

**PS20-2010 Integrated HIV Programs to
Support Ending the HIV Epidemic (EtHE) in
America Scope of Work (SOW)**

1. Service Overview

The Grantee agrees to provide to the California Department of Public Health (CDPH) the services described herein.

The Department shall provide a grant to and for the benefit of the Grantee; funded by the Centers for Disease Control and Prevention (CDC), *PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States* (CFDA 93.940), initiative is intended to build on the on-going activities funded through *PS18-1802: Integrated HIV Surveillance and Prevention Programs for Health Departments* to strategically advance (i.e., initiate new or expand existing) HIV prevention efforts. The purpose of the Grant is to implement comprehensive HIV programs that complement programs, such as the Ryan White program and other Health and Human Services (HHS) programs, designed to support ending the HIV epidemic in America by leveraging powerful data, tools and resources to reduce new HIV infections. The Grantee will plan, develop, and implement programs tailored to ending the HIV epidemic (EtHE) in America as described in the Scope of Work (SOW).

The Legislature authorized in the Health & Safety Code (HSC) Section 131019 the CDPH, Office of AIDS (OA) as the lead agency within the State responsible for coordinating state programs, services and activities related to HIV and Acquired Immune Deficiency Syndrome (AIDS). HSC 131085 (a) and (b) authorize the CDPH to enter into contracts to perform public health activities.

2. Service Location

The services shall be performed at applicable locations within the Grantee's jurisdiction.

3. Service Hours

The services shall be provided during normal Grantee working hours, Monday through Friday, except official holidays if observed by the Grantee. Some activities are conducted in non-traditional hours such as evening and weekends.

4. Project Representatives

The project representative for the Ending the HIV Epidemic (EtHE) in America at CDPH OA is Angelique Skinner. A list of current EtHE Program Coordinators for each of the local health jurisdictions is maintained by CDPH OA EtHE staff. A list of current EtHE assignments can be requested at ETE@cdph.ca.gov.

5. Services to be Performed

See the attached Exhibit A, Attachment 2 as follows for a detailed description of the services to be performed.

Exhibit A, Attachment 2

ALAMEDA COUNTY SCOPE OF WORK FOR CDC RFA PS20-2010 Start Date: 8/1/2020; End Date: 7/31/2025		
Major Functions, Tasks, and Activities	Timeline	Performance Measure and/or Deliverable
<p>Routine Opt-out Testing (ROOT) in Healthcare Settings/Correctional Facilities</p> <ul style="list-style-type: none"> • Implement or expand ROOT in healthcare settings and/or correctional settings to identify people with HIV who would not be diagnosed otherwise • Issue an RFP to determine how ROOT will be expanded in Alameda County (e.g., medical detailing, capacity building for healthcare providers, navigators to link and re-engage PLWH in HIV care) 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Increased local availability of and accessibility to HIV testing services; increased HIV screening and annual rescreening among persons at elevated risk for HIV</p> <p>This activity contributes to Strategies 1A and 1C</p> <p>Year One SMART Objective:</p> <ul style="list-style-type: none"> • By March 31, 2021, one healthcare facility and one correctional facility will have begun establishment of ROOT
<p>Truth and Justice Healing Reconciliation (TJHR) Initiative</p> <ul style="list-style-type: none"> • Explore the feasibility a TJHR Initiative to address deep-seated past harms, especially related to how racism and other kinds of trauma have affected if and how people access health care services • Issue a one-year exploratory grant to an entity in AC to explore the feasibility of implementing this initiative 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Address deep-seated past harms, especially related to how racism and other kinds of trauma have fueled mistrust of public health interventions. Increase trust/satisfaction scores of people attending planning meetings</p> <p>This activity contributes to Strategies 1A, 1B, 1C, 2A, 2B, 3A 3B, 4A, 4B and 4C</p> <p>Year One SMART Objective:</p> <ul style="list-style-type: none"> • By 7/31/2021, a report on the feasibility of implementing a TJHR initiative will be completed and submitted to Alameda County

<p>Data to Care/Data to PrEP</p> <ul style="list-style-type: none"> • Use HIV surveillance data to identify newly diagnosed persons for linkage and partner services • Use HIV surveillance data to identify people living with HIV who are not in care and re-engage them in care • Use HIV and STD surveillance data to identify people diagnosed with an STD for HIV testing, PrEP, or PEP as indicated 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Link newly diagnosed individuals and people living with HIV (PLWH) who are out of care to HIV medical care expediently</p> <p>This activity contributes to Strategies 2B, 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By January 31, 2021, systems to use surveillance data to identify newly diagnosed persons for linkage to care and partner services, to identify people living with HIV who are not in care for re-engagement in care, and to identify people diagnosed with STDs for referral to HIV testing, PrEP, or PEP as indicated will be established • Between February 1, 2021 and July 31, 2021, 80% of newly diagnosed individuals, 75% of (PLWH) out of care, and 50% of people identified with STDs will be referred for linkage, reengagement, HIV testing, PrEP or PEP as appropriate
<p>Same-Day PrEP</p> <ul style="list-style-type: none"> • Provide same-day PrEP to B/AA and Latino MSM, MSM of color (24 and younger), transgender people, sexual and substance using partners of PLWH, and women at high-risk • Issue an RFP to expand same-day PrEP in Alameda County. Subcontracting agencies may provide capacity building for healthcare providers to implement same-day PrEP; navigators to link people with a recent HIV test and those diagnosed with an STD to a PrEP prescriber 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Increased screening for PrEP indications among HIV-negative clients; Increased referral and rapid linkage of persons with indications for PrEP</p> <p>This activity contributes to Strategy 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By July 31, 2021, At least 100 new B/AA and Latino MSM, 34 MSM of color ≤ 24 years of age, and 27 women will be enrolled in PrEP • By July 31, 2021, at least two subcontractors will be funded and will have provided capacity building assistance to at least two healthcare providers to implement same-day PrEP, and to navigate at least 80 people with recent HIV test or STD diagnosis to a PrEP prescriber

Training for PrEP and Harm Reduction Services

- Issue an RFP or determine an alternative means of procuring services to provide trainings
- Provide training for staff who conduct HIV/STD/HCV testing services in Alameda County on identifying gaps in PrEP uptake among priority populations in the County and how to identify providers and link clients to PrEP services
- Provide training for harm reduction principles, Narcan and overdose prevention, HIV testing and PrEP
- Training attendees would include staff from CBOs, HIV and STD testing providers, harm reduction service providers

Year One (8/1/2020 – 7/31/2021)

Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Increased knowledge of PrEP and PrEP prescribers; Increased awareness of harm reduction principles, overdose prevention, Narcan access and PrEP services for people who use drugs

This activity contributes to Strategy 3A

Year One SMART Objectives:

- By January 31, 2021, a contractor will be hired to conduct trainings in increasing PrEP uptake among priority populations, linking clients to PrEP Providers, harm reduction principals, Narcan and overdose prevention, HIV testing and PrEP
- By July 31, 2021, the contractor will provide at least six trainings to at least 30 HIV/STD/HCV testing staff, and staff of CBOs and harm reduction service providers

ORANGE COUNTY SCOPE OF WORK FOR CDC RFA PS20-2010 Start Date: 8/1/2020; End Date: 7/31/2025

Major Functions, Tasks, and Activities	Timeline	Performance Measure and/or Deliverable
<p>Mail to Home Test Kit Pilot Program</p> <ul style="list-style-type: none"> • Develop pilot program protocol • Offer Orange County HIV/STD clinic patients to receive HIV and/or STD test kits mailed to their home or preferred location 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Provide an alternative to needing to go to a clinic in person during the COVID pandemic; Increase testing options for individuals by adding an option that increases testing privacy</p> <p>This activity contributes to Strategies 1B and 1C</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By January 31, 2021, a pilot program protocol for distribution of HIV and/or STD home test kits will be developed • Between February 1, 2021 and July 31, 2021, at least 25 home test kits will be distributed, with data tracking and survey of client satisfaction being completed by at least 15 test kit recipients
<p>Mobile Testing, Care, and Referral Services</p> <ul style="list-style-type: none"> • Develop mobile unit program design and protocols • Collaborate with community provider(s) to reach marginalized and hard-to-reach individuals via mobile unit • Monitor and map new HIV cases for strategic deployment of mobile unit services • Provide testing, treatment, and referrals to marginalized and not-effectively served individuals 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Bring HIV testing, linkage services to HIV Care and PrEP, and referrals for other identified needs to marginalize and individuals yet to be successfully served</p> <p>This activity contributes to Strategies 1B, 2A and 4B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By January 31, 2021, a mobile unit program design and protocols will be developed and approved by appropriate supervisors • Between February 1, 2021 and July 31, 2021, the mobile unit will be deployed a minimum of 18 times, and at least 36 marginalized and not-effectively served individuals will have received testing, treatment, and/or referrals

<p>Health Summits for Gay Men and Transgender Persons</p> <ul style="list-style-type: none"> • Plan and implement the Health Summit for Gay Men • The summit will include a community and health care provider track • Provide HIV/Testing (25 Participants), STD testing (25 Participants) and PrEP services, (enroll at least 10 participants) to summit participants and community members • Provide CEUs to providers 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: To increase awareness of health issues faced by gay men and provide tools and community resources to be and stay healthy (e.g., U=U, self-care, success in the face of stigma, PrEP, STDs and addressing depression and addiction)</p> <p>This activity contributes to Strategies 1B, 1C, 3A and 3C</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By March 31, 2021, a Gay Men and Transgender persons health summit will be planned, and speakers and workshop facilitators scheduled to participate in the health summit • By June 30, 2021, the health summit will be conducted, with HIV testing provided to at least 25 participants, STD screening will be provided to at least 25 participants, and 10 participants will be enrolled in PrEP • By July 31, 2021, an evaluation of the health summit will be completed, and a copy provided to OA
<p>Health Education Videos</p> <ul style="list-style-type: none"> • Develop content for health education videos in multiple languages for newly identified HIV-positive people, youth, and/or immigrants to help address barriers for linkage to and retention in care • The project will be community driven, feature members of the community, and address the unique needs of the Orange County HIV epidemic • Develop a communications/dissemination plan 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Create and disseminate one video</p> <p>This activity contributes to Strategies 2A and 2B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By July 31, 2021, at least one health education video will have been produced by community members and featuring community members highlighting specific needs and services in Orange County • By June 30, 2021, a communications/dissemination plan for distribution of the video will be completed and ready to implement

Trauma-Informed Prevention and Care Services for Black/African American (AA) and Transgender Populations

- Engage: 1) Black/AA community, faith-based, and civic organizations and 2) transgender individuals, and community groups to identify barriers to HIV care and prevention services and inform service delivery
- Leverage long-standing partnerships with HIV prevention and care service providers within the County and in the community to enhance the current system of care and address barriers identified by the community utilizing a trauma-informed approach
- Conduct at least six community engagement activities (focus groups, key stakeholder interviews, or community listening sessions) and at least two staff/provider trainings on the delivery of culturally competent and trauma-informed care for AA and transgender populations

Year One (8/1/2020 – 7/31/2021)
Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Increase the percentage of AAs and transgender persons that are linked to care in the community in ten days; Increase retention in care for AAs and transgender persons in the community

This activity contributes to Strategies 2A and 2B

Year One SMART Objective:

- By July 31, 2021, at least six community engagement activities will have been conducted with Black/AA community, faith-based and civic organizations, and transgender individuals, with a written summary from each activity completed within 30 days of each activity

<p>Viral Suppression Patient Incentive Program</p> <ul style="list-style-type: none"> • Conduct 4 focus groups with HIV positive individuals not virally suppressed to identify barriers to care and inform service delivery • Develop program protocol to incentivize PLWH to engage in HIV care, reach and maintain viral suppression, and use case management support services • Develop client and provider recruitment strategy • Develop incentive program promotional/ recruitment messaging and materials • Identify and outreach to community providers • Conduct outreach to PLWH who meet program criteria • Conduct staff training for program implementation 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Identify barriers to care and contributors to not being virally suppressed, creating an incentive program to assist those who are not virally suppressed achieve viral suppression</p> <p>This activity contributes to Strategy 2B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By January 31, 2021, a set of four focus groups with PLWH who are not virally suppressed will be conducted and a summary report will be completed • By April 30, 2021, an incentive program to assist in achieving viral suppression will be developed, and staff trained on program implementation • Between May 1, 2021 and July 31, 2021, outreach to PLWH who meet program criteria will be conducted. Participants will be provided services through the incentive program
<p>Community Based Case Management Services</p> <ul style="list-style-type: none"> • Recruit and hire a Case Manager co-located and/or floating at community –based provider sites (outside of the Ryan White system of care) with a high volume of patients not virally suppressed • Identify at least three providers with a high volume of patients with unsuppressed viral load to partner with and develop MOUs 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Hire an HIV Case Manager who will provide services for clients receiving HIV medical care at non-Ryan White healthcare settings</p> <p>This activity contributes to Strategy 2B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By February 15, 2021, an HIV case manager will be hired to provide services for clients at non-Ryan White healthcare settings • Between date of hire and April 30, 2021, the Case Manger will assist in the development of the incentive program • Between May 1, 2021 and July 31, 2021, the Case Manager will enroll at least 12 non-virally suppressed PLWH and provide case management services and incentive program activities to each

Mental Health Services for HIV-positive and PrEP-Eligible Persons

- Design program protocols and hire staff
- Provide psychiatry and mental health services to individuals HIV+ and individuals PrEP eligible (100 persons)

Year One (8/1/2020 – 7/31/2021)

Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Improve viral load suppression rates and PrEP uptake and adherence

This activity contributes to Strategies 2B and 3A

Year One SMART Objectives:

- By November 31, 2020, protocols for a mental health service will be developed
- By December 31, 2020, staff to implement the mental health service will be hired
- Between January 1, 2021 and July 31, 2021, at least 100 PLWH and PrEP Eligible individuals will be provided mental health services

RIVERSIDE COUNTY SCOPE OF WORK FOR CDC RFA PS20-2010 Start Date: 8/1/2020; End Date: 7/31/2025

Major Functions, Tasks, and Activities	Timeline	Performance Measure and/or Deliverable
<p>Sexual Health Provider Education and Incentive Program</p> <ul style="list-style-type: none"> • Develop a provider detailing plan to encourage providers to obtain a comprehensive sexual health history and encourage routine HIV testing and PrEP referrals • Hire and train PrEP navigator(s) to develop a toolkit for the detailing program with resources for obtaining sexual health history and PrEP education • Recruit and hire new CDS by November 2020 • Train all Communicable Disease Specialists (CDS) staff (STD, prevention, surveillance, and LTC) to become PrEP navigators, so that however, and wherever, we might encounter HIV-negative persons, they can quickly be evaluated for, and started on PrEP • Develop protocol for tracking # of patients started on PrEP • Collaborate with Inland Empire Health Plan (IEHP) to develop an incentive program for providers to embrace PrEP and offer PrEP to high-risk individuals • Develop a MOU IEHP to offer a CME incentive program to IEHP providers who attend a PrEP education webinar • Develop incentive program for providers to embrace PrEP 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Develop and implement a provider training and detailing program for Inland Empire Health Plan (IEHP) providers</p> <p>This activity contributes to Strategies 1A and 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By November 31, 2020, PrEP Navigator(s) will be hired to develop a toolkit, and detailing plan for IEHP providers • By February 28, 2021, a provider detailing plan and tool kit, and a CME eligible PrEP Educational Webinar curriculum will be developed and approved by appropriate county staff • Between March 1, 2021 and July 31, 2021, PrEP Navigators will provide PrEP clinic detailing to at least three IEHP clinics

<p>PrEP-AP</p> <ul style="list-style-type: none"> • Apply to become a PrEP Assistance Program (AP) enrollment site through the Office of AIDS and become certified • Hire enrollment worker • Enroll clients in PrEP-AP 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Assist clients to enroll in the PrEP-AP program by becoming a PrEP-AP enrollment site</p> <p>This activity contributes to Strategy 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By October 31, 2020, the clinic will have successfully become a PrEP-AP enrollment site • By November 30, 2010, at least one enrollment worker will be hired and trained to enroll clients in PrEP-AP • Between December 1, 2020 and July 31, 2021, the enrollment worker will assist at least 40 clients enroll in PrEP-AP
<p>Testing Initiative for Young MSM of Color</p> <ul style="list-style-type: none"> • Use epi/surveillance data to determine high morbidity areas • Identify CBOs who serve targeted populations within those areas • Develop MOUs with identified CBOs to offer/ provide HIV testing and train them on HIV testing, linkage to care, and linkage to PrEP protocols • Identify other locations based on epi data where a mobile unit could be deployed • Develop outreach materials • Develop a campaign to promote free to user at home testing, partnering with Building Healthy Online Communities (BHOC) to increase access to Home Testing kits through gay dating apps/websites and digital/media campaigns 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: To increase the number of young MSM of color who test for HIV</p> <p>This activity contributes to Strategies 1B and 1C</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By January 31, 2021, MOUs with at least three CBOs providing services to young MSM of color will be initiated • By March 31, 2021, outreach material and a campaign promoting home HIV test kits will be created and approved by appropriate county staff • Between April 1, 2021 and July 31, 2021, at least 75 young MSM of color will have testing for HIV at either the participating CBOs, through the mobile clinic, or through the BHOC program

RAPID Starter Pack and Retention Program

- Train additional Early Intervention Program clinic staff (medical staff, Case Manager, Social Workers, Communicable Disease Specialists, Health Education Assistants and Office Assistants) in linkage to care procedures and best practices to start and keep HIV clients in care
- Increase available walk in appointment slots for new HIV diagnosis
- Stock HIV medication starter packs
- Start ART on first visit to HIV Clinic for newly diagnosed clients and provide a 30-60 day starter pack of medication
- Provide door to door transportation accompanied by social worker for clients who have fallen out of care or are not virally suppressed

Year One (8/1/2020 – 7/31/2021)

Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Increase Rapid ART for newly diagnosed and for PLWH who have been out of care

This activity contributes to Strategies 2A and 2B

Year One SMART Objectives:

- By December 31, 2020, Early Intervention Program clinic staff will have received training on rapid linkage to care procedures and best practices to start and keep PLWH in HIV medical care
- By December 31, 2020, HIV Medical Starter packs will be available in the HIV clinic
- Starting January 1, 2021, additional walk-in appointment slots will be available at the HIV clinic for newly diagnosed or PLWH returning to care
- Between January 1, 2021 and July 31, 2021, at least 30 newly diagnosed or returning to care individuals will receive RAPID linkage to HIV medical care and ART. Door to door transportation will be provided to eligible clients

Network Investigation and Intervention

- Recruit and hire Office Assistant to support logistics and data entry/management
- Develop protocol for HIV investigation and follow-up
- Assess incoming labs/reports to determine new diagnoses and refer to case manager for PS/network identification
- Contact providers to identify patients with new HIV diagnoses and refer them to a case manager, who will interview patient to identify contacts for partners services, and to identify any networks of transmission
- Interview 80% of all newly diagnosed patients within 30 days from receipt of labs and/or case reports

Year One (8/1/2020 – 7/31/2021)
Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Increase efficiency and speed of reviewing surveillance data and utilize data for rapid response to providing case management and partner services to newly diagnosed PLWH

This activity contributes to Strategy 4B

Year One SMART Objectives:

- By November 31, 2020, hire an office assistant to support logistics and data entry/management
- By December 31, 2020, have a protocol for HIV investigation and follow-up developed and approved by appropriate county staff
- Between January 1, 2021 and July 31, 2021 refer at least 80 percent of newly diagnosed individuals to Case Management and Partner Services within 30 days of receipt of laboratory information

SACRAMENTO COUNTY SCOPE OF WORK FOR CDC RFA PS20-2010 Start Date: 8/1/2020; End Date: 7/31/2025

Major Functions, Tasks, and Activities	Timeline	Performance Measure and/or Deliverable
<p>Planning & Start-up of the Wellness Without Walls Mobile Clinic (W³)</p> <ul style="list-style-type: none"> • Conduct three community engagement meetings, with an emphasis on including stakeholders who are members of unhoused populations, TAY, and/or the agencies that serve this population • Collaborate with partners to develop protocol for mobile services (services provided, locations served, staffing roles) • Identify an appropriate vehicle that could provide capacity for a mobile services unit • Hire/allocate staff to the mobile services unit • Set up mobile unit with needed materials and supplies • Train all personnel who will staff the mobile services unit • Conduct outreach to promote the mobile services unit and support education/awareness among unhoused and TAY populations • Pilot the mobile services unit 1-2x a week, for 8 weeks; document challenges and successes; collect data on services provided • Refine protocol for mobile services outreach based on data and lessons learned from pilot period 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: To provide HIV testing, ART, PrEP and other medical services to people who are unhoused via a mobile clinic</p> <p>This activity contributes to Strategy 1B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By December 31, 2020, have completed and summarized three community engagement meetings soliciting input on what services a mobile clinic should provide, locations where the mobile clinic should be stationed, and other input relative to creating a Wellness Without Walls intervention • By February 28, 2021, acquire and outfit a vehicle for use as the mobile clinic • By February 28, 2021, have protocols for mobile services developed in collaboration with community partners and approved by appropriate county staff • By January 31, 2021, hire or allocate staff to the mobile services unit • By February 28, 2021, complete training of all staff assigned to the mobile services unit • Beginning February 15, 2021, start conducting outreach promoting the mobile services unit • Between March 1, 2021 and April 30, 2021, pilot the mobile services unit, documenting challenges and successes, collecting data on services provided • From May 1, 2021 through July 31, 2021, refine protocols and service delivery based on data and lessons learned from the pilot period and additional information gained throughout the provision of services

Integration of the Wellness Without Walls Mobile Clinic (W³) with care services

- Using HRSA Ending the HIV Epidemic Funding, extend the Sacramento County Sexual Health Clinic services to include HIV treatment/care in addition to HIV testing (offered currently)
- Establish protocol for administering Same-Day ART at Sacramento County Sexual Health Clinic
- Staff W³ Clinic with a 1.0 FTE Communicable Disease Investigator (CDI) who will serve as a Linkage to Care Coordinator
- Provide transportation to Sacramento County Sexual Health Clinic for individuals who receive a Preliminary Positive HIV test result through the W³ clinic
- CDI will perform Partner Services activities with newly diagnosed individuals

Year One (8/1/2020 – 7/31/2021)
Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Provide HIV treatment and care within the Sacramento County Sexual Health Clinic, including same-day ART initiation and partner services for newly diagnosed individuals

This activity contributes to Strategy 2A

Year One SMART Objectives:

- By February 1, 2021, the Sacramento County Sexual Health Clinic will begin providing HIV treatment and care. Same-Day ART will be administered using the protocol developed in the first 6 months of Year 1
- Starting March 1, 2021, a 1.0 FTE Communicable Disease Investigator will work within the mobile clinic, providing people with preliminary positive HIV test results transportation to the Sexual Health Clinic, and providing Partner Services to newly diagnosed individuals

Planning & Start-up of the Wellness Without Walls Mobile Clinic (W³)

- Train CDI to screen W³ clients for PrEP eligibility
- Establish protocol for linking W³ clients with the Sacramento County PrEP Navigator (housed at the Sacramento County Sexual Health Clinic)
- Provide transportation to Sacramento County Sexual Health Clinic for individuals interested in PrEP who receive a negative HIV test result through the W³ clinic
- Enroll eligible participants in the California PrEP-Assistance Program (PrEP-AP)
- Initiate Same-Day PrEP with eligible clients
- Sacramento County PrEP Navigator will schedule follow-up appointments for PrEP Patients and assist with medication adherence

Year One (8/1/2020 – 7/31/2021)
Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: Screen W³ clients for PrEP Eligibility and initiate same-day PrEP for clients who choose to use PrEP

This activity contributes to Strategy 3A

Year One SMART Objectives:

- By February 28, 2021, the CDI will be trained to screen clients for PrEP eligibility
- Starting March 1, 2021, the CDI will screen W³ clients for PrEP eligibility and arrange for same-day PrEP initiation for those choosing to use PrEP

SAN BERNARDINO COUNTY SCOPE OF WORK FOR CDC RFA PS20-2010 Start Date: 8/1/2020; End Date: 7/31/2025

Major Functions, Tasks, and Activities	Timeline	Performance Measure and/or Deliverable
<p>Rapid Response Team (RRT)</p> <ul style="list-style-type: none"> • Develop and implement protocols in collaboration with HIV Surveillance Team to assign newly diagnosed HIV cases • Develop Request for Proposal (RFPs) for Peer Educators and Mental Health/Case Management teams to work directly as part of RRT • Train Peer Educators in RRT operating procedures and HIV basic counseling skills • Hire additional RRT staff as needed (e.g., PrEP Navigator, nursing personnel) • Train staff on DIS and HIV/PrEP Navigation best practices • RRT will identify partners of newly diagnosed individuals and offer testing, partner services and linkage to care; identify syphilis cases and/or rectal gonorrhea cases, with emphasis on MSM, and follow up with PrEP education and navigation services; and follow up with newly diagnosed individual after first medical appointment for treatment adherence and retention support • RRT staff will staff the mobile clinic • HIV Prevention Team will support re-engagement and retention in HIV medical care for positives in danger of falling out of care and those who have fallen out of care 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Create a team who can meet with newly diagnosed individuals, conduct partner services and offer PrEP to eligible clients</p> <p>This activity contributes to Strategies 1B, 2A, 2B and 3A</p> <p>Year One SMART Objective:</p> <ul style="list-style-type: none"> • By February 28, 2021, the rapid response team will be formed and trained to meet with newly diagnosed individuals, conduct partner services and offer PrEP to eligible clients

<p>Mobile Clinic</p> <ul style="list-style-type: none"> • Acquire mobile medical vehicle • Operate weekly in each health planning region of the County and offer rapid HIV, HCV, and STD (syphilis/GC/CT) testing; hepatitis A vaccination; dispense medication (STD treatment and/or PrEP/PEP) per physician order; offer Rapid ART for confirmed newly diagnosed individuals; offer PrEP to clients who tested with preliminary negative results and were assessed to be high-risk 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Operate a mobile clinic offering sexual health services in designated locations currently not well served</p> <p>This activity contributes to Strategies 1A,1B,1C, 2A, 2B and 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By February 28, 2021, a vehicle for mobile testing will have been acquired and outfitted with necessary supplies • Between March 1, 2021 and July 31, 2021, the mobile clinic will operate in designated locations offering rapid HIV, HCV, and STD (syphilis/GC/CT) testing; hepatitis A vaccination; dispense medication (STD treatment and/or PrEP/PEP) per physician order; offer Rapid ART for confirmed newly diagnosed individuals; offer PrEP to clients who tested with preliminary negative results and were assessed to be high-risk
<p>Expand HIV Prevention Services to People Who Inject Drugs (PWID)</p> <ul style="list-style-type: none"> • Develop partnerships with Inland Empire Harm Reduction and similar community-based groups working with people who inject drugs • Develop a plan and timeline to increase awareness of services targeting injecting drug users • Work with existing Department hepatitis A outbreak response teams to provide homeless with information on HIV harm reduction, naloxone, and other services 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: To increase awareness and use of community-based groups providing services to people who inject drugs</p> <p>This activity contributes to Strategy 3B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By December 31, 2020, have MOUs with at least two community-based groups serving people who inject drugs • By March 31, 2021, have a plan and timeline to increase awareness of services for people who inject drugs completed and approved by appropriate county staff • By January 1, 2021, begin working collaboratively with the Hepatitis A Outbreak Response Team to provide homeless individuals with information on HIV harm reduction, naloxone, and other services

SAN DIEGO COUNTY SCOPE OF WORK FOR CDC RFA PS20-2010 Start Date: 8/1/2020; End Date: 7/31/2025

Major Functions, Tasks, and Activities	Timeline	Performance Measure and/or Deliverable
<p>Routine HIV Testing Implementation Grants</p> <ul style="list-style-type: none"> • Provide competitive start-up grants for local community health centers and other non-profit health care providers to implement routine HIV testing in primary care, urgent care and emergency departments • The funding will pay for any needed revisions to electronic health record systems, training for all staff, educational materials for clients, funding for unfunded (uninsured) tests, and funding for linkage to care for clients who are diagnosed with HIV • The funding will last for a period of 12 months • As a condition of award, clinics will be required to continue routine, opt-out HIV testing for a period of four years following the end of the grant 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Increase the number of health care facilities/systems providing ROOT</p> <p>This activity contributes to Strategy 1A</p> <p>Year One SMART Objective:</p> <ul style="list-style-type: none"> • By July 31, 2021, at least two start-up grants will have been issued to healthcare facilities to establish ROOT protocols, systems, and training for staff
<p>Benefits Navigation</p> <ul style="list-style-type: none"> • Hire benefits counselors • Train benefits counselors • Help clients enroll in necessary benefits programs, including Medi-Cal, Covered California, ADAP, PrEP-AP, CalFresh, pharmaceutical patient assistance programs, etc., to increase availability of testing services, ability to rapidly link clients to PrEP or ART, and ability to rapidly re-engage persons disengaged from care 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Provide benefits enrollment assistance to persons living with or vulnerable to HIV</p> <p>This activity contributes to Strategies 1A, 2A, 2B and 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By January 31, 2021, at least two benefits counselors will be hired and trained • Between February 1, 2021 and July 31, 2021, at least 75 people living with or vulnerable to HIV will have been assisted in enrolling in benefit programs, referred for HIV testing services and to PrEP or ART as appropriate

<p>Enhanced Support for HIV Planning Group/Ending the HIV Epidemic Advisory Committee</p> <ul style="list-style-type: none"> • Provide additional staff support to the HIV Planning Group to augment the group’s ability to effectively plan for and evaluate HIV testing efforts in alignment with the County of San Diego’s Getting to Zero initiative and the federal Ending the HIV Epidemic initiative. Negative results and were assessed to be high-risk 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Increase support to the HIV Planning Group in order to more effectively evaluate HIV testing efforts per the San Diego Getting to Zero initiative and the federal Ending the HIV Epidemic initiative</p> <p>This activity contributes to Strategies 1A, 1C, 2A, 2B, 3A, 3B, 4A and 4C</p> <p>Year One SMART Objective:</p> <ul style="list-style-type: none"> • By December 31, 2020, an additional staff person will be hired to work with the HIV Planning group, starting work with the planning group in January 2021
<p>Evaluation</p> <ul style="list-style-type: none"> • Hire a program evaluator • Design evaluation • Begin collecting data 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Hire an evaluator to design and begin evaluating Ending the HIV Epidemic activities</p> <p>This activity contributes to Strategies 1A, 3A and 4A</p> <p>Year One SMART Objective:</p> <ul style="list-style-type: none"> • By January 31, 2021, an evaluator will be hired and begin evaluation activities focused on Ending the HIV Epidemic Activities
<p>Wrap-Around Services for People Who Inject Drugs</p> <ul style="list-style-type: none"> • Develop a plan to provide comprehensive testing (HIV, HCV, STDs), status-neutral health care navigation (for PrEP or ART), and linkage to substance use disorder treatment and mental health resources for people who inject drugs • Pilot test and evaluate intervention components • Scale up successful efforts 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Develop a program of wrap-around services for people who inject drugs</p> <p>This activity contributes to Strategies 1B, 2A, 3A and 3B</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> • By February 28, 2021, have a program of wrap-around services for people who inject drugs designed and approved by appropriate county staff • Between March 1, 2021 and July 31, 2021, provide wrap around services to at least 50 people who inject drugs, documenting and evaluating services routinely

<p>Peer-based Mobile PrEP</p> <ul style="list-style-type: none"> Recruit and hire Black and Latinx MSM and Transgender persons who are currently utilizing PrEP to become PrEP champions to support outreach and education efforts connected with mobile PrEP clinics Provide PrEP-related medical evaluation, including comprehensive testing (HIV, HCV, STDs and safety labs), ongoing PrEP medical care, linkage to Benefits Navigation, and prescriptions for PrEP via mobile clinics 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: Increase comprehensive testing (HIV, HCV, STDs) and PrEP enrollment among Black and Latinx MSM and Transgender persons</p> <p>This activity contributes to Strategies 1B and 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> By November 30, 2020, at least three black and Latinx MSM and transgender persons will be hired as PrEP Champions Between December 1, 2020 and July 31, 2021, a mobile clinic will provide PrEP-related medical evaluations and rapid PrEP starter kits to at least 130 PrEP eligible Black and Latinx MSM and transgender persons
<p>Getting to Zero App and Resource Guide</p> <ul style="list-style-type: none"> Develop a mobile application to increase knowledge among persons living with or vulnerable to HIV in SDC of availability and accessibility of HIV testing services, ART and PrEP resources, and support services Pilot test the app Publicize the app Create and distribute printed versions of the resource guide, as well, to ensure accessibility by a large proportion of residents 	<p>Year One (8/1/2020 – 7/31/2021) Years 2 – 5 (8/1/2021 – 7/31/2025)</p>	<p>Goals: To develop and implement a mobile application to increase knowledge of HIV resources and services</p> <p>This activity contributes to Strategies 1B, 2A and 3A</p> <p>Year One SMART Objectives:</p> <ul style="list-style-type: none"> By January 31, 2021, have a beta version of a Getting to Zero app ready for testing By January 31, 2021, have a resource guide printed Between January 31, 2021 and July 31, 2021, pilot test the app and make adjustments as appropriate. Distribute resource guide throughout the community

Surveillance Program Improvements

- Increase the ability of the County of San Diego’s HIV Epidemiology Surveillance Program (HESP) to detect potential clusters
- Specifically, this funding will ensure timely entry and assignment of all new HIV case reports as well as entry of lab reports not received via electronic lab reporting
- Improve data reporting and QA activities to create a “real-time” surveillance system capable of providing updates regarding HIV transmission
- Develop a system to integrate STD surveillance data with HIV surveillance data to improve the ability to identify and deploy resources to emerging hot spots in the County
- Work with the Tijuana Health Jurisdiction to develop an EHE situational analysis
- Develop protocols for maintaining services for individuals receiving care on both sides of the border
- Explore possibilities for implementing Black Box technology to de-duplicate HIV/AIDS cases between Tijuana and San Diego

Year One (8/1/2020 – 7/31/2021)

Years 2 – 5 (8/1/2021 – 7/31/2025)

Goals: To enhance surveillance capacity and initiate Interventional Surveillance activities

This activity contributes to Strategy 4A

Year One SMART Objectives:

- By November 30, 2020, additional resources will be provided to the HIV Epidemiology Surveillance Program (HESP) to enter new HIV case reports and lab results more timely
- Beginning January 1, 2021, the HESP will begin data analysis to detect potential clusters of new infections
- By January 31, 2021, have STD surveillance data integrated with HIV surveillance data
- By July 31, 2021, an EHE situational analysis draft and a draft of protocols supporting continuity of care for individuals receiving services on both sides of the board will be completed by San Diego and Tijuana Health Jurisdictions