide medical treatment of HIV-positive people in drug treatment programs, a permitted use of the funds. ADP also does not require collection of information on sexual orientation, which could assist in targeting the funds to MSM and MSM/IDUs.

Additional barriers were identified in a survey of CCLAD. Some local AIDS directors expressed concern that HIV Set-Aside funds pass through many hands before they get to the point of care, that there is little collaboration at the state or local level in some jurisdictions in appropriately targeting the funds, and that there are instances of waste, missed opportunities or duplication of efforts. Concern was also expressed about the quality of services provided. Among the challenges identified by ADP is that not all of the HIV Set-Aside funds that are allocated to the counties have been used in the past.

In the next funding cycle, OA will work to address these and other barriers by: 1) collaborating with ADP, LHJs, AOD Departments, CCLAD and the County Alcohol and Drug Programs Administrators' Association of California to develop a best practices document for

county AOD departments to use in making local programming decisions; 2) systematically identifying ADP-funded agencies that are entering HIV testing data into LEO, correcting the LEO set-up information to differentiate the funding streams, and analyzing the resultant data in order to inform allocation and program design decisions; 3) exploring with ADP barriers to their collecting data on the use of HIV Set-Aside funds and work to address those barriers; and, 4) modifying the ADP funding formula for Set-Aside funds to address the highest burden populations in California. The CPG, LHJs and local AOD departments will also partner in the collaboration.

Although OA's primary partner in this work will be ADP, this policy initiative takes place within a context of the planned dissolution of ADP as a state agency, with key responsibilities to be reassigned to the Department of Health Care Services and to county AOD and/or Behavioral Health Departments. This realignment may result in OA directly managing the HIV set-aside funds, which would allow us to leverage our use with funds we receive from CDC to eliminate many of the gaps and overlaps in services that currently exist and to provide wrap-around services for people affected by both substance use and HIV.

Public Health Use of HIV/AIDS Surveillance Data (Implementation of Assembly Bill [AB] 2541): In 2010 California removed many barriers to utilizing HIV/AIDS surveillance data for public health purposes through the enactment of AB 2541 (Portantino, Chapter 470). Prior to this bill, California state and local public health departments could only share HIV/AIDS surveillance data for the purposes of disease investigation, control, or surveillance without the written authorization of the HIV-positive person who is the subject of the data. This meant that HIV/AIDS surveillance data could not be further shared by state and local public health departments for the purpose of HIV/AIDS case management. Now California Health and Safety

(H&S) Code 121025 allows state and local health departments to use HIV/AIDS surveillance data collected by OA to contact an HIV-positive person or his/her HIV care provider for the purpose of offering assistance with the coordination of care and treatment services.

OA will share data and collaborate with LHJs and local health care providers to identify out-of-care clients and transition them into care. OA will employ three strategies towards this goal, utilizing eHARS and ARIES, and potentially its ADAP database and Medi-Cal data.

Strategy 1 — Examine eHARS data to identify clients without a CD4 count or viral load test in past the 12 months; these clients will be considered out-of-care. The laboratory data in eHARS should be sufficient to identify out-of-care clients since all laboratories in the state are legally required to report CD4 and viral load results (including undetectable values) to the LHJ, which then reports them to OA. The eHARS data on out-of-care clients will be sent to the appropriate LHJ for follow-up. **Strategy 2** — OA's HIV Care Program providers will be directed to use an existing ARIES report to identify out-of-care clients themselves. Clients with an active, lost to follow-up, or an unknown in-care status who have not had a medical service in the past year will be considered out of care; providers will subsequently follow up with such clients. **Strategy 3** — OA will also work with its legal office to determine whether or not we can use an ongoing match between ADAP data and Medi-Cal data to identify out-of-care clients. Clients from the ADAP/Medi-Cal match without a prescription in 12 months from ADAP and who have not transitioned to Medi-Cal will be considered out-of-care. Information about these out-of-care clients will be sent to the LHJ for follow-up.

All three of these strategies will combine policy analysis and structural change, as well as program development.

Health Care Reform (HCR) Planning: Given the complexities of federal and state financing of medical services for people living with HIV infection, the need for HIV treatment expertise in an expanding universe of medical care settings, and the increasing focus on routine HIV screening and finding individuals with previously unknown HIV status and linking them to care and treatment, OA believes it is critical to start to consider HIV-specific issues for health service delivery associated with the implementation of the ACA. It is also important to consider the HIV testing and prevention issues and opportunities associated with the ACA. Thus, OA convened a stakeholder input process between May and August of 2011 to assist in addressing the following objectives: 1) Identify potential HIV-related issues associated with implementation of the ACA in 2014; 2) enable OA to provide TA to support a seamless transition for medical care, support, testing and prevention service delivery systems; related providers; and individuals living with and at risk for HIV prior to full implementation of the ACA; and, 3) develop a summary document that outlines the key HIV-specific issues in the areas of health care delivery systems, provider and workforce issues, patient needs, and financing. For each issue, the summary will include experts, resources and key outstanding questions when they have been identified.

Two of the highest priority “next step” issues identified in this process thus far include: 1) Develop the infrastructure within OA to move this process forward, understanding that OA’s current capacity is limited in terms of staff availability to develop this expertise and to devote time to these efforts; and, 2) develop a communication strategy and materials for consumers and healthcare and support service providers as well as HIV testing and prevention providers.

Using resources available in this FOA, OA will ensure that a minimum of 50% of an FTE will be dedicated from the HIV Prevention Branch to develop and participate in a newly formed OA HCR Task Force that will also include membership from OA’s Care, Treatment, Policy and

Research areas. The OA HCR Task Force will ensure that OA stays abreast of all policy developments and provides TA to OA and our LHJ and service delivery partners.

In addition, OA will create a Tier I activity for LHJ focus on preparing for HCR. OA will ask each LHJ to dedicate a specified proportion of an FTE to devote to HCR preparedness activities. This staff person will work in collaboration with state partners at OA as well as collaborating with other LHJ OA-supported HCR preparedness staff. OA will expect this person to keep OA informed of HCR-related policy and implementation issues with their LHJ.

Program Description - Recommended Activities

HIV Prevention Interventions for HIV-Negative Persons

1a. Behavioral Interventions: Behavioral interventions for HIV-negative persons are designated as Tier II activities which may be undertaken by LHJs that have adequately implemented all Tier I activities using whatever resources are available in the LHJ. OA will restrict evidence-based behavioral interventions for HIV-negative persons at highest risk of acquiring HIV to serodiscordant couples, MSM, IDU, Transgender persons, and African American and Latina women.

Serodiscordant couples can include those engaged in sexual activity or injection drug use sharing. Interventions targeting the other high risk populations will be required to focus on those with high risk behavior, such as having multiple sexual partners, engaging in unprotected sex, injecting drugs, crystal methamphetamine, crack or cocaine use. OA will monitor incidence and prevalence data of African American and Latino MSM and work with contractors to ensure behavioral interventions for MSM target these populations proportionally to local trends.

Contractors funded to conduct evidence-based interventions for serodiscordant couples and/or MSM will be required to have a means of outreach and recruitment that includes risk screening to identify those at high risk of HIV infection.

LHJs that choose to provide evidence-based HIV prevention interventions for HIV-negative persons at highest risk of acquiring HIV must select interventions that are evidence-based and that have training available, unless providers have been previously trained. Providers of the intervention must complete the training prior to initiating the intervention. The intervention must be sufficiently funded to provide the intervention throughout the contract year.

The OA choiceHIV website has 23 MSM behavioral interventions, including nine interventions targeted to African American or Latino MSM and two targeting crystal methamphetamine using MSM. Jurisdictions will be encouraged to select from these interventions. Information on the interventions, training and TA available through the California PTC and the CDC Capacity-building Providers will be provided to all funded LHJs to assist in selecting appropriate and manageable interventions. California PTC has a course on Intervention Selection, and OA is placing that training on the choiceHIV website where providers can complete the course online. A central directory of interventions being conducted in each of the funded LHJs will be compiled and distributed to increase networking and exchange of information between providers.

Contractors will be required to submit a recruitment plan demonstrating capacity to identify and enroll high-risk serodiscordant couples or MSM into their evidence-based interventions. The plan may outline locations where target populations congregate, agencies and organizations that serve the target populations and are willing to collaborate with contractors,

and a peer referral process or other methodology to ensure sufficient numbers of participants to effectively and efficiently provide risk reduction services.

Various evidence-based interventions have different intervention outcome goals, however commonly expected outcomes include: 1) reduction in unprotected anal and vaginal intercourse; 2) reduction in shared injection drug equipment and increase in use of unique sterile equipment; 3) reduction in the number of sexual and needle sharing partners; 4) routine testing for HIV infection; 5) screening for STIs, hepatitis and TB; 6) increased sexual negotiations, such as discussion of serostatus, serosorting or positioning based on serostatus; and, 7) routine medical care for HIV infection and use of ART to suppress viral load as appropriate.

Each contractor will need to submit their expected intervention outcomes and document their means of measuring intervention outcomes during and after completion of the intervention.

1b. Syringe Services Programs: Syringes Services Programs (SSPs) are designated as a Tier I activity. OA's SSP initiative aims to expand access to sterile syringes and other safer injection equipment throughout the state, improve efforts to properly dispose of syringe waste, and link IDUs to relevant prevention services, medical care and social services. The initiative comprises three strategies: 1) funding for SEPs and for health department coordination of nonprescription sale of syringes (NPSS) in pharmacies, as deemed a priority by LHJs; 2) provision of sterile syringes through the CAC to authorized SEPs; and, 3) syringe access-related policy work, which includes TA to LHJs in navigating the network of state and local laws that govern syringe distribution, recovery and disposal as well as TA to help LHJs effectively support HIV and viral hepatitis prevention among IDUs.

California H&S Code Section 121349.1 permits SEPs when authorized by local government. California Business and Professions Code Section 4145 and H&S Code Section

121285 permit local government to authorize NPSS in pharmacies. Since the 2009 cuts in HIV prevention funds, California SEPs have experienced an increase in interruption of services due to lack of syringes; in 2010 half of all programs statewide reported running out of syringes at least once. In order to address these service gaps, OA will add sterile injection supplies to the CAC catalog of materials along with the other primary prevention tool, condoms. All authorized SEPs operating in OA-funded LHJs will be eligible to participate in the supplies bank, which will provide sterile syringes, syringe disposal containers and safer injection supplies including alcohol wipes and sterile water. Participating SEPs must conform to federal, state and local standards for program operation, and must include among their services HIV and HCV testing or referral to testing, safer sex education and materials, linkages to medical, social and drug treatment services, overdose prevention education and wound prevention and care, as well as syringe distribution, recovery and disposal.

LHJs may also use their HIV Prevention funds to support SEP operations, and may use those funds to pay for costs including but not limited to personnel, syringe disposal services, equipment additional to that provided by the materials bank, and monitoring of OA-required program elements. Additionally or alternately, LHJs may fund coordination of the local NPSS program, which includes among its statutorily-defined components referrals to HIV and HCV testing and drug treatment. LHJs that elect to support NPSS must set specific goals for pharmacy enrollment and make updated information about syringe access available to the public.

LHJs without locally-authorized syringe access may choose to develop an analysis of local barriers to syringe access and a plan to address such barriers. In the last three years of this funding period, these LHJs will be asked to implement a pilot SSP program consistent with local

authority parameters or, if unsuccessful in removing identified barriers, to shift funds to other prioritized prevention activities. Extensive TA will be offered to support these efforts.

The final component of OA's SSP initiative involves policy work necessary to support structural change to expand access to sterile syringes in California. Although SEPs were established as early as 1988 in San Francisco, California statute restricts access to sterile injection equipment. Of the states which have authorized SEPs, California is one of only two to require authorization to take place at the local (city or county) government level, which results in a politicized climate for authorization and regulation of programs. Syringe possession is criminalized in most counties, and NPSS operates as a pilot program in which pharmacies in only 16 out of 59 counties may participate. OA will work to expand syringe access consistent with California's current statutes, while also analyzing the statutory, structural and environmental barriers that limit the ability and readiness of injection drug users to possess sterile syringes for risk reduction purposes.

2. Social Marketing, Media, and Mobilization: Social Marketing is a Tier II activity, meaning that funded LHJs may choose to conduct social marketing, media, and mobilization if all Tier I objectives have been met using any available resources in the jurisdiction. These activities will be limited to CDC-approved, simple social marketing or media campaigns focused on: 1) benefits of early detection of HIV infection; 2) need for routine and regular HIV health care visits in order to sustain health and reduce viral load; 3) the benefits of ART for the health of people living with HIV; 4) the role of suppressed viral load in reducing but not eliminating transmission risks; 5) the benefits of screening for viral hepatitis, TB and STDs and HIV; 6) the value of initial and ongoing PS; 7) information related to community viral load; and, 8) and/or emerging messages deemed appropriate by CDC and OA.

All funded LHJs have access to the materials developed and delivered through the CAC and the CDC Materials Catalog. If they choose to purchase or develop additional media, they must be targeted to people living with HIV or high-risk populations, especially MSM. Prior to developing material for providers, OA will ask LHJs to consult with the CAC to learn about resources that are already developed and available. No large scale social marketing campaigns can be undertaken unless the LHJ can demonstrate sufficient funding to successfully complete the campaign in the contract period.

OA provides the general population information on local resources and programs through its Service Referral telephone line, internet “live chat” and website. This project was developed in collaboration with CDC and its contractor, National Prevention Information Network. These services are promoted through our LHJ contractors and colleagues, the Advisory Network, the CPG and other stakeholders.

Funded LHJs will be asked to demonstrate how they will utilize the most contemporary media technologies in their dissemination of health messages including websites, Facebook and twitter for any social marketing funded through this FOA. OA will place special emphasis on technology that supports medical adherence and reminds patients of clinical appointments. These activities can be done without social marketing funds, but through their required activity resources and resources dedicated to targeting HIV-positive persons at highest risk for transmitting HIV.

It is not anticipated that there will not be sufficient funding available to develop large community mobilization activities. However, even with limited funds, we expect all social marketing development to include formative activity that includes involving community members in the development of messages; selecting means to communicate the messages; and to

train the community members to be an additional route of communicating the health messages to the broader community.

Our target populations for HIV prevention services have narrowed to target those HIV-positive persons at high risk of transmitting HIV, their partners, IDUs MSM (especially AA and Latino MSM) and African American and Latina women. In accord with the NHAS and OA's strategic goals, greater emphasis is being placed on social marketing messages that increase behavioral risk screening of people living with HIV, enabling regular and ongoing access to HIV care, use of biomedical interventions, such as ART to decrease viral load and transmissibility, and addressing psychosocial factors that increase the likelihood HIV-positive individuals may engage in risk. The Social Marketing goals should assist in achieving the outcomes of early detection, access to care, suppression of viral load and attending to psychosocial factors that increase risk behavior.

Simple outcome measurements will be used to evaluate social marketing efforts. Those who receive funding to conduct social marketing activities will be required to include an evaluation plan, which may include activities such as:

- Record of products developed and record of their distribution, including locations and number of items distributed;
- Pre- and post-marketing surveying related to information being dispersed through social marketing, e.g., query as to the relationship of viral load and HIV transmission pre- and post-marketing campaign;
- Comparison of target population utilization of testing services in a period prior to and after the launch of social marketing messages encouraging routine testing among MSM.

Appreciating the limited resources available to conduct social marketing, LHJs will be guided toward simple methods to convey community-developed health messages related to the pre-determined health issues, and keeping their evaluation activities realistic and achievable as well.

3. Pre-Exposure Prophylaxis (PrEP): PrEP planning and potential delivery for high risk MSM is designated as a Tier II activity, and if undertaken must be part of a comprehensive program including medication adherence, STI screening, HIV testing, risk reduction counseling, condom distribution, program evaluation and referral to related services. Funds may be used for planning activities, assessment, limited educational materials, and personnel. However, funds may not be used for medical care or for the purchase of prescription medications. OA will use the CDC's *Interim Guidance: PrEP for the Prevention of HIV Infection in Men Who Have Sex with Men*, and any future CDC guidance, when assisting LHJs with implementing PrEP. Given recent positive results in studies involving heterosexual sero-discordant couples as well as the potential for positive results with IDUs, OA will consider these groups as appropriate for PrEP pending CDC guidance.

Required Activities

Jurisdictional HIV Planning: Based on a motion put forward by the membership in June 2008, the California HIV Planning Group, in collaboration with OA, reconfigured the group and redefined the strategies used to fulfill its tasks. The goal was to ensure that the new planning body reflected changes outlined by HRSA and CDC while ensuring that its structure and function would provide maximum benefit to persons living with and at risk for HIV in California. The new CPG resulting from this process is in the process of developing a consolidated, jurisdictional HIV surveillance, prevention, care and treatment plan as well as enhancing OA's capacity to solicit and engage statewide community input.

The reconfigured CPG separates planning and advising functions. The planning function is achieved through its smaller community planning group of 15-21 members which focuses on the following core responsibilities: taking an active role in the development of an integrated and comprehensive jurisdictional HIV surveillance, prevention, care and treatment plan; engaging in activities designed to determine that the work of OA is effective in addressing the goals and objectives of those planning documents; and providing periodic advice on emerging issues identified or generated by OA and/or the community.

The advising function is met in part through CPG activities, but the CPG is only one facet of a more broad-based approach to soliciting statewide community input and implementing community-focused advisory functions. Other advising functions are met in part through the use of the Internet-based Advisory Network, which includes the HIV Information Network. The HIV Information Network allows OA to share information with stakeholders, and is open to anyone who is interested. Participants may choose to receive information only, and may specify types of information they wish to receive. The Advisory Network also facilitates consultation with stakeholders who agree to participate in surveys and other online requests for input from OA and/or CPG.

Based on this overall structure, individual CPG members are not responsible for representing specific communities in their planning work. Instead, each member commits to the complex task of constantly seeking to ascertain whether all critical perspectives, including those of the most disenfranchised, have been included and inform all key decisions. Additionally, each member commits to working from a statewide, rather than local, perspective in the planning process.

CPG does not include non-voting members, nor does it include representatives from other government agencies. Instead, the critical involvement of representatives from these agencies as well as other planning groups, community health centers, substance abuse and mental health services, and other entities will be incorporated where appropriate as the Advisory Network is developed further. In addition to the Advisory Network, there are outreach and stakeholder engagement activities focused uniquely on each stakeholder/representative/group type, accompanied by individual outreach to these specific groups.

The primary purpose of the CPG is to collaborate with OA in developing, approving, and finalizing the jurisdictional HIV Prevention Plan for California, which will be presented in the form of our larger integrated HIV Surveillance, Prevention, Care, and Treatment Plan. Once the plan is finalized, CPG will also be involved in monitoring its implementation and impact. OA and CPG have worked together to set the timelines, goals, and objectives for the planning process. To date, CPG and OA have outlined the major components of the plan, developed a timeline for completion, analyzed and refined the plan as needed to ensure alignment with NHAS, identified the information and data needed to inform the plan, and initiated its collection and analysis.

The tasks involved with producing the plan are carried out by workgroups whose membership and focus are phased in order to reflect the variety of steps involved in creating the document. For example, the group tasked with creating the working outline for the plan has completed its job, and its members have transitioned to other work groups. More recently, CPG's Community Assessment Workgroup initiated, developed, and implemented a comprehensive web-based survey in order to gather information from current and former OA care and prevention contractors. Results are in the process of being compiled into a state-wide inventory

of information regarding local met and unmet need and public/private funded service delivery and utilization.

Current workgroups are involved with preparing various sections of the plan, reviewing and synthesizing local community assessments and identifying any information gaps relevant to the plan, reviewing the statewide Epidemiological Profile, preparing information for the monitoring and evaluation portion of the plan, and working with the Advisory Network to disseminate information about CPG and planning to utilize the survey function of the Advisory Network to elicit community input about the Plan. The CPG expects to complete a first draft of the recommended Plan by March of 2012.

Capacity Building and TA: OA responds to requests from funded and non-funded LHJs and monitors training and TA needs by examining interim and annual progress reports submitted by all funded LHJs. TA is also provided during site visits and/or teleconference meetings. Staff assist with defining target populations and selecting effective interventions and advise on program implementation and assure compliance with contract requirements, program monitoring and evaluation. In collaboration with CPG, OA administered a needs assessment of all California LHJs in May 2011. This information will be analyzed, and results will be incorporated into our capacity building response in 2012. OA will collaborate closely in this effort with our training and capacity building partners, including our HIV testing contractor the AIDS Health Project (AHP), PTC, PAETC, Harm Reduction Coalition and the CDC's Capacity Building Program (CBA) Program.

With the new directions influenced by the NHAS and this FOA, OA will conduct an internal assessment of its own capacity and training needs in order to ensure staff have the expertise and knowledge to assist in the implementation of the new Prevention Plan. Utilizing

our training partners and other capacity building resources, all staff will participate in ongoing training and professional development to expand their skills and expertise as we continue to respond to the HIV epidemic.

OA will continue its current partnership with AHP through June 30, 2013 to provide the Basic HIV Counselor Training to all new HIV test counselors from funded LHJs and CBOs; after that time the contract will be re-bid. This training is also provided at cost for non-funded test sites. OA will continue administering an annual assessment of the HIV counselor training program. This assessment will identify gaps, new needs and emerging issues within the HIV test counselor training program to allow OA to appropriately modify the training. OA will also continue to work in partnership with the San Francisco Department of Public Health, the Office of AIDS Programs and Policy of Los Angeles County, and the AIDS Healthcare Foundation (AHF) to adapt and deliver the Basic HIV Test Counselor curriculum within their jurisdictions.

OA's LEO system has the capacity to track and record all staff training for LHJs and their funded CBOs. This includes both OA-sponsored and non-OA sponsored training activities such as conferences, in-service educational sessions, trainings provided by CDC CBA providers, or TA webinars. OA will require LHJ supervisors to maintain training records for all contracted staff members. OA manages records of the HIV Test Counselor Training, as well as additional training in critical topics such as hepatitis co-infection. This information is collected by OA's training partner, AHP, and reported to OA. The OA training coordinator enters individual results into our internal database and provides certificates to those who successfully complete the program.

Intervention Specialists track all requests made to the CDC's CBA program through the CBA Request Information System and follow up with the requesting LHJ/CBO to identify the status of the request and tracking into LEO.

OA will expand the use and scope of its Advisory Network, which OA uses to disseminate information to a current group of 365 contacts throughout the state on funding announcements, news about OA, trainings/capacity building resources and resources targeting providers, consumers, researchers, and clinicians. Content is developed by OA based on suggestions from local CBOs, national training organizations and resources brought to the attention of OA staff. To expand its use further, OA will register any contracted or sub-contracted LHJ or CBO staff not currently a member of the Advisory Network in order to ensure the flow of information is guaranteed to all funded stakeholders.

In collaboration with the STD Control Branch, OA will implement PS best practices webinars. OA/STD Control Branch has identified a number of innovative and/or successful approaches to PS by California LHJs. Staff from these LHJs will be asked to present their best practice to staff from other LHJs via webinar format. Topics will include imbedding Disease Intervention Specialists into medical care settings, developing policies and procedures and integration of HIV with STD and viral hepatitis programs.

OA will continue conducting teleconference calls with all LHJs care and prevention contractors on a quarterly basis. These calls provide an opportunity for OA to address contractor questions and concerns, update contractor staff on recent legislative, policy and organizational news and exchange additional information between contractors and OA. Contractors also use this opportunity to highlight best practices, requests ideas on program implementation or to share resources.

Additionally, OA will continue to hold monthly LEO teleconference calls for all LHJ and CBO staff using the LEO system.

C. Program Planning, Monitoring and Evaluation, and Quality Assurance

Identification of Cities/MSAs with at least 30% of HIV Epidemic: No city/MSA within the CPA has 30% of the people living with HIV or AIDS.

Coordination with State and Local Surveillance Programs: The HIV Incidence Surveillance (HIS) project uses surveillance data, lab result data and information on testing and treatment history (TTH) to create population-based incidence estimates. This project's success is dependent on successfully linking these data sources as well as data completeness. Links are dependent upon eHARS having a valid OA Counseling, Testing and Referral number (OAID, captured on the Client Information Form (CIF) and entered in LEO). The OAID is used by OA staff to identify and track HIV tests conducted by OA-funded CTRS providers; however, the OAID is not used by all the California labs to identify HIV tests, so OAIDs are not always included in eHARS. OA will require that all OA-funded CTRS providers complete and submit an HIV/AIDS Case Report Form (ACR) for every confirmed HIV positive test result received; additionally, OA will explore the feasibility of providers including the OAID on the ACR (using a local field) and including the lab accession number on the CIF. Recently OA identified four indirect identifiers or matching criteria (i.e., race, date of birth, gender, and first initial of last name) to successfully identify unique individuals within the prevention data (sensitivity=.93 and specificity=.96). This combination of matching criteria could also be used to match the prevention and surveillance data, when the OAID is insufficient, and for preliminary positive results with no confirmatory result. To further assist with the collection of TTH data, testing history variables will be added to ARIES which can then be linked to the surveillance data using

personal health identifiers (PHI) available in both databases (e.g., first name, last name, date of birth, Social Security number). Finally, LEO can be used to identify prevention providers who repeatedly report unlinkable clients. Interviews with these providers should identify barriers to matching and correcting these barriers, thereby improving the matching of these two data system.

Collaboration with Local National HIV Behavioral Surveillance (NHBS) Staff: OA

contracts directly with the Chicano Federation of San Diego County, Inc., to conduct NHBS in the San Diego MSA. With the assistance of community stakeholders, key informants, and focus groups, local NHBS staff develops local prevention questions to identify access to and use of local prevention resources among MSM, IDU and heterosexuals at high risk (HET) for HIV infection. Local prevention survey topics address participant use of and experiences gained from specific HIV health education, prevention, and care and treatment programs or services offered by HIV/AIDS health and prevention agencies within the San Diego MSA. Questions include participant access to or utilization of prevention services offered by the county health department, as well as participant knowledge of HIV testing locations, access to specific programs offering HIV prevention information, and participation in drug or alcohol treatment programs.

Data collected from the prevention activities section of the core survey in conjunction with data from the local prevention survey will be analyzed to characterize prevention service gaps and missed opportunities for prevention among MSM, IDU, and HET populations within San Diego. Further analyses on core and local survey data obtained from NHBS will enable OA to make recommendations for improving the quality, efficiency, and usefulness of HIV

prevention programs to local health departments and CBOs in the San Diego MSA and will contribute to national efforts to do the same.

NHBS data may be used by public health officials, HIV prevention planning groups, and scientists to identify needs, allocate resources, and to develop or improve prevention programs that target communities at high risk for HIV.

Refer to Appendix N for Program Goals and S.M.A.R.T. Objectives.

Data Security and Confidentiality: Client-level data are collected on OA-provided client encounter forms designed specifically to capture performance measures relevant for each of the different service types. Data are entered into the LEO system by local service providers. LEO has a complex system of validation rules in place to ensure data quality, and a variety of real-time reports are available to local providers as well as OA operations advisors to monitor data and service quality.

LEO follows strict CDPH and CDC data security and confidentiality guidelines and is housed on a secure server. Data submitted to OA is secured via the LEO system's three-tiered security architecture that includes stringent authentication procedures to allow access only to authorized users. In addition, role and agency membership is used to further restrict access to specific data and reports relevant to the user. LEO requires a user identification and password for access, which is limited to active staff specifically engaged in delivering services, program monitoring and evaluation, and administration. OA staff with data access is required to complete annual security trainings and abide by all state and federal requirements for protecting health data as well as information specifically related to HIV/AIDS.

Raw data sets are only available to LHJ administrators and epidemiologists, and only include data reported by the respective LHJ. These data sets are encrypted and password

protected and sent via secured e-mail. Public reports restrict small denominator populations to eliminate the possibility of identifying individuals.

OA converts LEO client-level testing data into a CDC-supplied XML file format then uploads these data into EvaluationWeb following CDC data submission guidelines.

If CDC continues to require HE/RR and PS client-level data, then OA will convert LEO HE/RR and PS data into the appropriate CDC-approved XML data format; these data will be encrypted using CDC-approved PGP software and then submitted to CDC through the CDC Secure Data Network.

Category B: Expanded HIV Testing (ET) for Disproportionately Affected Populations

A. Background and Need

Previous Experience with HIV Testing in Healthcare Settings

The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) participated in the Centers for Disease Control and Prevention (CDC) Funding Opportunity Announcement 10-10138. Upon receiving this funding OA was unable to implement our plan on the expected timeline due to budget difficulties in California that led to a hiring freeze and a delay in obtaining legislative spending authority. As soon as OA received legislative spending authority we immediately released a Request for Applications (RFA). A panel of HIV testing and monitoring and evaluation experts reviewed the applications. The reviewers recommended funding three applicants: San Diego County, AltaMed Health Services of Orange County, and the University of California Davis Medical Center Emergency Department. The reviewers also recommended the possibility of funding Orange County and Alameda County if suggested improvements could be made to the application proposals. The two counties made the revisions and will be funded. These five grantees represent HIV testing in approximately 65 health care settings (HCS)/venues. OA expects our grantees to provide 67,569 tests which will result in 337 new HIV positive patients (.5 percent positivity rate) in Year 2 and subsequent years of PS12-1201 Category B funding. Based on our experience with the PS07-768 venue start-up and with the RFA process, we expect to be able to provide about 37,163 HIV screening tests with which will result in 185 new positives in Year 1. ET is expected to begin at three of the five grantees' sites in October 2011 and at all sites by January 1, 2012.

OA will fund the above HCSs for two years until December 2013. During 2013 OA will determine the best use of Category B funds for the remaining three years of PS 12-1201.

OA participated in the FOA PS07-768 *Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV* (07-768) project beginning October 2007. With 07-768 monies, OA funded two local health jurisdictions (LHJs), Alameda and San Francisco Counties, to provide rapid HIV testing in three hospital emergency departments (EDs). The hospitals, Highland and Summit in Alameda County and San Francisco General Hospital (SFGH), provide the majority of ED care to underserved and vulnerable populations in those LHJs. Each hospital has been successful in providing rapid HIV testing in their ED.

OA has supported these programs as they were created, developed, implemented, and maintained for the two and one-half years since the inception of the project. Following the initial start-up year of October 2007 through September 2008, the three hospitals in aggregate met 85 percent of their CDC-defined goals for HIV testing in the second year of 07-768 funding, with 226 newly diagnosed for a HIV positivity rate of .39 percent. In addition, the program achieved a 77 percent linkage to care (LTC) rate with all of those patients also receiving an offer or referral to Partner Services (PS). In Year 3 the OA-funded sites provided 24,137 HIV tests or 80% of their CDC-defined goals. The small decrease in testing is due to the decrease in state funding for HIV prevention services which meant that the two sites (Highland and Summit Hospitals) that had relied on HIV test kits being provided by OA were no longer provided them. These programs decreased staffing in order to purchase HIV test kits. In Year 3 ninety-four people were newly diagnosed as HIV positive for a HIV positivity rate of .38 percent.

Throughout the grant period, OA provided on-going training and technical assistance (TA) to the funded sites as well as to other EDs around the state. Summit Hospital had no prior experience with HIV testing in their ED setting. OA provided training on specimen collection and test processing for their HIV testers and helped them to establish a data collection system

and increase their HIV testing volume. The OA project coordinator held quarterly meetings for the coordinating personnel of all sites to discuss productivity, exchange ideas, and troubleshoot problems.

OA also collaborated in March 2009 with CDC to provide a workshop for hospital ED staff in Southern California entitled, “HIV Screening in Acute Care, Ambulatory Care, and Inpatient Settings.” Ten hospitals participated in the workshop. OA’s staff and PS07-768-funded sites provided presentations on lessons learned, as well as California-specific regulations and law. OA also provided TA as the hospital teams worked through their action plans. Along with our partners the Pacific AIDS Education and Training Center (PAETC) and the HIV Prevention Training Center (PTC), OA continued to provide TA and training to these hospitals and others that have expressed interest in HIV screening. OA has also collaborated with the American Academy of HIV Medicine (AAHIVM) on issues related to insurance reimbursement for routine HIV screening and has just initiated collaborations with the California Primary Care Association (CPCA) regarding implementation of routine HIV screening in community health centers (CHCs). OA is also planning to work with the California Medical Association (CMA) to encourage their members to incorporate routine, opt-out HIV testing in their practice.

On January 1, 2009, California eliminated the requirement for separate, written consent for HIV testing. In order to encourage quick and widespread adoption of this change, and to support CDC guidelines, OA distributed an “All Facilities Letter” that was sent to every licensed health care facility in the state. This letter provides background about HIV screening, explains the 2006 CDC guidelines and recommendations and provides information regarding training and TA resources available to health care facilities. In addition, the letter explains changes to California law that require private health insurance companies to reimburse for routine HIV

testing regardless of primary diagnosis. OA continues to utilize this letter as a TA tool to increase routine HIV screening in California.

In addition to 07-768 funding, OA received CDC Perinatal Project funding. OA was funded to assist California's labor and delivery hospitals in implementing rapid HIV testing in labor and delivery (RTLTD). The project coordinator worked directly with hospital administrators and staff to stress the importance and value of this important public health intervention, and has used several methods of encouragement including personal visits, in-person and on-line training, letters explaining the legal requirement of RTLTD, and direct assistance to minimize barriers to laboratory approval. With the assistance of our training subcontractor PAETC, OA increased hospitals providing RTLTD from 15 in 2004 to 210 by June 2011.

Target Population

OA will target African Americans, Latinos, men who have sex with men (MSM), and injection drug users (IDU) with Category B funding. Almost one-half (49 percent) of people living with HIV/AIDS in California are either African American or Latino. African Americans make up only 6.7 percent of California's population, but represent 37 percent of all people living with HIV/AIDS. While Latinos represent 37 percent of California's population and 30 percent of people living with HIV/AIDS, they are a very large and vulnerable population in California that can find it difficult to initially engage in and remain in HIV care and treatment. For those African Americans and Latinos who do not have health insurance, hospital EDs and urgent care clinics have become providers of primary care. Of those patients with public insurance such as Medi-Cal, many use CHCs to obtain primary care. Normalizing HIV screening in these settings will increase the number of people in these populations who know their HIV status.

Eighty-one percent of Californians living with HIV/AIDS are MSM/IDU, MSMs, or IDUs. These populations also use hospitals and CHCs to meet basic health care needs, such as sexually transmitted disease (STD) diagnosis and treatment and wound care. Again, normalizing HIV screening for these groups in health care settings will increase this population's knowledge of their HIV status.

With Category B funding, OA will focus primarily on hospitals, CHCs, and other health care venues that serve the populations described above. Based on epidemiological data, OA selected 18 LHJs that were eligible to submit applications for ET funding via the previously mentioned RFA (described in detail below). They are: Alameda, Contra Costa, Fresno, Kern, Long Beach, Marin, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma and Ventura. These LHJs represent 93 percent of all living HIV/AIDS cases (excluding Los Angeles and San Francisco) for the target populations of African American, Latino, MSM/IDUs, MSMs, and IDUs.

Current Collaboration

In the first year of Category B funding, which will be the first full year of ET funding for our grantees, they will not be pursuing integrated screening activities. It is likely the sites that successfully incorporate HIV testing into their medical settings will then be able to provide some integration of other screening activities for STDs, Tuberculosis and hepatitis.

2. Non-Healthcare Settings *(Not applicable to California Project)*

B. Program Description

Selection of Healthcare Settings

OA identified 18 LHJs that were eligible to apply for PS10-10138 funding. (The LHJs of Los Angeles and San Francisco are not eligible for this funding because they are eligible to apply

for PS10-10138 funding directly from CDC.) The identified LHJs represented 93 percent of all people living with HIV/AIDS and reported in the statewide HIV/AIDS surveillance system (not including Los Angeles and San Francisco) who are African American, Latino, MSM/IDUs, MSMs, or IDUs in California. Fifteen of the 18 eligible LHJs have also received CDC Prevention Funds through OA; with the revised LHJ allocation strategy described in Part A, all of the eligible LHJs will also receive Part A prevention funds. Additionally, 17 of the eligible 18 LHJs also receive Health Resources Services Administration, Minority AIDS Initiative (MAI) funds to provide outreach to people of color who know their HIV status but are not engaged in HIV care and treatment. In sum, these LHJs have the appropriate epidemiology and are in the best position to identify and implement high-volume HIV screening to benefit the populations most in need of this service. In addition, any facility within an eligible LHJ could apply directly to OA for this funding via the previously mentioned RFA (described in detail below). For example, a hospital with a large ED could apply directly. However, these facilities had to obtain a letter of support from the AIDS director of their LHJ and discuss how they would work with the LHJ to integrate LTC and PS, and prevention services. The grantees identified in this process, which was completed in July 2011, will receive the PS12-1201 Category B funds. Because OA funding eligibility decreased from \$3.5 million to \$2.4 million before we had established contracts with our grantees, we were able to adjust their funding levels and testing numbers to account for this.

In order to obtain the best qualified and most motivated participants for this program, OA developed and released an RFA in April 2011. The health departments and previously described facilities within the identified 18 LHJs were eligible to apply for the funding. The RFA required the applicants to address and describe the following the elements:

- Site(s) within LHJ and/or facility which will perform routine HIV screening;
- Number of HIV screening tests to be performed in first and subsequent years;
- Evidence of probability that selected sites will obtain at least a 0.5 percent identification rate of new positives;
- Plan for integrating HIV screening into work flow at identified facilities without funding for staff positions from this grant;
- Plan for providing HIV confirmatory testing to patients receiving a preliminary positive HIV screening test result;
- Plan to provide those with a confirmed HIV diagnosis LTC and treatment, PS, and prevention services;
- Plan to obtain reimbursement for HIV testing from public and private insurance sources;
- Description of facility's relationship and plans for collaboration with LHJ health department; and
- Any previous success with high-volume HIV screening.

OA is committed to using PS10-10138 and PS12-1201 Category B funding to establish the future sustainability of HIV screening in LHJs and healthcare settings. To that end applicants were only funded for the following activities:

- LHJ staff to coordinate PS10-10138 and PS12-1201 Category B activities. This includes assisting selected venues with HIV screening implementation, analysis of barriers or problems encountered, establishing data collection systems, developing and maintaining LTC networks, working to ensure referrals to PS and prevention services, and monitoring HIV screening insurance reimbursement rates for each site.

- Cost of HIV screening for patients without any other means of paying for HIV screening. Venues funded by PS10-10138 and PS12-1201 Category B are expected to pursue reimbursement from all appropriate public and private insurers before using PS12-1201 Category B funds are used to pay for HIV screening. California law requires that all private insurers provide reimbursement of HIV testing regardless of diagnosis. Medicare will reimburse for HIV screening when the patient requests the test or is at increased risk for HIV per United States Prevention Services Task Force guidelines. While Medi-Cal (California's Medicaid program) does not reimburse for routine HIV screening, it will provide reimbursement for International Classification of Diseases, Ninth Revision (ICD-9) codes for which many patients would qualify. OA will provide TA to all HIV screening venues regarding working with Medicare and Medi-Cal patients and appropriate coding for maximum reimbursement from public and private insurers. It is expected that lessons learned in one venue will be transferred easily to others with the assistance of this TA.

All applications were judged on their ability to provide high-volume HIV screening in selected venue types and appropriate LTC, treatment, PS, and prevention services for those with preliminary or confirmed HIV-positive screening results. LHJs were encouraged to think broadly when considering the facilities within their jurisdictions that could provide high-volume HIV screening. These could include hospital EDs and inpatient units, CHCs, STD clinics, jails, and substance abuse treatment settings. For proposals including substance abuse treatment venues, applicants were required to collaborate with local alcohol and drug administrators and to explain the coordinated use of Substance Abuse and Mental Health Services Administration set-aside funds and funds from this grant.

The submitted applications were formally evaluated by a committee of OA staff and others that included HIV testing experts from the San Francisco and Los Angeles PS07-768 program, a member of the PAETC and Monitoring and Evaluation experts.

Three LHJs and two health care systems were chosen to be OA ET in Healthcare Settings grantees. These grantees represent 65 HCS in four counties that will provide routine, opt-out HIV testing by the end of Year 2.

San Diego County will implement HIV testing in six county jails and five CHCs with a total of 30 clinic locations. These settings will use a variety of testing strategies but the majority will be routine and opt-out using conventional or rapid HIV testing technologies. San Diego County represents 21 percent of the living HIV/AIDS cases in the California Project Area (CPA).

UC Davis Medical Center will implement routine, opt-out HIV testing with lab-based conventional testing on their high volume analyzer. The general consent used will allow for the contact information of a patient that tests HIV positive to be given to the local HIV care setting. This setting has a well-developed test result notification and LTC service that will contact the patient, disclose test results, and determine with the patient the best place for that to pursue HIV care and treatment services. Patients will learn their HIV negative status by mail. Sacramento County represents 5.5 percent of the living HIV/AIDS cases in the CPA.

AltaMed Health Services of Orange County will implement routine, opt-out HIV testing in eight primary care clinics using conventional and rapid HIV testing depending on patient preference for oral fluid screening, other blood work the patient needs, what clinic the patient is using, i.e., STD, family planning, internal medicine, etc. and whether the patient need a follow up appointment for their presenting medical problem.

Orange County will implement HIV testing in two healthcare settings to be determined. The Orange County Health Care Agency is required by their Board of Supervisors to conduct an RFA process to select their participating healthcare settings. The staff in Orange County has assured OA that several appropriate HCSs are interested in applying and capable of providing high volume, routine, opt-out HIV testing. Orange County represents 12 percent of the living HIV/AIDS cases in the CPA.

Alameda County will implement ET in four healthcare venue types including the two local jails; at least six newly re-established Planned Parenthood clinics; three community and three high school clinics of La Clinica de la Raza, a large CHC and four methadone clinics. A variety of HIV testing strategies and methods will be used in Alameda County, depending upon the needs of the specific testing site. The Alameda County Planned Parenthood affiliate will be able to quickly move to sustainability by pursuing the example of their other affiliates in the state for reimbursement from California's statewide family planning program, Family PACT. Alameda County represents approximately ten percent of the living HIV/AIDS cases in the CPA.

These four counties represent 48.3 percent of all people living with HIV/AIDS and reported in the statewide HIV/AIDS surveillance system who are African American, Latino, MSM/IDUs, MSMs, or IDUs in the CPA, OA has contracts in place with the three LHJs. This funding will be added to the contract quickly and efficiently. For those facilities selected that are directly-funded, i.e., UC Davis and AltaMed, OA will contract with the facility.

OA fully expects our grantees to provide 67,569 tests in Year 2 and subsequent years of PS12-1201 Category B funding. Based on our experience with the PS07-768 venue start-up and with the RFA process, we expect to be able to provide about 37,163 HIV screening tests in Year 1. OA now has extensive experience with HCSs with HIV testing start up; however, we are

cautious about committing to too many tests in the first year given that we are expanding from three sites to over sixty.

OA is applying for the ceiling amount of the award range, \$2.4 million. After subtracting approximately \$502,000 for state-level staff positions, \$1.9 million will remain for distribution to our grantees. State level positions include a Project Coordinator, a LTC/PS Specialist, a Contract Monitor, a Data Manger and a .5 full-time equivalent (FTE) Information Technology Specialist. Given the expanded scope of the project and the geographical and medical setting variety of the testing sites, OA has expanded its staffing to meet grantees needs for training and TA related to HIV testing, LTC/PS, and Monitoring and Evaluation. Specific duties and supervision will be explicated in Section E. Staffing and Management. Because OA received notification of the decrease in funding for ET before we contracted with our grantees, we were able to work with them to adjust their scopes of work and testing numbers to account for that. OA expects to be able to perform 67,596 HIV screening tests in the second year of funding for an average per test cost of \$29.

Promoting Routine HIV Testing in Selected Healthcare Settings

OA recruited eligible LHJs and eligible facilities to apply for this funding with the following methods:

- Working directly with AIDS and HIV Prevention directors of eligible LHJs to encourage them to think broadly about the facilities in their LHJs that would be appropriate for this funding;
- Sending letters announcing the RFA to all eligible hospitals. These letters were directed to the president/chief executive officer (CEO), and chiefs and nurse managers ,of Emergency, Internal Medicine and Family Medicine Departments;

- Posting OA's application to the CDC in order to alert eligible LHJs and HCSs of the possibility of ET funding;
- Dissemination of RFA to all members of OA Advisory Network;
- Contacting the presidents/CEOs, medical directors, and nursing directors of primary care and STD clinics in eligible LHJs to encourage them to consider applying for this funding;
- Collaborating with PAETC, PTC, the CDPH STD Control Branch, the California Planning Group and other OA Stakeholders to disseminate this information.

Based on lessons learned from 07-768 funding, OA provided examples to eligible LHJs and HCSs about the activities OA would use to evaluate their application. These examples included the value of implementing high-volume rapid HIV screening in hospital ED settings using laboratory analyzers such as Ortho Vitros or Siemens, thinking creatively about delivering HIV-negative test results through discharge papers or other means that do not require an in-person disclosure, providing immediate LTC and treatment services, and pursuing reimbursement for routine HIV screening from public and private insurers. Grantees were responsible for incorporating these ideas into their applications and that was reflected in the scoring.

Grantees are responsible for promoting routine HIV testing in their respective organizations and testing venues. Each grantee has staff in the HIV testing venues responsible for the success of the grant in their setting. They are responsible for promoting routine HIV screening to clinical staff and patients. Given OA's experience with PS07-768, our RFA required applicants to provide detailed descriptions of how routine HIV testing will be fully integrated into the work flow of the venue without the funding HIV testing and LTC staff. Grantees provided these detailed plans which included adding HIV screening to the general consent for care that patients sign before receiving care and orders for blood specimens to be taken for other routine tests.

Selection of Testing Technology

Grantees are using a variety of testing technologies and methods that will maximize the HIV testing venues can provide and have provided descriptions of innovative ways that patients will receive their results. For example, one site will use their high volume laboratory analyzer platform to process many HIV tests from the ED. Although patients will not know their HIV status before leaving the ED, the program has an excellent LTC plan using the existing resources of the local HIV care clinic. Most HIV testing within CHCs will be done with conventional testing. However, testing done in CHCs providing services to the homeless population or providing STD services will be rapid. In those settings, anyone with a preliminary HIV positive test result will be linked immediately to HIV care for HIV confirmation testing.

Culturally and Linguistically Appropriate Staffing

Each of the five contractors chosen has culturally and linguistically appropriate staff. They have been providing services to their communities for many years and have developed the awareness and trust of their patients and the community at large.

HIV Testing and CDC Recommendations

All contracted venues are required to provide HIV testing in a manner consistent with applicable CDC guidelines and recommendations. Site visits and quality assurance measures will be used to ensure this.

Revising HIV Testing Consent Procedures

California law allows for routine, opt-out HIV screening as described in CDC guidelines and recommendations. Patients must be told in writing or orally that they may be screened for HIV during their health care visit, but that they have the right to decline HIV screening. They must also be provided information about the test, informed that treatment options are available,

and advised that a person who tests HIV negative should continue to be routinely screened. This information can be provided in written or oral form and can be included in the general consent for treatment.

Providing HIV Positive Test Results to Patients

Grantees have provided detailed descriptions of how each HIV testing site will deliver preliminary and confirmed HIV-positive results. Sites providing conventional testing will inform patients testing HIV negative by mail. Patients testing HIV positive will be notified in person by their medical provider, a LTC specialist or a Disease Intervention Specialist (DIS) who will be able to actively link these patients to HIV care, treatment, prevention counseling and PS. Testing sites using rapid HIV testing will link patients who test HIV positive directly to HIV care in order to have their HIV confirmatory test at the HIV care site. All grantees have agreements with their most frequently used HIV care sites that will allow new identified patients to an intake appointment within a day or two after testing HIV positive. All of the HIV testing sites are implementing changes to their general consent process that will allow the sharing of patient contact information with LTC coordinators and specialists. This will ensure follow up for patients who miss appointments for HIV testing results and HIV care, treatment, prevention counseling and PS.

Linkage to Care, PS, Prevention Counseling and Surveillance Reporting

Grantees have provided detailed plans for LTC, PS, prevention counseling and HIV/AIDS surveillance reporting for each HIV screening venue. For applicants proposing jail testing, the plan must also include coordination with existing transitional case management programs (TCMP). Successful grantees provided detailed answers to the following questions:

- Who within the venue will be responsible for providing LTC activities? How will the responsible individual (the local LTC coordinator) be informed of patients who receive a preliminary or confirmed HIV-positive screening result?
- How will the venue ensure that the LTC coordinator can contact the patient? For example:
 - *Can the venue include contact by the LTC coordinator in the consent to treat materials?*
 - *How will the venue ensure the LTC coordinator has correct contact information for the patient?*
- Will a venue providing preliminary HIV-positive results immediately refer the patient to an HIV care and treatment facility or will they provide confirmatory testing at their venue?
 - *If providing confirmatory testing, what kind: Western blot, Immunofluorescence Assay, Viral Load, Ribonucleic acid, nucleic acid amplification testing?*
- To which HIV care and treatment facility will the LTC coordinator refer patients with a preliminary or confirmed HIV-positive test result? Letters of support from these sites will be required.
- How will they confirm if patients have attended their first appointment?
- How will the LTC coordinator be able to determine if the patient has continued with HIV care and treatment services? If they have not, how will local MAI resources be engaged to assist with retention in care?
- How will PS be provided to the patient?

- *Will the HIV care and treatment setting refer the patient to a PS provider or will the HIV care and treatment site be responsible for offering PS, eliciting partner information from the patient and passing that information on for notification?*
- *How will the LTC coordinator know that the PS's elicitation has been offered and provided? A letter of support from the local PS program will be required.*
- How will prevention services be provided to those testing HIV positive?
 - *How will the LHJ encourage use of existing HIV prevention services such as Prevention with Positives, individual and group level interventions?*
- How will compliance with HIV/AIDS surveillance reporting requirements be monitored?

All grantees have established relationships with HIV care and treatment settings that facilitate early entry into care usually within 24 to 48 hours and in the case of co-located facilities, immediately. In addition, the grantees will be changing general consent procedures so that they allow for the sharing of patient information with LTC coordinators and specialists.

All grantees are healthcare providers and have the capacity to obtain third party reimbursement for HIV testing. Each grantee detailed how they would pursue this reimbursement and identified the staff positions within their organizations responsible for these activities. It is expected our grantees will learn from each other regarding reimbursement. Once reimbursement is successful in these settings, it is expected that the HCSs will expand HIV testing to other services in their settings and possibly within the community as well.

Grantees are only permitted to use this funding to pay for the HIV tests of patients with no other funding source. The current uninsured rate in California is approximately ten percent, however; due to the populations they serve many of our grantees have higher percentage of uninsured patients. Each grantee detailed their current level of service to uninsured patients and

understands the requirement to pursue all possibilities of reimbursement before charging the grant for the test.

Integration of HIV Testing with Other Healthcare Services

In their second year of funding, grantees will be exploring the possibilities of integrating HIV testing into other types of screening programs in their healthcare facilities. This seems especially feasible in the CHCs where it is likely that if one clinic has success with implementation and reimbursement other clinics will follow. In the same manner, if a clinic has success integrating HIV testing it is likely they will be more willing to integrate other types of screening that will improve patient care.

Promoting HIV Testing in all Healthcare Settings

OA is using Category A funding for two Testing Specialists whose primary function will be to encourage and support implementation of routine, opt-out HIV testing in HCSs not funded by Category B. The Testing Specialists expect to disseminate the knowledge gained from implementation in Category B funded sites related to issues such as choosing testing technologies and methodologies, LTC from HCSs and reimbursement to increase testing in other HCSs. Please see Section **B1. Program Description – Required Activities** in Category A for a description of these strategies.

2. Non-Healthcare Settings (*Not applicable to California Project*)

3. Service Integration (*Optional - Not applicable to California Project*)

C. Capacity Building and TA

All OA staff currently working with the ET Project were evaluated for their existing skills in order to meet to meet their job responsibilities. In the same manner, future applicants will be evaluated and interviewed to determine their capacities to meet the job requirements. OA staff

will have additional training available as needed ensure appropriate skill level. Skill level and capacity will be assessed regularly by OA's Prevention Branch management.

Grantees will be required to participate in all training and TA activities provided by OA. These activities will include monthly All Grantee conference calls, site visits from OA project staff and any required CDC activities. We do not plan any All Grantee in-person meetings because travel is very restricted at the state and county level at this time. We will employ webinar technology when appropriate. Grantees will be responsible for documenting and tracking the provision of training and TA they receive from OA and our training and TA collaborators. They will then report this to the Health Department (HD) in quarterly reports.

Due to travel restrictions, it is expected that HD staff will assist grantees in the exchange of information across sites. However, some grantees are located in the same LHJ and will need to collaborate in order to best accomplish LTC and PS. For instance, in Orange County we are funding AltaMed, the largest CHC, and separately the LHJ to implement testing in two other healthcare venues. We anticipate these programs will have regular meetings to exchange information and community resources. San Diego County submitted joint application with five CHCs and several county-run clinics. They will continue to meet together in order to support implementation.

In addition, OA's partners PAETC and PTC will provide training and TA to the grantees and their HIV testing sites. Topics may include determining the best HIV testing technology, incorporating HIV testing into healthcare setting flow, providing HIV positive test results to the patient, facilitating linkage to care and successful reimbursement strategies.

D. Program Planning, Monitoring and Evaluation, and Quality Assurance

Based on epidemiological data obtained from our statewide HIV/AIDS surveillance system OA selected 18 LHJs that were eligible to submit applications for ET funding. These LHJs represent 93 percent of all living HIV/AIDS cases among the target populations of African American, Latino, MSM/IDUs, MSMs, and IDUs in the CPA. The four LHJs awarded ET funds, San Diego, Orange, Alameda and Sacramento, represent 48.3 percent of the living HIV/AIDS cases in the CPA.

Each grantee has agreed to collect the data required by CDC in the “Expanded HIV Testing for Disproportionately Affected Populations: Monitoring and Evaluation Plan” dated December 2010. Grantees will submit HIV negative test data in an XML file that will be uploaded directly to Evaluation Web. HIV positive test results will be entered directly into OA’s Local Evaluation Online by the grantees and/or their subcontractors. OA will transfer these data to Evaluation Web. OA has one and one-half FTEs dedicated to data collection, analysis and submission for the ET Project.

SMART objectives and key action steps for ET in healthcare settings.

Objective 1: Between January 1 and December 31, 2012, perform 32,095 HIV screenings in the five funded contractor and/or sub-contractor sites.

Key Action Steps:

- (A) By January 31, 2012, develop program plan including data collection and quality assurance for each funded HIV screening venue.
- (B) By January 1, 2012, implement HIV screening in each funded HIV screening venue.
- (C) By August 1, 2012, assess first six months of Year 1 HIV screening implementation by funded contractor and/or sub-contractor sites using total HIV screening, total and new HIV-

positive yield, LTC, and PS outcome data to determine continued appropriateness of each of these venues.

- (D) By December 31, 2012, assess appropriateness of first year of insurance reimbursement by source, level, and type of reimbursement.

Objective 2: Between January 1 and December 31, 2013, perform 67,569 HIV screenings in funded contractor and/or sub-contractor sites.

Key Action Steps:

- (A) By January 1, 2013, make adjustments if necessary to funded HIV screening venues and provide implementation assistance to newly chosen venues.
- (B) By April 1, 2013, make adjustments to insurance reimbursement processes to obtain maximum level and type of reimbursement by source.
- (C) By August 1, 2013, assess first six months of Year 2 HIV screening using total HIV screening, total and new HIV-positive yield, LTC, and PS outcome data to determine continued appropriateness of each of these venues.
- (D) By December 31, 2013, assess second year of insurance reimbursement by source, level, and type of reimbursement.

Objective 3: Between April 1 and December 31, 2013, determine and implement plan for Years 3, 4 and 5 of ET funding.

Key Action Steps:

- (A) By July 1, 2013, determine how funding will be used to support ET throughout the high HIV prevalence areas in the CPA and create plan for implementation.
- (B) By December 31, 2013, implement plan for ET and necessary contracts for contractors and subcontractors.

Objective 4: Between January 1 and December 31, 2014, perform 67,569 HIV screenings according to plans for Years 3, 4 and 5.

E. Staffing and Management

OA's ET Project will be managed by a full-time ET Project Coordinator (to be hired), who will report to the Chief of OA's HIV Prevention Branch. The project coordinator will be supervised by the Branch Chief to ensure that the project is implemented in a manner consistent with CDC directives and policies for this grant. The ET Project Coordinator serves as the lead working with the LTC and PS Specialist, Health Program Specialist I. The LTC and PS Specialist, supervised by the Chief of OA's HIV Prevention Programs Section will provide oversight, training, and TA to RFA-funded contractors in developing, implementing, and maintaining an effective system to link HIV-positive clients to care and PS. The ET Project Coordinator will also work with the Data and Evaluation Program Coordinator, supervised by the Chief of OA's Program Evaluation and Research Section, (to be hired) and the Operations Systems Analyst, supervised by the Chief of OA's Data Systems Support Section. They will be responsible for planning, managing, and overseeing all components of the program related to data collection, data management and data evaluation. The Contract Monitor (Associate Government Program Analyst), supervised by the Chief of OA's Prevention Operations Section, will provide contract oversight to ensure that the project is in compliance with CDC administrative requirements and state contracting guidelines. Project staff, in collaboration with relevant staff funded under Part A, will meet weekly to discuss the implementation plans and the on-going monitoring and evaluation of project as well as opportunities to leverage best practices and lessons learned throughout all funded jurisdictions in the CPA. Project staff will develop a site visit tool and schedule site visits on a regular basis, especially in the first year of the project. In addition to the staff funded by this grant, support

and expertise will be provided by other OA staff including: two HIV Testing in Medical Settings Specialists, a PS Specialist, an MAI Specialist, an IDU Specialist, the Health Disparities Coordinator, Health Disparities Steering Committee members with expertise in African Americans, Latinos, women, MSM, and transgender people, and the Division Chief who is a practicing HIV specialist physician.

OA has an excellent relationship with our STD Control Branch, Laboratory Field Services, Medi-Cal (Medicaid) and other government entities needed for the success of this project.

Appendix A: Overview of California Office of AIDS Approach for Part A Funding

Table 1 – Tier 1 OA Prevention Activities

Activity	CDC Category	Roles	New or continuing activity
Testing in healthcare settings	Required	LHJ TA from OA	Continuing
Testing in non-healthcare settings	Required	LHJ TA from OA Training from OA	Continuing with changes
Linkage to and retention/ reengagement in care	Required	LHJ TA from OA	LTC – Continuing; Retention/ Reengagement - New
Partner Services	Required	STD Control Branch OA LHJ	Continuing/ substantial changes
Risk assessment, linkages to services and behavioral interventions for HIV positive persons in clinical settings	Required	LHJ with TA and training from OA	New
Integrated hepatitis, TB, and STD screening, and PS for HIV positive persons	Required	LHJ with TA and training from OA	New
Treatment adherence	Required	LHJ TA from OA	New
Policy Initiative – Use of surveillance lab report data (CD4 and viral load) to identify loss of engagement in medical care and track community viral load	Required	OA LHJ	New
Policy Initiative – Coordination and leveraging of Substance Abuse and Mental Health Services Administration (SAMHSA) HIV Set-Aside Funds	Required	OA LHJ	New
Policy Initiative - Healthcare reform planning	Required	OA LHJ	New
Condom distribution and marketing	Required	OA centralized LHJ	Continuing/ substantial changes

Activity	CDC Category	Roles	New or continuing activity
Syringe services programs	Recommended	OA centralized LHJ	Continuing/ substantial changes

Table 2 – Tier 2 OA Prevention Activities

Activity	CDC Category	Roles	New or continuing activity
Hepatitis C testing ¹	Recommended	LHJ with TA and training from OA	Continuing
Integrated HIV, hepatitis, TB, and STD screening, and PS for persons with unknown HIV status ²	Recommended	LHJ with TA and training from OA	Continuing
Behavioral interventions for high-risk negative persons	Recommended	LHJ with TA and training from OA	Continuing/ substantial changes
Social marketing, media and mobilization	Recommended	LHJ with TA and training from OA	Continuing/ substantial changes
Pre-exposure prophylaxis planning and/or delivery ³	Recommended	LHJ with TA and training from OA	New
Educational Materials to all 59 LHJs	Recommended	OA	Continuing

¹ Although hepatitis C testing is a Tier II activity, LHJs are not required to fulfill all Tier I activities prior to funding hepatitis C testing in non-healthcare settings.

² Not to exceed 5% of total LHJ allocation.

³ May not pay for medication.

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A. Required Program Components

1. HIV Testing in Healthcare Settings

Program Goal #1: Maximize the number of people with HIV infection who know their HIV status.

Objective 1-1: By December 31, 2012, OA will develop a best practices document based on the outcomes and lessons learned from the Category B-funded Expanded Testing Project.

Objective 1-2: By March 1, 2013, OA will disseminate the best practices document to LHJs to aid the effort at the local level to increase routine, opt-out testing.

Objective 1-3: By December 31, 2012, OA will increase the number of newly identified HIV- positive clients in funded LHJ HIV test settings by 10 percent compared to the number identified in 2011.

2. HIV Testing in Non-Healthcare Settings

Program Goal #1: Maximize the number of people with HIV infection who know their HIV status.

Objective 1-1: By January 1, 2012, OA will contract with the 19 LHJs that comprise the greatest burden of the HIV epidemic in the California Project Area (CPA) to provide HIV testing services (with counseling when needed), to priority clients identified as African American, Latino, MSM, Transgender persons and IDUs.

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Objective 1-2: By December 31, 2012, OA will increase the numbers of high risk clients, (as defined by OA Guidance) tested by 10 percent in the first year (2012) compared to the number tested in 2011.

Objective 1-3: By December 31, 2012, OA will assist funded LHJs with adequately completed Tier I activities to facilitate voluntary testing for other STDs (e.g., syphilis, gonorrhea, Chlamydia), viral hepatitis, and/or TB, in conjunction with HIV testing, including referral and linkage to appropriate care and partner services, where feasible and appropriate.

Objective 1-4: By December 31, 2012, in order to facilitate HIV testing in conjunction with other services, OA will strengthen ongoing relationships with the CDPH – STD Control and TB Control Branches by meeting with them at least biannually.

Objective 1-5: By December 31, 2012, OA will assess the feasibility of adopting additional rapid technologies into our testing initiatives, including the purchase of blood-based rapid HIV test kits.

Objective 1-6: By December 31, 2012, OA will assess capacity of its funded LHJs to screen clients for coverage by public or private health insurers in all funded testing settings.

Program Goal #2: Maximize the number of people with HIV infection who are accessing appropriate care and treatment.

Objective 2-1: By December 31, 2012, OA will increase the number of newly identified HIV-positive clients that are linked to care and have verified medical services within 90 days by 10 percent compared to the number in 2011.

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Objective 2-2: By December 31, 2012, OA will increase the number of newly identified HIV-positive clients referred to Partner Services (PS) within 30 days by 10 percent compared to the number in 2011.

3. Comprehensive Prevention with Positives (PWP)

Program Goal #1: Increase the percentage of newly-diagnosed HIV-positive clients that are linked to and retained in HIV primary care.

Objective 1-1: By March 31, 2012, OA will have convened a Linkage to/Retention in Care Workgroup developed and facilitated by OA staff from the Prevention, Care and Surveillance, Research and Evaluation branches.

Objective 1-2: By May 1, 2012, OA will assess the capacity of its funded LHJs to initiate or enhance collaboration with RW-funded care providers conducting linkage to and retention in care activities.

Objective 1-3: By July 1, 2012, OA will provide guidance and TA to funded LHJs for activities that initiate or enhance collaboration with RW-funded care providers conducting linkage to and retention in care activities.

Objective 1-4: By June 2013, OA will increase by 10 percent the number of persons who attend an initial medical evaluation within 90 days of diagnosis among those who receive their confirmed HIV-positive test results at OA-funded sites.

Program Goal #2: Improve linkage to and engagement with other medical and social services for HIV-positive persons.

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Objective 2-1: By May 1, 2012, OA will assess capacity of its funded LHJs for conducting activities that initiate or enhance collaboration with RW-funded care providers engaged in activities that link HIV-positive individuals to other medical and social services.

Objective 2-2: By December 31, 2012, OA will provide guidance and TA to its funded LHJs for activities that initiate or enhance collaboration with RW-funded care providers engaged in activities that link HIV-positive individuals to other medical and social services.

Objective 2-3: By December 31, 2012, OA will provide training and TA to at least ten funded LHJs to assist them in identifying HIV-positive clients at risk for substance abuse, mental health problems, and/or other factors that compromise their capacity to engage and remain in HIV care.

Program Goal #3: Increase the number of persons living with HIV and AIDS who receive Partner Services (PS).

Objective 3-1: By January 1, 2012, OA will initiate the contract process with the LHJs in the CPA that have the highest living HIV and AIDS prevalence in order to offer PS services (including offer, elicitation and partner notification), to newly identified HIV positive persons, select individuals in HIV care settings, and syphilis/HIV co-infected persons.

Objective 3-2: By December 31, 2012, OA will increase the number newly identified HIV positive persons, select individuals in HIV care settings and Syphilis/HIV co-infected persons offered PS by ten percent each compared to 2011 referral numbers.

Objective 3-3: Through December 31, 2012, OA will provide TA support to the funded LHJs in HIV PS implementation, systems development, operating protocols, and quality assurance measures.

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Program Goal #4: Increase the number of Ryan White-funded clinics or HIV care providers providing a comprehensive risk screening program and, to the extent that resources are available, initiate behavioral, structural or biomedical interventions for HIV-positive persons, or develop a referral plan to community-based PWP interventions.

Objective 4-1: By July 1, 2012, each funded LHJ will select at least one Ryan White-funded clinic or provider to initiate behavioral risk screening within their clinic, and initiate an evidence-based risk reduction intervention or develop a referral plan to community-based PWP interventions.

Objective 4-2: By October 1, 2012, each funded clinic or provider will report their choice to implement a risk reduction intervention or a referral process to community PWP interventions to their contractor.

Objective 4-3: By December 1, 2012, each funded clinic choosing to implement a risk reduction intervention will inform their contractor of the selected evidence-based intervention for HIV-positive persons.

Objective 4-4: By December 15, 2012, each funded clinic choosing to implement a risk reduction intervention will have scheduled staff to attend training on the intervention from an appropriate training source.

Objective 4-5: By December 1, 2012, each funded clinic choosing to develop a referral process to community PWP interventions will submit a referral plan to their contractor, including a means to record referral outcomes.

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Objective 4-6: By January 1, 2013, each funded clinic will begin screening HIV-positive patients to identify those at risk of transmitting HIV and referring them to appropriate risk reduction interventions. Documentation of risk screening will be maintained and submitted to their LHJ at least quarterly.

Program Goal #5: Enhance the use of CD4 and viral load results in identifying those out of care and/or at increased risk of transmitting HIV, monitor community viral load (CVL) and use the data for targeting quality assurance activities as appropriate.

Objective 5-1: By September 1, 2012, OA will develop a plan to work with OA funded LHJs to better understand and consider the potential uses of CVL information that OA is able to provide to them.

Objective 5-2: By December 31, 2012, OA will begin formative work to develop a sentinel pilot program to monitor CD4 and viral load and to inform LHJs of HIV-positive persons who may need assistance returning to care.

Program Goal #6: OA and its contractors will support and promote the use of antiretroviral Therapy (ART) in accordance with current treatment guidelines.

Objective 6-1: Throughout the contract year, OA will continue its ongoing work to support and promote the appropriate use of ART, including ongoing collaboration with the CA PTC, PAETC, and CSTEP contractor.

Objective 6-2: Maintain and monitor client ART information in the ARIES data system.

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Objective 6-3: Maintain the ADAP program and provide the ongoing analysis of usage and cost benefits to our funders.

Objective 6-4: By December 31, 2012, OA will begin formative activity to utilize its various databases to develop a sentinel method to identify client viral loads and status of ART appropriateness, in order to share this information with health care providers and medical case managers who can discuss consideration of ART in accordance with current treatment guidelines as appropriate.

4. Condom Distribution

Program Goal #1: Recruit venues serving HIV-positive persons and/or persons at highest risk of acquiring HIV infection in funded LHJs to actively distribute condoms.

Objective 1-1: By March 31, 2012, OA will have analyzed its 2009-2011 condom orders and identified which of those venues serve OA's identified priority populations, based on information submitted by the venues on their targeted populations.

Objective 1-2: By October 1, 2012, OA will have collaborated with their funded LHJs to identify a minimum of 10 venues in each LHJ that serve HIV-positive persons and/or persons at highest risk of acquiring HIV infection.

Objective 1-3: By December 31, 2012, the LHJs will have recruited all of their venues to participate in the condom distribution, and will have given their respective OA operations advisor a contact list of those venues. The venues will be contacted and given directions on how they can order condoms.

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Program Goal #2: Set up an ordering system by which participating venues can order condoms directly from OA.

Objective 2-1: By January 31, 2012, OA will have an order form available on OA's website for participating venues to fill-in and submit their orders.

Program Goal #3: Adapting existing resources as feasible, develop condom marketing campaign materials.

Objective 3-1: By March 31, 2012, OA will have drafts of posters and palm cards ready for focus groups.

Objective 3-2: By June 30, 2012, OA will have had their materials approved by their Materials Review Panel, guided by the CDC Basic Principles set forth in 57 Federal Register 26742.

Objective 3-3: By July 31, 2012, OA will have posters and palm cards printed and ready to be sent out with condom orders.

Objective 3-4: Beginning August 1, 2012, each participating venue will be expected to display these posters and make the palm cards available with the condoms.

5. Policy Initiative: SAMHSA HIV Set-Aside Funds Initiative

Program Goal #1: Achieve a more coordinated state response to the HIV epidemic.

Objective 1-1: By December 31, 2011, OA will systematically identify ADP-funded agencies that are entering HIV testing data into LEO and correct the LEO setup information to differentiate the funding streams.

Objective 1-2: By December 31, 2012, OA will collaborate with local AOD Departments and LHJs to determine and report to OA which services are provided through HIV Set-

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Aside funds and which subcontractors provide these services, and evaluate the program plan to eliminate gaps and overlaps in services.

Objective 1-3: By December 31, 2012, OA will collaborate with ADP, LHJs, AOD Departments, CADPAAC and CCLAAD to develop a best practices document for county AOD departments to use in making local programming decisions for their HIV Set-Aside Fund allocations.

Objective 1-4: By December 31, 2012, OA will evaluate LEO data on HIV testing and other EIS in substance use treatment facilities to inform decisions designed to target funds to high-risk populations.

6. Policy Initiative: Public Health Use of HIV/AIDS Surveillance Data

Program Goal #1: Utilize surveillance data to identify out-of-care HIV-positive individuals.

Objective 1-1: By July 1, 2012, create and execute a plan to identify people in eHARS without a CD4 count or VL test in the prior 12 months.

Objective 1-2: By July 1, 2012, LHJs will use an existing ARIES report to identify potentially out-of-care patients.

Objective 1-3: By July 1, 2012, OA will work with CDPH legal office to determine if OA can use an ongoing match between ADAP and Medi-Cal data to identify out-of-care patients.

Objective 1-4: By December 31, 2012, OA and LHJs will collaborate to create and execute a plan to encourage identified out-of-care patients to re-enter HIV care, treatment and prevention.

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7. Policy Initiative: Healthcare Reform Planning

Program Goal #1: Provide TA to support a seamless transition for medical care, psychosocial support, HIV testing and HIV prevention service delivery systems, their related providers, and individuals living with and at risk for HIV prior to full implementation of the ACA in 2014.

Objective 1-1: By March 1, 2012, OA will dedicate 50% of an FTE from the HIV Prevention Branch to develop and participate in a newly formed “OA HCR Task Force” that will also include membership from OA’s Care, Treatment, Policy and Research areas.

Objective 1-2: By April 1, 2012, OA will develop a strategy to gather stakeholder input to address the impact of ACA on prevention activities.

Objective 1-3: By July 1, 2012, OA will create guidelines to support the Tier I requirement for funded LHJs to dedicate a specified proportion of an FTE to devote to HCR preparedness activities.

Objective 1-4: By October 1, 2012, OA will develop a communication strategy and materials for consumers and healthcare and support service providers as well as HIV testing and prevention providers.

8. Jurisdictional HIV Planning

Program Goal #1: Develop a jurisdictional HIV prevention plan that aligns with NHAS.

Objective 1-1: By January 2012, OA will produce a work plan designed to enhance the capacity of the AN to serve as a vehicle for receiving stakeholder recommendations and

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requests, for supporting stakeholder participation in group discussion of pertinent issues, and to serve as a tool for soliciting broad community input.

Objective 1-2: By January 2012, OA, in collaboration with CPG, OA will outline a plan for soliciting broad community input regarding California's Integrated HIV Prevention, Care and Surveillance Plan.

Objective 1-3: By March 2012, OA, in collaboration with CPG, will produce a draft version of California's Integrated HIV Prevention, Care and Surveillance Plan.

Objective 1-4: By April 2012, the draft version of California's jurisdictional HIV prevention plan will be disseminated for stakeholder and community input.

Objective 1-5: By June 2012, OA, in collaboration with CPG, OA finalize California's Integrated HIV Prevention, Care and surveillance Plan.

Objective 1-6: By June 2012, the CPG membership will submit a letter of concurrence, concurrence with reservations, or non-concurrence regarding California's Integrated HIV Prevention, Care and Surveillance Plan

9. Capacity Building and Technical Assistance

Program Goal #1: Identify and address the training and technical assistance needs of funded LHJs and CBOs.

Objective 1-1: By January 31, 2012, OA and its planning group, CPG, will analyze the results of the needs assessment conducted in May 2011 of all California LHJs to identify capacity building needs.

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Objective 1-2: By February 28, 2012, OA staff will follow up with LHJs to determine if additional capacity building needs have emerged as a result of the new direction in HIV prevention.

Objective 1-3: By December 31, 2012, OA will collaborate with state training partners to revise the HIV test counselor training curriculum as needed.

Objective 1-4: By December 31, 2012, OA will analyze the effectiveness of Advisory Network (AN) as a tool to communicate with LHJs regarding capacity building needs.

Program Goal #2: Identify and address the capacity building needs of OA staff in alignment with the new direction of HIV prevention.

Objective 2-1: By October 31, 2011, OA administration will conduct an assessment of the skills and expertise of OA staff members to realign with the new HIV prevention strategy.

Objective 2-2: By October 31, 2011, OA administration will conduct an assessment of the organization's structure to reevaluate the ability to address the activities of the new HIV prevention strategy.

Objective 2-3: By December 31, 2012, OA will collaborate with local training partners to provide education and training on topics related to the new approach to HIV prevention.

Objective 2-4: By December 31, 2012, OA administration will implement any needed changes resulting from analysis of OA's organizational structure.

Program Goal #3: Track training and technical assistance provided to LHJ and CBO staff.

Objective 3-1: By June 1, 2012, OA will notify all funded LHJ Prevention Coordinators that training and technical assistance activities of LHJ and funded CBO staff must be

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entered into the LEO system.

Objective 3-2: By December 31, 2012, all training and technical assistance activities of funded LHJs and CBOs will be entered into the LEO system.

Objective 3-3: By December 31, 2012, OA Intervention Specialists will keep record of all CBA requests entered into CRIS and periodically contact requesting LHJs and CBOs to determine progress and satisfaction.

Program Goal #4: Facilitate exchange of information and peer-to-peer consultation among service providers.

Objective 4-1: By December 31, 2012, OA will expand the use and scope of its AN to include staff from all funded LHJs and CBOs.

Objective 4-2: By December 31, 2012, OA, in collaboration with the CDPH/STD Control Branch, will implement a number of best practices webinars presented by LHJs staff funded for PS.

Objective 4-3: By December 31, 2012, OA will conduct quarterly teleconference calls with all funded LHJs to disseminate OA news, answer questions and identify best practices.

Objective 4-4: By December 31, 2012, OA will conduct monthly teleconference calls with all users of the LEO system in order to disseminate news about LEO, answers questions from LHJs and identify improvements to the system.

B. Recommended Program Components

1. HIV Prevention Interventions for HIV-Negative Persons: Behavioral Interventions

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Program Goal #1: Increase the number of LHJs targeting serodiscordant couples, MSM, Injection Drug Users, Transgender persons, and African American and Latina women with evidence-based interventions.

Objective 1-1: By September 30, 2012, each funded LHJ conducting an intervention for high-risk negatives will report the evidence-based intervention they have selected to implement and the plan to train staff who will conduct the intervention.

Objective 1-2: By October 15, 2012, each funded LHJ will submit a participant recruitment plan and an evaluation plan that includes at least one intervention outcome goal and their means for measuring the outcome.

Objective 1-3: By January 30, 2013, each funded LHJ will have commenced delivering the first series of the intervention.

2. HIV Prevention Interventions for HIV-Negative Persons: Syringe Services Programs

Program Goal #1: Maximize the number of IDUs receiving sterile injection materials from authorized syringe exchange programs.

Objective 1-1: By June 30, 2012, OA will have established protocols to add sterile injection equipment to the California AIDS Clearinghouse catalog of risk reduction materials and supplies and will accept orders from qualified SEPs.

Program Goal #2: Expand access to sterile syringes through pharmacies, syringe exchange programs and policy initiatives which permit legal access to sterile injection equipment at the local level.

Objective 1-1: By June 30, 2012, OA will have entered into agreements with the funded LHJs that have authorized syringe access which will include funding for SSPs and NPSS.

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Objective 1-2: By June 30, 2012, OA will have entered into agreements with the funded LHJs out of the Prevention-funded LHJs which do not have authorized syringe access to develop an analysis of barriers to expanding syringe access and a plan to address such barriers.

Objective 1-3: By March 31, 2012, OA will have developed a statewide plan which includes analysis of relevant California statutes and federal and state SSP policy and a plan to expand syringe access consistent with such policy.

Objective 1-4: By October 31, 2012, OA will provide technical assistance to a minimum of five LHJs working to increase local access to sterile injection equipment or enhance linkages to care for HIV-positive IDUs.

3. Social Marketing, Media, and Mobilization (Focus: Linkage/Retention/Adherence)

Program Goal #1: Improve linkage to and retention in care and medical adherence through implementation of social marketing and media campaigns targeted to specified relevant audiences.

Objective 1-1: By September 30, 2012, each funded LHJ conducting social marketing will submit a social marketing plan to the state OA, including defining the health issue they are addressing and rationale for its selection, a plan to incorporate other required messages including support and promotion of ART, PS and integration of other clinical concerns such as Hepatitis, TB, and STDs, the formative work planned to develop the messages and how community members will be involved in the development and implementation of the social marketing activities, and the explicit means to disseminate the health messages. The plan

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will also require assessment of the usefulness of existing materials from around the country to avoid unnecessary duplication of efforts.

Objective 1-2: By September 30, 2012 each funded LHJ conducting social marketing will submit an evaluation plan to measure the effectiveness of the social marketing or media campaign.

Objective 1-3: By January 1, 2013, LHJs conducting social marketing will have begun formative activity and report on this activity in their interim progress report.

4. Pre-Exposure Prophylaxis (PrEP)

Program Goal #1: To support the development of multi-disciplinary, integrated programs for high-risk MSM that provide PrEP.

Objective 1-1: By June 30 2012, each funded LHJ considering utilizing their funds for PrEP preparedness or implementation will notify OA.

Objective 1-2: By December 31, 2012, OA will assist funded LHJs in planning for implementation of appropriate PrEP activities.

Objective 1-3: By December 31, 2012, OA will expand PrEP planning activities to include serodiscordant heterosexual couples and IDUs as appropriate pending CDC guidance.