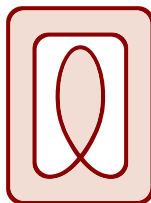

LAYING A FOUNDATION FOR GETTING TO ZERO:



California's Integrated HIV Surveillance, Prevention, and Care Plan

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Center for Infectious Diseases
Office of AIDS

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SEPTEMBER
2016



California's Integrated HIV Surveillance, Prevention, and Care Plan

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In partnership with the
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Center for Infectious Diseases
California Department of Public Health

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In collaboration with the
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DEDICATION

We dedicate this document to the approximately 140,000 Californians living with HIV and the over 100,000 Californians with HIV who have died since the beginning of the epidemic.

We offer this Integrated Plan in memory of Channing-Celeste Wayne, a tireless activist and member of the California Planning Group and the San Francisco HIV Health Services Planning Council, who passed away in 2016 after more than 27 years living with HIV. Her dedication to advocacy for improving the health outcomes of people living with HIV, especially transgender women of color, has improved the lives of countless Californians.



FOREWORD

In 2013, the State of California released its first Integrated HIV Surveillance, Prevention, and Care Plan, only three years after the first National HIV/AIDS Strategy (NHAS) was put forth by the White House Office of National AIDS Policy. One year ago, NHAS was updated to reflect goals and strategies through 2020. Today, we update California's Integrated Plan to articulate our vision for "Getting to Zero" in California – through improving HIV surveillance strategies, preventing new HIV infections, and caring well for those living with HIV.

It is our vision that **"Getting to Zero"** is within reach in California. This means getting to a time when there are:

Zero New HIV infections;
Zero AIDS-related Deaths; and
Zero Stigma and Discrimination
Against People Living
with HIV (PLWH)

We can achieve this vision using existing resources only through collaboration with many partners throughout California and a determined effort to implement evidence-based strategies to prevent HIV and care for PLWH. To that end, we have developed this Integrated Plan through a joint effort between the California Department of Public Health (CDPH), Office of AIDS (OA), local health jurisdictions, and HIV planning bodies in California. The Integrated Plan was also developed in collaboration with other state programs that serve PLWH, including Medi-Cal, Covered California, and the California Department of Corrections and Rehabilitation (CDCR), as well as key stakeholders in the private sector. The process engaged people at higher risk for HIV infection, PLWH, service delivery providers, and

other community stakeholders throughout the state, through a number of mechanisms to gather feedback.

California's Integrated Plan uses the NHAS as its organizing framework, and includes goals, objectives, strategies, activities, and existing resources designed to achieve a more coordinated and effective response to the HIV epidemic in California. While this plan fulfills the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) requirements for an Integrated Plan for the State of California and the three Ryan White HIV/AIDS Program Part A co-authors (the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas [TGAs]), it serves as a vision for the entire state, to be used in coordination with the more detailed local plans being developed by the other five Ryan White HIV/AIDS Program Part A jurisdictions in California.

The Integrated Plan responds to California's HIV epidemic, in which gay, bisexual, and other men who have sex with men (MSM) represent the majority of those living with HIV and those newly infected with the virus. Persons who inject drugs, transgender women, and other high-risk heterosexuals, including sex workers and persons with HIV-positive sex partners, represent smaller but significant HIV-infected populations. Our collective efforts in response to the epidemic have led us to more effective approaches for engaging with communities who are disproportionately affected by HIV, and we have developed a clearer understanding of the direct relationship between social and health inequities. Because of that enhanced understanding, we believe a holistic framework that encompasses social and structural determinants of health is essential for all communities experiencing HIV-related disparities. This Integrated Plan is meant to give a voice to all Californians at risk for and living with HIV, and to implement strategies that recognize the interplay



between biological, behavioral, psychosocial, and structural factors that affect the health and well-being of those most profoundly affected by the epidemic.

This Integrated Plan demonstrates the State of California's commitment to collaboration, efficiency, and innovation to achieve a more coordinated response to HIV. It does this while clearly establishing the blueprint for achieving HIV prevention, care, and treatment goals. Because

of California's full scale implementation of the Affordable Care Act (ACA), PLWH are now cared for by a wide variety of payer sources. Stretching beyond the traditional role of state and local health departments, it is our goal that many entities throughout California will continue to work together, taking responsibility for our respective roles in Getting to Zero. With this guiding principle, we set forth this Integrated Plan to guide our combined work for 2017-2021, striving to finally get to zero.

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Section I: California Needs Assessment for HIV

EXECUTIVE SUMMARY

The California Needs Assessment for HIV, 2016 outlines the needs of persons at risk for and living with HIV infection, identifies resources available to meet those needs, and determines what gaps and barriers in prevention, care, and treatment services currently exist throughout California. The California Needs Assessment for HIV, 2016 was developed by OA in collaboration with the San Bernardino/Riverside, Sacramento, and San Jose TGAs to support data-driven decision making for the development and implementation of California's Integrated HIV Surveillance, Prevention, and Care Plan, as well as to meet federal requirements.

The needs assessment is broken into four sections: a summary of the methods used; an epidemiologic overview, including the continuum of HIV care; a human and financial resources inventory; and a collection of detailed assessments of the needs, gaps, and barriers for HIV-related services and activities that stakeholders selected as highest priority to assess.

Epidemiologic Overview

OA estimates that in 2014 there were approximately 139,000 PLWH in California, of whom 91 percent had been diagnosed. The vast majority (87 percent) of people living and diagnosed with HIV in California in 2014 were male. Seventy-three percent of infections were among gay, bisexual, or other MSM and 14 percent were among people who inject drugs (PWID). More Whites (42.0 percent) were living with diagnosed HIV infection than any other racial/ethnic group, followed by Hispanics/Latinos (33.7 percent) and Blacks/African Americans (18.2 percent). However, the highest prevalence rate

(1,031.1 per 100,000) was among Blacks/African Americans, followed by Whites (354.4 per 100,000) and Hispanics/Latinos (284.7 per 100,000). A higher proportion of PLWH in the Sacramento and San Bernardino/Riverside TGAs were White (55 percent and 53 percent, respectively) than statewide (42 percent); the San Jose TGA percentage (41 percent) was lower than the statewide percentage. All three jurisdictions also had a smaller proportion of PLWH who were MSM (54 percent, 67 percent, and 64 percent, respectively).

Among the 5,002 people newly diagnosed with HIV in California in 2014, Blacks/African Americans had the highest rate of infection (38.5 per 100,000), followed by Hispanics/Latinos (14.8 per 100,000). Sixty-eight percent of persons newly diagnosed were gay, bisexual, or other MSM. However, this was lower in all three TGAs (Sacramento: 39 percent; San Bernardino/Riverside: 67 percent; and San Jose: 69 percent).

Among the 126,241 persons living and diagnosed with HIV statewide in 2014, 71 percent were in HIV care and 57 percent were virally suppressed. The percentage of PLWH who were in care ranged from 69-74 percent and the percentage of PLWH who were virally suppressed ranged from 49-54 percent among the three TGAs. Among persons newly diagnosed with HIV at the state level, 74 percent were linked to care within 1 month of diagnosis, and 61 percent were virally suppressed within 12 months of diagnosis. In the TGAs, linkage to care ranged from 69 percent to 80 percent within 1 month of diagnosis; viral suppression was 61-63 percent within 12 months of diagnosis.



At the state level, notable disparities in viral suppression were found in the following groups: Blacks/African Americans, American Indians/Alaska Natives, Hispanics/Latinos, transgender persons, 13-24 year olds, and PWID. Disparities in linkage to care for persons newly diagnosed with HIV were particularly notable in: women, Black/African Americans, Hispanic/Latinos, 13-24 year olds, and non-high-risk heterosexuals. Notable disparities in the Sacramento TGA in viral suppression were found in: Black/African Americans, Hispanic/Latinos, transgender persons, 19-24 year olds, and PWID. Disparities in linkage to care appeared in: men, Black/African Americans, and 19-24 year olds. Notable disparities in the San Bernardino/Riverside TGA in viral suppression existed in: Black/African Americans, American Indian/Alaska Natives, transgender persons, 19-34 year olds, and PWID. Disparities in linkage to care appeared in: women, Black/African Americans, 19-24 year olds, and heterosexuals. Notable disparities in the San Jose TGA in viral suppression existed in: Black/African Americans, Hispanic/Latinos, 19-24 year olds, PWID, and heterosexuals. Disparities in linkage to care appeared in: Hispanic/Latinos, Asians, and 19-34 year olds.

Human and Financial Resource Inventory

OA and the California Department of Health Care Services have approximately \$994 million in budget authority for California HIV-related services and activities in State Fiscal Year 2016-17. This number excludes some costs associated with medical care for PLWH who are enrolled in Medi-Cal through a managed care plan and medical costs associated with PLWH who are enrolled in private or employer-based health insurance and not receiving assistance from state-run programs.

While it is not possible to fully enumerate the number of health care providers who routinely provide care to PLWH, Ryan White clinics serve approximately 45 percent of PLWH in California

and the distribution of Ryan White clinics generally correlates well with the distribution of PLWH throughout the state. However, many communities, especially small to medium-sized cities and rural areas, report challenges maintaining sufficient numbers of HIV providers in their area. This is particularly true for dental and mental health providers who are comfortable and familiar with treating PLWH.

Needs, Gaps, and Barriers

Routine Opt-out HIV Testing

Performing routine HIV testing in health care settings can decrease the proportion of people unaware of being infected with HIV, and improve linkage and re-engagement in care. Routine opt-out HIV testing is a U.S. Preventive Services Task Force (USPSTF) Grade A recommendation for persons aged 15-65 years. The Patient Protection and Affordable Care Act of 2010 made routine, opt-out HIV testing and other preventive health services available at no-cost to insured Californians by requiring health insurance plans to cover 100 percent of USPSTF A and B recommendations. Therefore, there are 26.2 to 28.3 million Californians who should receive an HIV test at least once in their lives. According to population-based surveys, less than 41 percent of Californians have had an HIV test in their lifetime. While there is evidence that individuals with higher risk behaviors are more likely to be tested, this is still well short of the goal of 100 percent testing. Barriers to routine testing include lack of insurance, clinician knowledge, attitudes, and practices, and lack of HIV-testing reminders integrated in to electronic health records.

Pre-Exposure Prophylaxis (PrEP)

PrEP is the process of taking an anti-HIV medication daily to prevent HIV infection. Using CDC estimates applied to California, OA estimates that there are 220,000 to 240,000 Californians with an indication for PrEP, including 104,000-121,000 MSM. Data from multiple sources, including



Medi-Cal, the Los Angeles County Comprehensive HIV Plan (2017-2021), and multiple sources in San Francisco, suggest that a minimum of 9,000 people are currently taking PrEP in California. This number has increased dramatically since 2014.

Common barriers to PrEP include: insufficient number of providers who are comfortable prescribing PrEP and costs for patients. Currently, there are at least 200 clinical sites offering PrEP in California.



Section II: Integrated HIV Surveillance, Prevention, and Care Plan

California's Integrated HIV Surveillance, Prevention, and Care Plan responds to the needs identified in the California Needs Assessment for HIV (see Section I), and aligns closely with the goals of the NHAS. Our California-specific goals include:

- 1** - Reducing New HIV Infections in California;
- 2** - Increasing Access to Care and Improving Health Outcomes for PLWH in California;
- 3** - Reducing HIV-Related Disparities and Health Inequities in California; and
- 4** - Achieving a More Coordinated Statewide Response to the HIV Epidemic.

This Integrated Plan is divided into seven parts:

Part 1 Summarizes our Integrated Plan with “Actions-at-a-glance,” to make it easy to see how our strategies and activities are designed to help us reach our four California-specific goals.

Part 2 Identifies each of our 12 objectives, to be completed by December 2021, and outlines the ways in which each objective aligns with one or more of our goals. It also provides baseline measures and sources of data for these objectives, which are designed to be measurable and ambitious, yet achievable. First are the main objectives, then a series of sub-objectives specifically designed to address health disparities in our key populations, then a series of local sub-objectives that apply to each of the Part A counties co-authoring the Integrated Plan.

Part 3 Identifies each of our 15 strategies, and outlines the ways in which each strategy corresponds to the objectives detailed in Part 2.

Part 4 Describes the activities/interventions planned within each strategy listed in Part 3, along with the targeted populations, responsible parties, existing resources committed toward implementing the activity, and metrics that will be used to monitor progress. These metrics are consistent with the most current U.S. Department of Health and Human Services Core Indicators and NHAS Indicators. Part 4 also identifies any activities specifically aimed at addressing gaps along the HIV Care Continuum, with this icon:



Activities that specifically relate to Goal 3, Reducing HIV-Related Disparities and Health Inequities, are indicated by this icon:



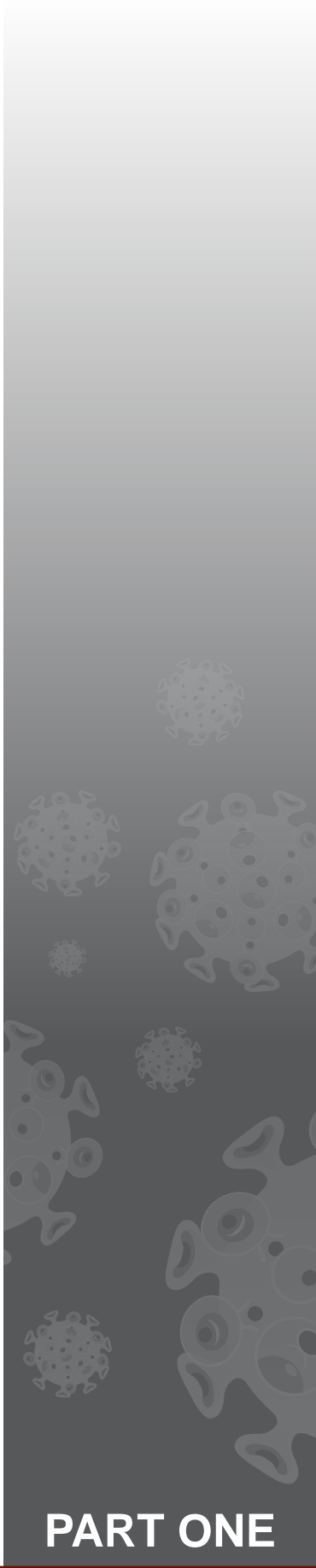
Activities that specifically relate to Goal 4, Achieving a More Coordinated Statewide Response, are indicated by this icon:



Part 5 Describes the anticipated challenges or barriers in implementing this plan.

Part 6 Details the collaborations, partnerships, and stakeholder involvement that informed the details of the Integrated Plan.

Part 7 Provides information about community engagement and the specific involvement of PLWH in California.



PART ONE

Actions At-A-Glance



GOAL 1: REDUCING NEW HIV INFECTIONS IN CALIFORNIA

Objective 1: Increase the estimated percentage of Californians living with HIV who know their serostatus to at least 95 percent

Strategy B: Increase and Improve HIV Testing

Strategy C: Expand Partner Services

Strategy M: Improve Usability of Collected Data

Strategy N: Enhance Collaborations and Community Involvement

Objective 2: Reduce the number of new HIV diagnoses in California by at least 50 percent, to fewer than 2,500 per year

Strategy A: Improve PrEP Utilization

Strategy C: Expand Partner Services

Strategy E: Improve Retention in Care

Strategy L: Increase General HIV Education and Awareness and Reduce Stigma Around HIV, Sexual Orientation, and Gender Identity

Strategy N: Enhance Collaborations and Community Involvement

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

Objective 3: Increase the number of Californians at high risk for HIV infection who are on PrEP to 60,000

Strategy A: Improve PrEP Utilization

Strategy F: Improve Overall Quality of HIV-Related Care

Strategy G: Improve Availability of HIV Care

Strategy K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

Strategy L: Increase General HIV Education and Awareness and Reduce Stigma around HIV, Sexual Orientation, and Gender Identity

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

Objective 4: Decrease the percentage of persons with new HIV diagnoses in California that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to less than 17 percent

Strategy B: Increase and Improve HIV Testing

Strategy C: Expand Partner Services

Strategy F: Improve Overall Quality of HIV-Related Care



Objective 5: Increase the percentage of sexually active PLWH in care who are tested at least once in a year for gonorrhea, syphilis, and chlamydia to at least 75 percent

Strategy G: Improve Availability of HIV Care

Strategy H: Improve Integration of HIV Services with Sexually Transmitted Diseases (STD), Tuberculosis (TB), Dental, and Other Health Services

Strategy I: Improve Case Management for PLWH with High Need

Strategy N: Enhance Collaborations and Community Involvement

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

Objective 6: Increase the percentage of newly diagnosed persons in California linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent

Strategy D: Improve Linkage to Care

Strategy G: Improve Availability of HIV Care

Strategy K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

Strategy N: Enhance Collaborations and Community Involvement

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

Objective 7: Increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75 percent

Strategy D: Improve Linkage to Care

Strategy E: Improve Retention in Care

Strategy F: Improve Overall Quality of HIV-Related Care

Strategy G: Improve Availability of HIV Care

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

Objective 8: Increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 80 percent

Strategy D: Improve Linkage to Care

Strategy E: Improve Retention in Care

Strategy F: Improve Overall Quality of HIV-Related Care

Strategy G: Improve Availability of HIV Care

Strategy I: Improve Case Management for PLWH with High Need

Strategy K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California



GOAL 2: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PLWH IN CALIFORNIA

Objective 5: Increase the percentage of sexually active PLWH in care who are tested at least once in a year for gonorrhea, syphilis, and chlamydia to at least 75 percent

See strategies under previous Objective 5

Objective 6: Increase the percentage of newly diagnosed persons in California linked to HIV medical care within one month of their HIV diagnosis to at least 85 percent

See strategies under previous Objective 6

Objective 7: Increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75 percent

See strategies under previous Objective 7

Objective 8: Increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 80 percent

See strategies under previous Objective 8

Objective 9: Increase the percentage of Californians with diagnosed HIV infection who are in HIV medical care (at least one visit per year) to at least 90 percent

Strategy D: Improve Linkage to Care

Strategy G: Improve Availability of HIV Care

Strategy I: Improve Case Management for PLWH with High Need

Strategy J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP

Objective 10: Increase the percentage of California ADAP clients with public or private health insurance to at least 85 percent

Strategy I: Improve Case Management for PLWH with High Need

Strategy J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP

Strategy M: Improve Usability of Collected Data

Strategy N: Enhance Collaborations and Community Involvement



Objective 11: Reduce the percentage of Californians with diagnosed HIV infection who are homeless to less than 5 percent

- Strategy F: Improve Overall Quality of HIV-Related Care
- Strategy I: Improve Case Management for PLWH with High Need
- Strategy M: Improve Usability of Collected Data
- Strategy N: Enhance Collaborations and Community Involvement

Objective 12: Reduce the age-adjusted death rate among Californians with diagnosed HIV infection to less than 650 per 100,000 persons per year

- Strategy D: Improve Linkage to Care
- Strategy E: Improve Retention in Care
- Strategy F: Improve Overall Quality of HIV-Related Care
- Strategy G: Improve Availability of HIV Care
- Strategy H: Improve Integration of HIV Services with STD, TB, Dental, and Other Health Services
- Strategy I: Improve Case Management for PLWH with High Need
- Strategy O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

GOAL 3: REDUCING HIV-RELATED DISPARITIES AND HEALTH INEQUITIES IN CALIFORNIA

Objective 2: Reduce the number of new HIV diagnoses in California by at least 50 percent, to fewer than 2,500 per year

See strategies under previous Objective 2

Objective 3: Increase the number of Californians at high risk for HIV infection who are on PrEP to 60,000

See strategies under previous Objective 3

Objective 4: Decrease the percentage of persons with new HIV diagnoses in California that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to less than 17 percent

See strategies under previous Objective 4

Objective 10: Increase the percentage of California AIDS Drug Assistance Program (ADAP) clients with public or private health insurance to at least 85 percent

See strategies under previous Objective 10



Objective 11: Reduce the percentage of Californians with diagnosed HIV infection who are homeless to less than 5 percent

See strategies under previous Objective 11

GOAL 4: ACHIEVING A MORE COORDINATED STATEWIDE RESPONSE TO THE HIV EPIDEMIC

Objective 5: Increase the percentage of sexually active PLWH in care who are tested at least once in a year for gonorrhea, syphilis, and chlamydia to at least 75 percent

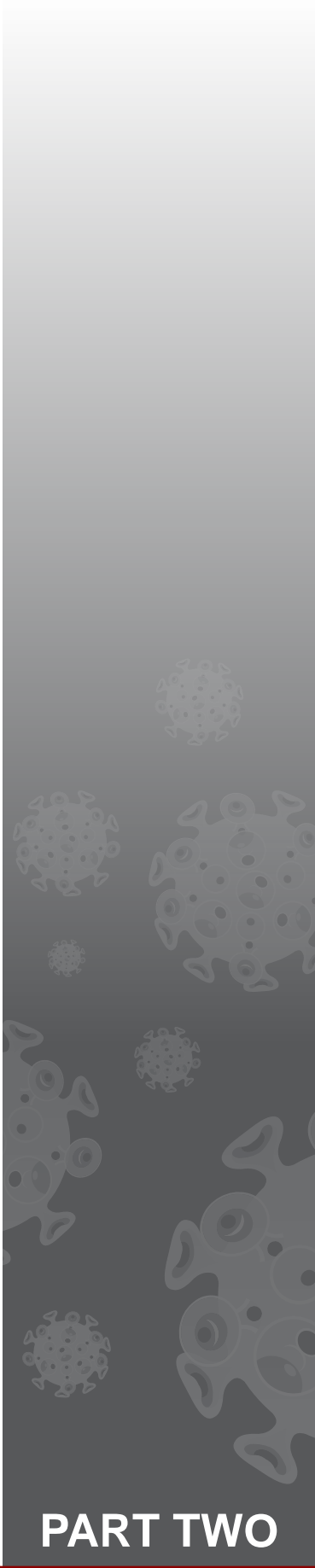
See strategies under previous Objective 5

Objective 10: Increase the percentage of California ADAP clients with public or private health insurance to at least 85 percent

See strategies under previous Objective 10

Objective 11: Reduce the percentage of Californians with diagnosed HIV infection who are homeless to less than 5 percent

See strategies under previous Objective 11



PART TWO

Objectives



GOALS			
1: Reducing New HIV Infections in California	2: Increasing Access to Care and Improving Health Outcomes for PLWH in California	3: Reducing HIV-Related Disparities and Health Inequities in California	4: Achieving a More Coordinated Statewide Response to the HIV Epidemic
MAIN OBJECTIVES: (All objectives to be achieved by December 2021)			
OBJECTIVE	BASELINE MEASURE (YEAR)	DATA SOURCE	
1: Increase the estimated percentage of Californians living with HIV who know their serostatus to at least 95%.	91% (2013)	Surveillance	
2: Reduce the number of new HIV diagnoses in California by at least 50%, to fewer than 2,500 per year.	5,002 (2014)	Surveillance	
3: Increase the number of Californians at high risk for HIV infection who are on PrEP to 60,000. ¹	≥9,000 (2016)	Multiple	
4: Decrease the percentage of persons with new HIV diagnoses in California that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to less than 17%.	23% (2014)	Surveillance	
5: Increase the percentage of sexually active PLWH in care who are tested at least once in a year for gonorrhea, syphilis, and chlamydia to at least 75%.	57% (2014)	Medical Monitoring Project (MMP)	
6: Increase the percentage of newly diagnosed persons in California linked to HIV medical care within one month of their HIV diagnosis to at least 85%.	74% (2014)	Surveillance	
7: Increase the percentage of Californians newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75%.	48% (2014)	Surveillance	
8: Increase the percentage of Californians with diagnosed HIV infection who are virally suppressed to at least 80%.	57% (2014)	Surveillance	
9: Increase the percentage of Californians with diagnosed HIV infection who are in HIV medical care (at least one visit per year) to at least 90%.	71% (2014)	Surveillance	
10: Increase the percentage of California ADAP clients with public or private health insurance to at least 85%.	54% (FY 2014/15)	ADAP	
11: Reduce the percentage of Californians with diagnosed HIV infection who are homeless to less than 5%.	12% (2014)	MMP	
12: Reduce the age-adjusted death rate among Californians with diagnosed HIV infection to less than 650 per 100,000 persons per year. ²	1,000 per 100,000	Surveillance	

: Indicates the objective relates to the goal
¹ Number of people on PrEP was estimated based on 2015 and Q1 2016 Medi-Cal data, estimates from the Los Angeles County Comprehensive HIV Plan (September 2016), and multiple sources in San Francisco.
² The age-adjusted death rate was calculated by dividing the number of PLWH who died in California in 2014 by the total number of PLWH who were alive at any time in 2014 in California, and normalizing the age-specific rates using the overall California population.

³Populations were selected for sub-objectives based on a review of available data and the presence of health disparities for that specific objective. For information about available baseline data for other populations, please see the California Needs Assessment for HIV Epidemiologic Overview, "California Needs Assessment for HIV: Table 1," "California Needs Assessment for HIV: Tables 4 and 5," "California Needs Assessment for HIV: Table 6," "California Needs Assessment for HIV: Table 9," "California Needs Assessment for HIV: Table 10," "California Needs Assessment for HIV: Tables 7 and 8."

⁴Baseline percentage excludes men who have sex with men who also inject drugs.

SUB-OBJECTIVES RELATED TO ADDRESSING DISPARITIES:

DESIRED ACTION	SUB-POPULATION ³	FOCUS	TARGET	BASELINE (YEAR)	DATA SOURCE
1a: Increase the estimated percentage of ⁴	Black/African American Hispanic/Latino	PLWH in CA who know their serostatus to	at least 95%	91% (2013)	Surveillance
			at least 95%	87% (2013)	Surveillance
2a: Reduce the number of new HIV diagnoses in ⁵	Black/African American	Californians	by 50% to ≤ 428 per year	857 (2014)	Surveillance
	Hispanic/Latino		by 50% to ≤ 1,103 per year	2,207 (2014)	Surveillance
	13-24 year old		by 50% to ≤ 477 per year	954 (2014)	Surveillance
3a: Increase the number of	Black/African American	Californians with high risk for HIV infection who are on PrEP to at least	11,000	Unknown (N/A)	Multiple
	Hispanic/Latino		20,000		
4a: Decrease the percentage of persons with new HIV diagnoses in CA who were ⁶	infected through injection drug use	that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to	less than 25%	39% (2014)	Surveillance
	infected through heterosexual sex		less than 25%	31% (2014)	Surveillance
	45 years old and older		less than 25%	35% (2014)	Surveillance
5a: Increase the percentage of sexually active	gay men and other MSM	in care for HIV who are tested at least once in a year for syphilis to	at least 90%	80% (2014)	MMP
	women	in CA newly diagnosed linked to HIV medical care within one month of their HIV diagnosis to	at least 85%	68% (2014)	Surveillance
6a: Increase the percentage of ⁷	Black/African American		at least 85%	66% (2014)	Surveillance
	Hispanic/Latino		at least 85%	73% (2014)	Surveillance
	persons aged 13-24 years old		at least 85%	70% (2014)	Surveillance
	heterosexual (non-high risk) persons	Californians who are virally suppressed within six months of diagnosis to	at least 85%	63% (2014)	Surveillance
7a: Increase the percentage of newly HIV diagnosed ⁸	infected through injection drug use		at least 75%	39% (2014)	Surveillance
	13-24 year old		at least 75%	40% (2014)	Surveillance
	transgender persons		at least 75%	42% (2014)	Surveillance
	Black/African American		at least 75%	40% (2014)	Surveillance
	American Indian/Alaska Native	persons in CA with diagnosed HIV infection who are virally suppressed to	at least 75%	36% (2014)	Surveillance
	Black/African American		at least 80%	49% (2014)	Surveillance
8a: Increase the percentage of ⁹	American Indian/Alaska Native		at least 80%	48% (2014)	Surveillance
	Hispanic/Latino		at least 80%	54% (2014)	Surveillance
	transgender	infected through injection drug use	at least 80%	51% (2014)	Surveillance
	13-24 year old		at least 80%	45% (2014)	Surveillance
			at least 80%	45% (2014)*	Surveillance

MAIN OBJECTIVES: Sacramento TGA (including El Dorado and Placer Counties)

(All objectives are to be completed by 2021)

OBJECTIVE	BASELINE (YEAR)	DATA SOURCE
1: Not available (Estimates of undiagnosed are not available at the local level).	-	-
2: Reduce the number of new HIV diagnoses in the Sacramento TGA by at least 50%, to fewer than 85 per year.	170 (2014)	Surveillance
3: Increase the number of Sacramento TGA residents at high risk for HIV infection who are on PrEP to at least 3,100.	Unknown (N/A)	Multiple
4: Decrease the percentage of persons with new HIV diagnoses in the Sacramento TGA that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis to less than 20%.	26% (2014)	Surveillance
5: Not available (Estimates of STD testing are not available at the local level).	-	-
6: Increase the percentage of newly diagnosed persons in the Sacramento TGA linked to HIV medical care within one month of their HIV diagnosis to at least 85%.	77% (2014)	Surveillance
7: Increase the percentage of Sacramento TGA residents newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75%.	41% (2014)	Surveillance
8: Increase the percentage of Sacramento TGA residents with diagnosed HIV infection who are virally suppressed to at least 80 percent.	54% (2014)	Surveillance
9: Increase the percentage of Sacramento TGA residents with diagnosed HIV infection who are in HIV medical care to at least 90%.	71% (2014)	Surveillance
10: Not applicable (ADAP is a statewide program; therefore, this measure is not applicable at the local level).	-	-
11: Increase the percentage of PLWH receiving Ryan White services in the Sacramento TGA who are stably housed to at least 80%. ¹⁰	45% (2015)	ARIES
12: Reduce the death rate among Sacramento TGA residents with diagnosed HIV infection to less than 900 per 100,000 persons per year.	1,108 per 100,000 (2014)	Surveillance

¹⁰ Estimated homelessness among PLWH is not available at local level. Therefore local objective was changed to only include Ryan White clients.



SUB-OBJECTIVES FOCUSED ON HEALTH DISPARITIES: Sacramento TGA (including El Dorado and Placer Counties)

DESIRED ACTION	SUB-POPULATION	FOCUS	TARGET	BASELINE (YEAR)	DATA SOURCE
2a: Reduce the number of new HIV diagnoses in	Black/African American	Sacramento TGA residents	by 50% to ≤ 21 per year	42 (2014)	Surveillance
	Hispanic/Latino		by 50% to ≤ 19 per year	37 (2014)	Surveillance
	19-24 year old		by 50% to ≤ 14 per year	28 (2014)	Surveillance
	high-risk heterosexuals		by 50% to ≤ 24 per year	47 (2014)	Surveillance
	MSM		by 50% to ≤ 40 per year	80 (2014)	Surveillance
4a: Decrease the percentage of persons with new HIV diagnoses in the Sacramento TGA who were	infected through heterosexual sex	that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to	less than 25%	30% (2014)	Surveillance
	45 years old and older		less than 25%	46% (2014)	Surveillance
6a: Increase the percentage of	men	in the Sacramento TGA newly diagnosed linked to HIV medical care within one month of their HIV diagnosis to	at least 85%	75% (2014)	Surveillance
	Black/African American		at least 85%	69% (2014)	Surveillance
	persons aged 19-24 years		at least 85%	64% (2014)	Surveillance
	heterosexual persons		at least 85%	78% (2014)	Surveillance
7a: Increase the percentage of newly HIV-diagnosed	13-24 year old	Sacramento TGA residents who are virally suppressed within six months of diagnosis to	at least 75%	30% (2014)	Surveillance
	Black/African American		at least 75%	31% (2014)	Surveillance
	infected through heterosexual sex		at least 75%	40% (2014)	Surveillance
8a: Increase the percentage of	Black/African American	Sacramento TGA residents with diagnosed HIV infection who are virally suppressed to	at least 80%	47% (2014)	Surveillance
	Hispanic/Latino		at least 80%	52% (2014)	Surveillance
	transgender		at least 80%	44% (2014)	Surveillance
	19-24 year old		at least 80%	34% (2014)	Surveillance
	infected through injection drug use ¹¹		at least 80%	46% (2014)	Surveillance
	infected through high-risk heterosexual sex		at least 80%	53% (2014)	Surveillance

¹¹ Excludes men who have sex with men who also inject drugs.

MAIN OBJECTIVES: San Bernardino/Riverside TGA

(All objectives are to be completed by 2021)

OBJECTIVE	BASELINE (YEAR)	DATA SOURCE
1: Not available (Estimates of undiagnosed are not available at the local level).	-	-
2: Reduce the number of new HIV diagnoses in the San Bernardino/Riverside TGA by at least 50%, to fewer than 134 per year.	267 (2014)	Surveillance
3: Increase the number of San Bernardino/Riverside TGA residents at high risk for HIV infection who are on PrEP to at least 6,850.	Unknown (N/A)	National HIV Behavioral Surveillance (NHBS), California Health Interview Survey (CHIS), Medi-Cal
4: Decrease the percentage of persons with new HIV diagnoses in the San Bernardino/Riverside TGA that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis to less than 17%.	23% (2014)	Surveillance
5: Not available (Estimates of STD testing are not available at the local level).	-	-
6: Increase the percentage of newly diagnosed persons in the San Bernardino/Riverside TGA linked to HIV medical care within one month of their HIV diagnosis to at least 85%.	69% (2014)	Surveillance
7: Increase the percentage of San Bernardino/Riverside TGA residents newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75%.	47% (2014)	Surveillance
8: Increase the percentage of San Bernardino/Riverside TGA residents with diagnosed HIV infection who are virally suppressed to at least 80%.	55% (2014)	Surveillance
9: Increase the percentage of San Bernardino/Riverside TGA residents with diagnosed HIV infection who are in HIV medical care to at least 90%.	69% (2014)	Surveillance
10: Not applicable (ADAP is a statewide program; therefore, this measure is not applicable at the local level).	-	-
11: Increase the percentage of PLWH receiving Ryan White services in the Sacramento TGA who are stably housed to at least 80%. ¹²	71% (2015)	AIDS Regional Information and Evaluation System (ARIES)
12: Reduce the age-adjusted death rate among San Bernardino/Riverside TGA residents with diagnosed HIV infection to less than 900 per 100,000 persons per year.	1,206 per 100,000 (2014)	Surveillance

¹² Estimated homelessness among PLWH is not available at local level. Therefore local objective was changed to only include Ryan White clients.



SUB-OBJECTIVES FOCUSED ON HEALTH DISPARITIES: San Bernardino/Riverside TGA

DESIRED ACTION	SUB-POPULATION	FOCUS	TARGET	BASELINE (YEAR)	DATA SOURCE
2a: Reduce the number of new HIV diagnoses in	Black/African American	San Bernardino/Riverside TGA residents	by 50% to ≤ 31 per year	62 (2014)	Surveillance
	Hispanic/Latino		by 50% to ≤ 101 per year	202 (2014)	Surveillance
	13-24 year old		by 50% to ≤ 52 per year	103 (2014)	Surveillance
	gay, bisexual, and other MSM		by 50% to ≤ 151 per year	302 (2014)	Surveillance
4a: Decrease the percentage of persons with new HIV diagnoses in the San Bernardino/Riverside TGA who were	infected through injection drug use	that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to	less than 25%	48% (2014)	Surveillance
	45 years old and older		less than 25%	35% (2014)	Surveillance
6a: Increase the percentage of	women	in the San Bernardino/Riverside TGA newly diagnosed linked to HIV medical care within one month of their HIV diagnosis to	at least 85%	52% (2014)	Surveillance
	Black/African American		at least 85%	58% (2014)	Surveillance
	persons aged 19-24 years		at least 85%	56% (2014)	Surveillance
	heterosexual persons		at least 85%	59% (2014)	Surveillance
7a: Increase the percentage of newly HIV diagnosed	infected through injection drug use	San Bernardino/Riverside TGA residents who are virally suppressed within six months of diagnosis to	at least 75%	33% (2014)	Surveillance
	13-24 year old		at least 75%	41% (2014)	Surveillance
	Black/African American		at least 75%	36% (2014)	Surveillance
8a: Increase the percentage of	Black/African American	San Bernardino/Riverside TGA residents with diagnosed HIV infection who are virally suppressed to	at least 80%	42% (2014)	Surveillance
	American Indian/Alaska Native		at least 80%	39% (2014)	Surveillance
	transgender		at least 80%	32% (2014)	Surveillance
	19-34 year old		at least 80%	47% (2014)	Surveillance
	infected through injection drug use ¹³		at least 80%	36% (2014)	Surveillance

¹³ Excludes men who have sex with men who also inject drugs.

MAIN OBJECTIVES: San Jose TGA (Santa Clara County)

(All objectives are to be completed by 2021)

OBJECTIVE	BASELINE (YEAR)	DATA SOURCE
1: Not available (Estimates of undiagnosed are not available at the local level).	-	-
2: Reduce the number of new HIV diagnoses in the San Jose TGA by at least 50%, to fewer than 80 per year.	161 (2014)	Surveillance
3: Increase the number of San Jose TGA residents at high risk for HIV infection who are on PrEP to at least 2,300.	Unknown (N/A)	Multiple
4: Decrease the percentage of persons with new HIV diagnoses in the San Jose TGA that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis to less than 23%.	29% (2014)	Surveillance
5: Not available (Estimates of STD testing are not available at the local level).	-	-
6: Increase the percentage of newly diagnosed persons in the San Jose TGA linked to HIV medical care within one month of their HIV diagnosis to at least 90%.	80% (2014)	Surveillance
7: Increase the percentage of San Jose TGA residents newly diagnosed with HIV who are virally suppressed within six months of diagnosis to at least 75%.	43% (2014)	Surveillance
8: Increase the percentage of San Jose TGA residents with diagnosed HIV infection who are virally suppressed to at least 80%.	49% (2014)	Surveillance
9: Increase the percentage of San Jose TGA residents with diagnosed HIV infection who are in HIV medical care to at least 90%.	74% (2014)	Surveillance
10: Not applicable (ADAP is a statewide program; therefore, this measure is not applicable at the local level).	-	-
11: Increase the percentage of PLWH receiving Ryan White services in the San Jose TGA who are stably housed to at least 80%. ¹⁴	66% (2015)	ARIES

¹⁴ Estimated homelessness among people living with HIV is not available at local level. Therefore local objective was changed to only include Ryan White clients.



SUB-OBJECTIVES FOCUSED ON HEALTH DISPARITIES: San Jose TGA (Santa Clara County)

DESIRED ACTION	SUB-POPULATION	FOCUS	TARGET	BASELINE (YEAR)	DATA SOURCE
2a: Reduce the number of new HIV diagnoses in	Hispanic/Latino	San Jose TGA residents	by 50% to ≤ 39 per year	79 (2014)	Surveillance
	19-24 year old		by 50% to ≤ 12 per year	23 (2014)	Surveillance
4a: Decrease the percentage of persons with new HIV diagnoses in the San Jose TGA who were	45 years old and older	that are diagnosed with Stage 3 (AIDS) within 12 months of diagnosis (i.e., late diagnosis) to	less than 25%	47% (2014)	Surveillance
6a: Increase the percentage of	Hispanic/Latino persons	in the San Jose TGA newly diagnosed linked to HIV medical care within one month of their HIV diagnosis to	at least 90%	79% (2014)	Surveillance
	Asian persons		at least 90%	78% (2014)	Surveillance
	persons aged 19-34 years		at least 90%	75% (2014)	Surveillance
7a: Increase the percentage of newly HIV diagnosed	infected through injection drug use	San Jose TGA residents who are virally suppressed within six months of diagnosis to	at least 75%	30% (2014)	Surveillance
	13-24 year old		at least 75%	13% (2014)	Surveillance
	Hispanic/Latino		at least 75%	35% (2014)	Surveillance
8a: Increase the percentage of	Black/African American	San Jose TGA residents with diagnosed HIV infection who are virally suppressed to	at least 80%	47% (2014)	Surveillance
	Hispanic/Latino		at least 80%	45% (2014)	Surveillance
	19-24 year old		at least 80%	21% (2014)	Surveillance
	infected through injection drug use ¹⁵		at least 80%	43% (2014)	Surveillance
	infected through heterosexual sex		at least 80%	47% (2014)	Surveillance

¹⁵ Excludes men who have sex with men who also inject drugs.



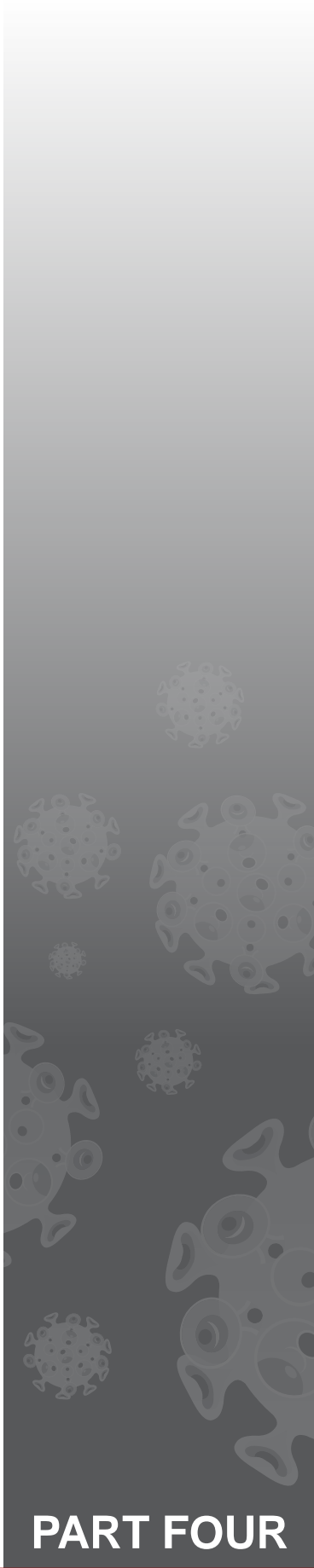
PART THREE

Strategies



STRATEGIES: (This table outlines the objectives that are expected to be impacted as a result of the strategies listed below. The activities to be implemented as part of each of these strategies are detailed in Part 4.)	OBJECTIVES											
	1	2	3	4	5	6	7	8	9	10	11	12
A: Improve PrEP Utilization		●	●									
B: Increase and Improve HIV Testing	●			●								
C: Expand Partner Services	●	●		●								
D: Improve Linkage to Care						●	●	●	●			●
E: Improve Retention in Care		●					●	●				●
F: Improve Overall Quality of HIV-Related Care			●	●			●	●			●	●
G: Improve Availability of HIV Care			●		●	●	●	●	●			●
H: Improve Integration of HIV Services with STD, TB, Dental, and Other Health Services					●							●
I: Improve Case Management for PLWH with High Need					●			●	●	●	●	●
J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP									●	●		
K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs			●			●		●				
L: Increase General HIV Education & Awareness and Reduce Stigma around HIV, Sexual Orientation, and Gender Identity		●	●									
M: Improve Usability of Collected Data	●									●	●	
N: Enhance Collaborations and Community Involvement	●	●			●	●				●	●	
O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California		●	●		●	●	●	●				●

● : Indicates the strategy is expected to impact the objective



PART FOUR

Activities



STRATEGY A: Improve PrEP Utilization

In 2014, the U.S. Public Health Services released a clinical practice guideline for the use of PrEP for the prevention of HIV in the United States. PrEP is a relatively new intervention that involves taking one pill a day of antiviral medication (currently a fixed-dose combination of tenofovir disoproxil fumarate/emtricitabine [TDF/FTC]). PrEP has been shown to be safe and effective in reducing the risk of sexual HIV acquisition in adults, and therefore, is recommended as an HIV prevention option for sexually active adult MSM, people who inject drugs, transgender women, and heterosexually active men and women who are at substantial risk

of HIV infection, including those whose partners are known to have HIV infection (considered “key populations” for PrEP).

PrEP strategies build on the long-term strategy of Post-Exposure Prophylaxis (PEP), which involves taking antiretroviral medications after a specific incident that may have exposed someone to HIV. PEP is intended for emergency situations and must be started within 72 hours of a possible HIV exposure, and continued for 28 days to prevent HIV infection.

Activity A1: Expand PrEP and PEP Access Throughout the State



This includes the development of best practices and supportive tools for the establishment of new programs or initiatives to promote and offer PrEP; capacity-building support to improve existing PrEP efforts to meet need; and encouragement by OA and local health jurisdiction staff for all PrEP providers to register on the PleasePrEPMe.org website. It also includes establishing guidance to refer patients presenting for PEP services to be transitioned onto PrEP upon completion of PEP medications, as well as implementation of the recent expansion of ADAP to provide services to HIV-negative persons at risk for acquiring HIV by covering PrEP medications on the ADAP formulary and related medical co-pays, co-insurance, and deductibles incurred by individuals accessing PrEP in California with annual incomes below 500 percent federal poverty level.

Targeted Populations:

- Medical providers and community organizations that serve key populations and individuals at high risk for HIV infection

Responsible Parties:

- OA HIV Prevention and ADAP staff
- Local health jurisdiction HIV prevention staff and ADAP enrollment workers
- CDC-funded capacity building assistance (CBA) providers (see appendix), including the Pacific AIDS Education and Training Center (PAETC) and STD/HIV Prevention Training Center



Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)
- State General Fund – PrEP Navigation Services
- State General Fund – HIV Prevention Demonstration Projects
- ADAP Rebate Fund – PrEP Drug Assistance Program
- (Years 1-2) Technical assistance (TA) from CBA providers to develop best practices and supportive tools for the establishment of new PrEP programs
- (Years 1-5) TA from CBA providers to support community organizations in expanding their existing PrEP programs to better meet demand in their area

Metrics:

- Number of PrEP providers (as listed in PleasePrEPMe.org)
- Number of PrEP prescriptions filled by Medi-Cal clients
- Percentage of MSM, PWID, and high-risk heterosexuals on PrEP in Los Angeles, San Francisco, and San Diego (from NHBS data)
- Percentage of MSM and transgender persons reporting PrEP use on CHIS

Activity A2: Educate Medical Providers About PrEP and PEP

This includes working closely with the PAETC and other CBA providers to provide trainings and distribute educational materials about PrEP throughout private clinics and large medical systems in California. This includes not only short-term, one-time trainings but also more intensive efforts designed to counter active provider resistance to PrEP, which has been frequently reported in HIV demonstration projects throughout California.

Targeted Populations:

- Primary care providers who serve patients at high risk for HIV infection
- Emergency department hospital staff, who serve patients who may be candidates for PEP

Responsible Parties:

- OA
- Local health jurisdictions
- California-based medical schools and primary care and infectious disease residency programs
- Health plans in California
- PAETC and other CBA providers (see appendix) as appropriate



Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)
- State General Fund – PrEP Navigation Services
- (Years 1-5) TA from the PAETC to develop trainings and educational materials as needed, then conduct targeted outreach to provide trainings, as well as academic detailing with staff of clinics and medical organizations that provide primary care

Metrics:

- Number of trainings conducted
- Number of providers participating in trainings
- Number of educational materials distributed
- Number of providers prescribing PrEP/PEP

Activity A3: Increase Availability of PrEP for Key Populations at Free or Low Cost



This includes developing systems for supporting low-income clients or those whose insurance coverage results in extremely high co-pays in accessing Gilead's Truvada® for PrEP Medication Assistance Program (MAP) and other similar programs, and implementing the expansion of ADAP to provide services to HIV-negative persons at risk for acquiring HIV by covering PrEP medications on the ADAP formulary and related medical co-pays, co-insurance, and deductibles incurred by individuals accessing PrEP in California with annual incomes below 500 percent federal poverty level. This activity will also be addressed through improving benefits enrollment (Strategy J), and improving systems to allow for reducing the wait time for screening and prescription appointments with PrEP providers for clients who are good candidates for PrEP.

Targeted Populations:

- Clinics and organizations that serve low-income, key populations, including people of color and MSM
- People insured through ACA or other systems who have extremely high co-pays for PrEP

Responsible Parties:

- OA
- Local health jurisdictions
- PAETC



Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)
- State General Fund – PrEP Navigation Services
- State General Fund – HIV Prevention Demonstration Projects
- ADAP Rebate Fund – PrEP Drug Assistance Program
- (Years 1-5) TA from PAETC for technical support to clinics and community organizations that have patients/clients who would benefit from Gilead's Truvada MAP

Metrics:

- Number of clients receiving support through ADAP for PrEP medication assistance
- Percentage of low-income MSM, PWID, and high-risk heterosexuals on PrEP in Los Angeles, San Francisco, and San Diego (from NHBS data)

Activity A4: Promote PrEP and Educate about PrEP in Key Populations with Low Uptake



This includes the development of social marketing campaigns, educational materials, and social media strategies that will promote PrEP. These materials must be developed in close consultation with key community stakeholders, including members of the targeted populations specified below.

Targeted Populations:

- Key populations for PrEP, including gay men, people who inject drugs, and people with known HIV-positive partners
- Non-gay-identified MSM
- Transgender women and men who have sex with men
- Blacks/African Americans
- Hispanics/Latinos

Responsible Parties:

- OA
- Local health jurisdictions, in partnership with community organizations

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)
- State General Fund – PrEP Navigation Services
- State General Fund – HIV Prevention Demonstration Projects



Metrics:

- Number of social marketing campaigns and other activities focused on targeted populations
- Percentage of MSM, PWID, and high-risk heterosexuals aware of PrEP in Los Angeles, San Francisco, and San Diego (from NHBS data)
- Percentage of MSM and transgender persons aware of PrEP use on CHIS

Activity A5: Improve Services that Support Linkage and Retention in PrEP

This includes many of the same strategies used to link and retain PLWH in care (see Strategies D and E). As PrEP programs expand throughout California, it is clear that making PrEP available at no cost is insufficient for adequate uptake, especially among certain high-need populations. Therefore, implementing systems that allow people to be rapidly linked to a provider who will prescribe PrEP, development of patient/client PrEP navigation programs, and treatment adherence interventions are critical to the success of PrEP as an intervention. As part of this activity, OA will support PrEP navigation and rapid PrEP linkage programs within local health jurisdictions, and encourage the development of training materials and toolkits for peer navigators. This activity also includes the expansion of HIV treatment adherence interventions to include people on PrEP, or creation of new mechanisms to support PrEP treatment adherence if needed.

Targeted Populations:

- Key populations for PrEP that have been shown to have low uptake of PrEP, challenges with retention in PrEP-related services, and/or adherence to PrEP, including young MSM, people who inject drugs, non-gay-identified MSM, and transgender women who have sex with men, as well as Blacks/African Americans and Hispanics/Latinos at risk for HIV.

Responsible Parties:

- OA
- Local health jurisdictions, in partnership with community organizations

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)
- State General Fund – PrEP Navigation Services
- State General Fund – HIV Prevention Demonstration Projects
- (Years 1-5) TA from CBA providers to support the development of training materials and toolkits for peer navigators



Metrics:

- Number of local health jurisdictions with PrEP navigation programs
- Number of clients served by PrEP navigation programs

STRATEGY B: Increase and Improve HIV Testing



In California in 2014, an estimated 91 percent of PLWH knew their serostatus – almost four percentage points better than the diagnosed rate for the United States as a whole. This is good, but there is still much work to be done – particularly in key populations where this rate is lower, including Blacks/African Americans and Hispanics/Latinos, those who were born outside the United States, and people over age 35. California is committed to continuing to improve the proportion of PLWH

who are aware of their serostatus through a combination of targeted testing and routine, opt-out HIV testing, using the best technology we have available.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who *know their serostatus*.

Activity B1: Expand Routine Opt-out HIV Testing in Health Care Settings



This includes encouraging and assisting hospital emergency departments, primary care providers, and health care systems in jails and prisons to offer routine, opt-out testing for all patients per [CDC](#) and [United States Preventive Services Task Force](#) guidance. It also includes advocating for the inclusion of additional measures related to HIV testing in quality improvement programs, including Healthcare Effectiveness Data and Information Set (HEDIS®), a tool used by more than 90 percent of health plans in California to measure performance related to care and service provision. Further, we will work with HRSA to have metrics related to routine, opt-out HIV testing in ambulatory care settings tracked within the Uniform Data System (UDS). This activity will involve collaborative work from OA, Department of Health Care Services (DHCS), and Covered California as well as providers in health care settings, to improve routine, opt-out testing rates. It will also include work with the National Committee for Quality Assurance (NCQA) to add HEDIS® measures, work with HRSA to incorporate routine, opt-out testing into the UDS measures for Federally Qualified Health Centers (FQHCs), and work with other quality improvement programs, including Medi-Cal and Covered California, to better measure HIV testing.

Targeted Populations:

- Hospital emergency departments
- FQHC and community health centers
- Primary care providers
- Jail and prison health systems

**Targeted Populations (*continued*):**

- Kaiser Permanente, Anthem Blue Cross of California, HealthNet, Covered California Qualified Health Plans, and other private payers in California
- Medi-Cal and Medi-Cal managed care plans
- NCQA

Responsible Parties:

- OA
- Local health jurisdictions
- Medi-Cal
- Covered California
- Health plans in California
- California Primary Care Association
- Medical provider “champions” who successfully launch routine opt-out testing programs in their health care settings
- PAETC

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- (Years 1-5) local TA from the PAETC to work with health care settings to implement or expand routine, opt-out testing through provider education and structural interventions

Metrics:

- Percentage of Californians reporting having had an HIV test on CHIS

Activity B2: Increase Use of Laboratory-based Fourth Generation Algorithms for HIV Testing to Identify Acute Infections

People in the acute stage of HIV infection (the early period when their viral load is extremely high and their immune system has not yet developed substantial antibodies to fight the infection) are very infectious and have been shown to have a significant impact on the spread of the epidemic. Additionally, people who are diagnosed with HIV and start antiretroviral medications during the acute stage of infection have been shown to have better long-term health than those who start medication later. For these reasons, efforts to identify people as early as possible during infection – even before a traditional HIV antibody test would be positive – are very important. This includes encouraging the purchase and adoption of fourth generation laboratory analyzers for laboratory-based screening as well as rapid point-of-care fourth generation tests for field-based screening in community organizations. It also includes CBA to clinicians, laboratory staff, or HIV testing staff in community organizations to encourage the use and promotion of fourth generation testing; use of the [latest CDC laboratory-based HIV testing algorithm](#), which calls for viral load testing for people who test antibody negative; and appropriate follow up with clients/patients



following evidence of an acute infection. As part of this activity, OA staff will investigate fourth generation testing technology, select appropriate test platforms, and develop protocols for use in various locations, in addition to developing guidance and educational materials to establish standards for appropriate follow up with clients/patients following evidence of an acute infection.

Targeted Populations:

- Local health department laboratories
- Hospital or medical clinic laboratories
- Clinicians who order HIV testing
- Community organizations providing targeted HIV testing

Responsible Parties:

- CDPH Laboratory Field Services
- Large commercial laboratories, which provide fourth generation testing options to California clinics
- OA
- Local health jurisdictions
- CDC-funded CBA providers

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)

Metrics:

- Number of persons newly diagnosed with HIV who are diagnosed with acute HIV infection

Activity B3: Expand HIV Testing Targeted to Key Populations



In California, we plan to focus targeted testing efforts on those most likely to be HIV-positive: gay men and other MSM, people who inject drugs, transgender people, sex workers, and people who report having an HIV-positive sex partner. Strategies to reach these groups through targeted testing include promoting HIV testing through social network strategies, social media, and social networking (“hookup”) sites, in addition to community-based and peer-based outreach to key populations. This activity includes the development of comprehensive local testing plans by local health department staff to improve targeting, provide increased outreach, and increase testing among those populations with the greatest likelihood of undiagnosed infection.

Targeted Populations:

- Gay men and other MSM
- People who inject drugs

**Targeted Populations (*continued*):**

- Transgender people
- Blacks/African Americans
- Hispanics/Latinos
- Low-income communities
- Non-English speaking communities

Responsible Parties:

- OA
- CDPH STD Control Branch
- Local health jurisdictions, in partnership with community-based organizations

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part B Base Funding, Early Intervention Services category (in non-Prevention funded jurisdictions)

Metrics:

- Number of HIV tests conducted in each of the targeted populations
- Percentage of HIV tests conducted that are positive

STRATEGY C: Expand Partner Services



Partner Services is a free service offered through local health departments in California, where health department staff provide assistance to PLWH in notifying their sexual and/or needle-sharing partners of possible exposure to HIV. This service includes working with PLWH to identify their partners, supporting the individual to notify their own partners of possible exposure if desired, anonymously contacting the other partners to notify them of the possible exposure, and encouraging all partners to be tested for HIV. Partner Services are always voluntary, client-centered, and confidential for both the person living with HIV and their partner(s). It is a critical service, both because it has been shown to be a highly effective way to identify people who are living with HIV but unaware of their status, and because it creates a vital opportunity to test people at risk for HIV and link them to care (if positive) or PrEP (if negative). In California, Partner Services are currently provided in STD clinics, care sites

where PLWH receive services, and HIV counseling and testing sites. OA provides technical assistance to health care or community-based organizations wishing to establish new Partner Services programs, and maintains a list of local coordinators for Partner Services programs to facilitate exchange of information and expertise on the local level. In 2013, California began using locally-acquired HIV surveillance data to identify PLWH and reach out to them to offer Partner Services. This strategy will continue to become more important as we continue to improve the proportion of PLWH in California who are aware of their HIV infection.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who *know their serostatus*, as well as the proportion who are *engaged in care*.



Activity C1: Increase Utilization of Surveillance-based Partner Services Activities

Currently, Partner Services is largely offered to people who are newly diagnosed in targeted testing sites. However, an increasing percentage of persons are diagnosed in other locations, such as with primary care providers. This underscores the need to use locally-acquired HIV surveillance data to identify PLWH and initiate Partner Services with them, and for HIV care providers to routinely offer Partner Services to PLWH in care. This activity involves local health jurisdiction staff creating the systems, procedures, and protocols needed to adopt policies to routinely share personally identifying information about individuals reported to be HIV positive with local health department staff responsible for Partner Services activities, without written authorization (see [CDPH Policy Letter](#), December 4, 2013). It also involves collaboration between HIV surveillance staff and information technology/informatics staff at CDPH and within local health jurisdictions to create systems for necessary data sharing.

Targeted Populations:

- Local health jurisdiction HIV surveillance staff
- Disease Intervention Specialist (DIS)/Partner Services staff within local health jurisdictions

Responsible Parties:

- OA
- CDPH STD Control Branch
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC HIV Surveillance Funding

Metrics:

- Percentage of persons newly diagnosed with HIV who are offered Partner Services
- Percentage of persons newly diagnosed with HIV who accept Partner Services
- Percentage of Ryan White clients who are offered Partner Services

Activity C2: Enhance Field-based Programs for Partner Notification and Testing

This includes routinizing the use of Partner Services with all people newly diagnosed with HIV, and increasing staff time for DIS/Partner Services staff within local health jurisdictions where needed. Full implementation of this activity may require hiring additional DIS by local health jurisdictions.

It also includes CBA to ensure robust and well-utilized Partner Services programs in places where uptake is low.

Targeted Populations:

- DIS staff in local health jurisdictions
- Community-based organizations and medical providers (for referrals to the program)

Responsible Parties:

- OA
- CDPH STD Control Branch
- Local health jurisdictions
- HIV Care Program contractors

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC Preventive Health and Health Services Block Grant
- HRSA Ryan White Part A Funding, Early Intervention Services category
- HRSA Ryan White Part B Base Funding, Early Intervention Services category

Metrics:

- Number of partners contacted through Partner Services
- Number of persons with newly diagnosed infections identified in partner contacts

Activity C3: Improve Linkage of Partners to Care (if HIV Positive), or PrEP and Other HIV Prevention Interventions (if HIV Negative)



This includes developing protocols for linkage to care, PrEP, and other HIV prevention interventions within local health jurisdiction field-based Partner Services programs, as well as guidance and CBA to DIS staff to improve linkage to care or PrEP once partners have been identified and contacted.

Targeted Populations:

- Partners of PLWH
- DIS staff in local health jurisdictions

Responsible Parties:

- OA
- Local health jurisdictions



Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)
- State General Fund – HIV Prevention Demonstration Projects
- HRSA Ryan White Part A Funding (Early Intervention Services)
- HRSA Ryan White Part B Base Funding (Early Intervention Services)

Metrics:

- Number of partners identified through Partner Services
- Number of partners receiving an HIV test
- Percentage of partners who test negative who are linked to PrEP navigation services
- Percentage of partners who test positive who are linked to care

Activity C4: Develop and Implement a Statewide HIV Outbreak Response Plan

This includes development of a written process, in the surge capacity, for identifying outbreaks of HIV, including co-infections with hepatitis B or C, syphilis, or other infections; completing an initial evaluation of them; and responding with state and local partners as needed to minimize the spread of disease. This may require memoranda of understanding with partners to ensure that surge capacity for outbreak response is available. Partner Services will be a key part of an outbreak response plan.

Targeted Populations:

- Local health jurisdictions

Responsible Parties:

- OA

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)

Metrics:

- Completion of outbreak response plan guidance document
- Number of memoranda of understanding with partners related to surge capacity



STRATEGY D: Improve Linkage to Care



Engagement in high-quality HIV care, including obtaining and adhering to HIV antiretroviral treatment, is a pivotal way to ensure that PLWH live the longest, healthiest lives possible. It is also a critical strategy for the prevention of further spread of HIV (otherwise known as Treatment as Prevention). Linkage to Care includes both the rapid linkage of people to medical care after a new diagnosis with HIV, and the re-engagement in care

of someone who has a known HIV infection and may have been engaged in care in the past but has subsequently fallen out of care.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who are *engaged in care*, as well as the proportion who are *virally suppressed*.

Activity D1: Implement Systems for Rapid Linkage to Care



This includes developing and implementing systems that allow appointments to be reserved for new diagnoses at key medical providers within 72 hours of diagnosis, as well as policy implementation of strategies to encourage antiretroviral treatment initiation on the same day as diagnosis (or linkage to care, if not possible on the same day as diagnosis). It also includes coordination within local health jurisdictions between HIV testing sites and care sites, so that those who provide testing know how to help those who test positive obtain a new appointment with a care provider within 72 hours.

Targeted Populations:

- HIV medical providers

Responsible Parties:

- OA
- Local health jurisdictions
- Leadership at major medical systems and HIV specialty medical clinics in California

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- State General Fund – HIV Prevention Demonstration Projects
- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding

**Metrics:**

- Percentage of persons newly diagnosed with HIV who are linked to care within 30 days of diagnosis
- Median time to viral suppression for persons newly diagnosed with HIV

Activity D2: Enhance 'Data to Care' Activities to More Rapidly Identify People Who Have Fallen Out of Care and Actively Re-engage Them in Care


This includes implementing the CDC Data to Care intervention in local health jurisdictions, which involves: a) rapidly determining whether people testing HIV positive are new or known cases to allow for appropriate prioritization of linkage and Partner Services; b) rapidly determining whether sex or needle-sharing partners named by a newly-diagnosed patient through Partner Services are already known to be living with HIV, to allow for prioritization of Partner Services outreach for other partners; c) determining whether clinic patients who are “not-in-care” are receiving care elsewhere, or should be prioritized for outreach and re-engagement into care; and d) conducting field work to find and re-engage PLWH who have fallen out of care. This activity will require the building of enhancements to surveillance data systems that will improve the ability for local health jurisdictions to utilize Data to Care strategies, and will require OA and local health jurisdiction staff to spend time generating, prioritizing, and distributing “not-in-care” lists. Local health jurisdiction staff may also need to conduct increased field work in order to re-engage PLWH into medical care.

Targeted Populations:

- HIV surveillance departments within local health jurisdictions
- DIS workers or other field teams who are skilled at outreach and re-engagement

Responsible Parties:

- OA HIV Surveillance staff
- CDPH STD Control Branch
- Local health jurisdictions surveillance staff
- Local health jurisdiction staff who provide linkage to care and Partner Services activities

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- HRSA Ryan White Supplemental Part B Funding
- HRSA Ryan White Minority AIDS Initiative Funding
- CDC Preventive Health and Health Services Block Grant
- CDC HIV Prevention Funding (PS 12-1201)

**Metrics:**

- Percentage of PLWH who are classified as out of care

Activity D3: Expand Use of Patient/Client Navigation Programs

The International Association of Providers in AIDS Care released [guidelines regarding entry and retention in HIV care](#) in 2012. One of the recommended approaches to support linkage to care was the use of peer and paraprofessional navigation programs, which have been shown to improve rates of linkage to care for PLWH. Patient/client navigation programs include the establishment of community-based programs that utilize peers or community-based workers such as case managers to support people newly diagnosed with HIV or living with HIV but fallen out of care, so that they may become (re-)engaged in care and eventually move toward viral suppression. To expand use of these programs, there must be an increase in training programs for navigators, as well as the development and promotion of easily accessible (e.g., online) toolkits for implementing client navigation systems. For this activity, existing funds will be used to support an increase in patient/client navigation programs among community-based organizations or specialty medical clinics.

Targeted Populations:

- Community-based organizations
- Specialty medical clinics
- Peer navigators

Responsible Parties:

- OA
- Local health jurisdictions
- Community-based organizations
- Medical clinics offering HIV care

Existing Resources Committed Toward Implementing the Activity:

- State General Fund – HIV Prevention Demonstration Projects
- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- (Years 1-5) TA from CBA providers to develop training materials and toolkits for peer navigators, and to train peers and paraprofessional staff to become highly effective navigators

Metrics:

- Number of Ryan White clinics with at least one peer navigator on staff
- Number of HIV care providers trained on peer/client navigation



Activity D4: Identify Barriers to Linkage to Care and Develop Strategies to Address Them



This includes systematic assessment of the barriers to linkage to care for PLWH (e.g., people diagnosed in one local health jurisdiction who reside in another county, or people diagnosed with HIV at a community-based organization or other non-HIV primary care provider), and strategic development of strategies that will address each identified barrier. This activity requires review of the literature and other analytic/research work to identify barriers through local needs assessments (some of which is currently underway in California). That will then be followed by structural/policy changes where indicated, as well as development of a robust case management infrastructure for newly-diagnosed people to address these barriers on an individual basis (also see Activity E3).

Targeted Populations:

- OA
- Local health jurisdictions
- Medical and community-based HIV service providers

Responsible Parties:

- OA and local health jurisdictions, in partnership with other stakeholders willing to participate on a working group to assess barriers to care and develop strategies to address them.
- California HIV/AIDS Research Program

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- State General Fund – HIV Prevention Demonstration Projects

Metrics:

- Release of written policy and barriers analysis on linkage to care
- Percentage of persons newly diagnosed with HIV who are linked to care within 30 days of diagnosis
- Percentage of PLWH who are in care



STRATEGY E: Improve Retention in Care



Unlike in the past, HIV prevention and care providers now recognize that linkage to high-quality HIV care is not sufficient – specific strategies are also needed to ensure that PLWH are retained in care once they have been initially linked. Benefits enrollment and case management, as well as improvements in the cultural competence and accessibility of care through provider education and training, all lead to improved retention in care. Less than one-half of people who are diagnosed with HIV in California were known to be retained in HIV care (at least two visits in one year, more than three months apart) in 2014; this is an area where we can and

will do better. Retention rates are especially poor among certain key populations, including those who are homeless or marginally housed, those who are uninsured or under-insured, people who are undocumented or recent immigrants, people who use substances or have mental health concerns, those with limited transportation options, transgender people, and young MSM of color.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who are *retained in care*, as well as the proportion who are *virally suppressed*.

Activity E1: Expand Provider Education to Improve Capacity to Retain Clients



This includes cultural and linguistic competency training, education about supportive services in the community that will help patients increase life stability, and training related to evidence-based retention strategies with the populations at highest risk for falling out of care. This will require the thoughtful development of curricula and production of educational campaigns and materials for distribution throughout the state.

Targeted Populations:

- Medical providers, particularly those who provide care to patients at high risk of falling out of care

Responsible Parties:

- OA
- Local health jurisdictions, who can work with major medical providers in their area to implement education and training as needed
- PAETC

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- HRSA Ryan White Supplemental Part B Funding
- (Year 1) TA from a CBA contractor to develop curricula and (Years 2-4) provide trainings

**Metrics:**

- Percentage of PLWH who are in care
- Number of Ryan White clinics with a missed appointment tracking system
- Number of providers trained on improving capacity to retain clients in care

Activity E2: Implement Pharmacy Tickler Programs

This includes implementing systems so that when a patient fails to pick up their automatically-scheduled prescription refill, their case manager or another relevant health care worker will be notified so they can reach out to the patient to re-engage them in care if needed. As part of this activity, OA will work with other stakeholders to identify the best mechanisms for development and implementation of pharmacy tickler programs to boost retention in care for PLWH, focusing initially on ADAP clients.

Targeted Populations:

- Pharmacists
- Staff of specialty pharmacies
- Medical care providers

Responsible Parties:

- OA
- Local health jurisdictions
- California State Board of Pharmacy
- California Pharmacists Association

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B ADAP Earmark Funding
- HRSA Ryan White Part B Base Funding

Metrics:

- Number of known pharmacy tickler programs
- Percentage of ADAP clients who missed prescription refills who had appropriate follow up to ensure continued engagement in care

**Activity E3: Increase the Number of Californians Living with HIV Who Are Enrolled in Health Insurance Coverage (Also See Activities Under Strategy J)**

This includes embedding or creating direct linkages to Medi-Cal, Covered California, and Ryan White-funded benefits counselors in key medical clinics or community organizations; identifying financial resources such as the OA-Health Insurance Premium Payment (OA-HIPP) program (in addition to tax credits) available to assist patients with premium payments, co-pays and other costs associated with HIV treatment; training pharmacists to refer clients to benefits enrollment counselors when needed; and educating people living with or at high risk for HIV about important things to consider when choosing coverage options, including: a) the plan's formulary and pharmacy network; and b) whether their chosen provider is in the coverage plan they select. These activities improve the ability of PLWH to afford, and be consistently retained in, care. As part of this activity, OA will work with Medi-Cal, Covered California, FQHCs, and Ryan White-funded benefits counselors in order to systematically embed them in medical clinics and community organizations, or create stronger linkages between these counselors and staff of HIV care, education, or prevention sites. This is already underway via training being developed in a collaboration between OA, Covered California, and community members for Covered California certified enrollment counselors that emphasizes relevant issues regarding HIV. It will also include orientation and training of pharmacists to refer to benefits enrollment services when needed.

Targeted Populations:

- Medical clinics, community organizations, and pharmacies that serve a large number of patients/clients/customers who are uninsured or under-insured

Responsible Parties:

- DHCS, County Eligibility and Enrollment (E&E) Workgroup
- Covered California certified enrollment counselors
- FQHCs
- Organizations funded by the Ryan White HIV/AIDS Program for Medical Case Management, Non-Medical Case Management Services, and Referral for Health Care and Support Services
- Specialty and other pharmacies, especially large chains

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- HRSA Ryan White Part B ADAP Earmark Funding
- ADAP Rebate Fund

Metrics:

- Proportion of PLWH who are comprehensively insured



Activity E4: Improve Integration of Basic Substance Abuse/Mental Health Interventions with HIV Care Settings



This includes broadly promoting a harm reduction-based approach to substance use, expanding capacity to reduce or eliminate wait times for substance use and mental health treatment, and changing facility policies to remove barriers to access for PLWH who are in need of these services. It will require that OA and/or local health jurisdiction staff spend time identifying and prioritizing key policy or logistical barriers to treatment access in each local health jurisdiction, and work closely with mental health and substance abuse treatment facilities to change facility policies or expand capacity to treat more PLWH in a timely manner.

Targeted Populations:

- Mental health facilities
- Substance use treatment facilities
- Medical insurance plans and providers

Responsible Parties:

- OA
- Local health jurisdictions
- Major funders of mental health and substance use services
- Leadership in mental health and substance use treatment facilities statewide

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B Base Funding

Metrics:

- Number of PLWH who access mental health services
- Number of PLWH who access substance use treatment/harm reduction services
- Percentage of PLWH with an unmet need for mental health services
- Percentage of PLWH with an unmet need for substance use treatment and/or harm reduction services

Activity E5: Strengthen Relationships with Organizations that Provide Housing Support for Clients in Unstable or Disadvantageous Living Situations



Establish a California Planning Group (CPG) subcommittee to address housing services. The subcommittee would identify the most effective housing services, best practices for integrating HIV health and housing providers and encouraging local collaboration, and methods for collaborative funding and service delivery. They will develop a written plan in Year 3 which could be implemented at the state and local levels.

Targeted Populations:

- Housing agencies (both governmental and community-based organizations)
- HIV care and treatment providers

Responsible Parties:

- CPG Subcommittee to develop and write the plan
- OA will staff the subcommittee

Existing Resources Committed Toward Implementing the Activity:

- U.S. Housing and Urban Development's (HUD) Housing Opportunities for Persons With AIDS (HOPWA) Funding
- HRSA Ryan White Part B Base Funding

Metrics:

- Percentage of Ryan White clients who are stably housed
- Percentage of PLWH who are homeless

STRATEGY F: Improve Overall Quality of HIV-Related Care



Making sure that HIV-related medical care is available and accessible to all PLWH in California is important, but it is not enough. Additional steps must be taken to ensure that the care that all PLWH receive is of the highest quality. This includes care that is cultural and linguistically competent, in addition to incorporating awareness of the impacts that housing instability, experiences of trauma, and/or intimate partner violence can have on engagement with care. It also means

setting standards and measuring adherence to key components of high-quality HIV care, such as treatment and viral suppression.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who are *retained in care*, as well as the proportion who are *virally suppressed*.

Activity F1: Improve Cultural Competency of Medical and Service Providers



Cultural competency is a critical factor influencing a person's retention in medical care. Cultural and linguistic competency of medical and service providers is, therefore, a vital issue to be addressed through education and training, whenever possible, in addition to systemic changes to improve the quality of care for all patients/clients. Cultural competency is important for everyone, and especially true for marginalized populations, such as those who are gay, lesbian, or bisexual; transgender people; racial and ethnic minorities; people who use drugs or alcohol; people who are homeless or marginally housed; and people with mental health concerns. In addition to cultural



competence related to issues of identity or behavior, it is also important to train medical and service providers to understand and provide:

- i) Trauma-informed care, which is care that recognizes the widespread impact that experiences of trauma can have on individuals, and responds by changing practices to empower patients, improve their health, and actively resist re-traumatization during the receipt of care. Good information about trauma-informed approaches and trauma-specific interventions are available through the [Substance Abuse and Mental Health Services Administration](#) and [The Trauma Informed Care Project](#).
- ii) Intimate partner violence (IPV) prevention and intervention, which is not, strictly speaking, a matter of cultural competency, but nonetheless presents a major barrier to access and retention to care for people impacted by IPV. Provider awareness and sensitivity to IPV as a potential health concern and barrier to care for their patients/clients, as well as knowledge of strategies that can help prevent further experiences of IPV, can have a significant impact on the care experience of patients who are impacted by IPV. More information about IPV and HIV can be found in this [HRSA Care Action newsletter](#).
- iii) HIV care for people who are simultaneously dealing with health issues related to aging. Thanks to great strides in HIV treatment and care, many PLWH are now beginning to face complications associated with aging. As such, it is important for medical providers to be aware of the unique challenges facing older PLWH. More information about these challenges can be found at [AIDS.gov](#) and the [National Institute on Aging](#).

Targeted Populations:

- Medical and service providers

Responsible Parties:

- Local health jurisdictions
- PAETC
- CDC-funded CBA providers (see appendix) or other training organizations as appropriate

Existing Resources Committed Toward Implementing the Activity:

- (Years 1-5) TA from PAETC and CBA providers to identify and train medical and service providers as needed

Metrics:

- Number of providers receiving training on cultural and linguistic competency
- Number of cultural competency trainings offered by CBA provider

**Activity F2: Expand the Use of Treatment Adherence Interventions**

This includes the use of evidence-based interventions to support treatment adherence for PLWH. As part of this activity, staff from medical providers and community-based organizations must select appropriate evidence-based medication adherence interventions (see [effectiveinterventions.org](#)), and implement them with fidelity.

Targeted Populations:

- PLWH and engaged in medical care

Responsible Parties:

- Medical providers
- Community-based organizations

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- TA from PAETC and CBA providers to identify and train medical and service providers who would benefit from training
- HRSA Ryan White Part B Base Funding (Outpatient/Ambulatory Health Services, Medical Case Management Services, or Health Education/Risk Reduction categories)

Metrics:

- Percentage of PLWH who are virally suppressed
- Percentage of PLWH who adhere to their prescribed antiretroviral medication regimen

Activity F3: Explore Establishing Standards of Care for Services Provided through Ryan White HIV/AIDS Program Funding, and Take Other Actions to Ensure that High-Quality Care can be Measured and is Tracked

This requires OA to explore developing service standards for each Ryan White service category in order to define the minimal level of service and to establish parity and equity among HIV Care Program providers throughout the state, as well as supporting the statewide dissemination of Standards of Care for all funded service categories. It also includes advocating for the inclusion of 'viral suppression' as a HEDIS® measure, which would then be used by more than 90 percent of health plans in California to measure performance in this area.



Targeted Populations:

- Ryan White-funded contractors
- NCQA

Responsible Parties:

- OA
- Contractors funded through the Ryan White HIV/AIDS Program
- California Primary Care Association

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding

Metrics:

- Completion of Standards of Care documents for all Ryan White HIV/AIDS Program services
- Inclusion of 'viral suppression' as a HEDIS® measure

Activity F4: Encourage Housing Evaluation as a Routine Part of Medical Assessment



This includes encouraging and assisting primary care providers to ask about housing status as part of their routine medical assessment, and supporting a process for immediate linkage to case management and housing resources based on identified housing assistance needs. To implement this activity, staff from OA and local health jurisdictions will work with primary care providers to educate them about case management services available to their clients to assist with housing.

Targeted Populations:

- Primary care providers
- HIV specialty care providers

Responsible Parties:

- OA
- Medical schools and residency programs
- PAETC
- Local health jurisdictions

**Existing Resources Committed Toward Implementing the Activity:**

- HUD's HOPWA Funding
- HRSA Ryan White Part B Base Funding

Metrics:

- Percentage of Ryan White clients with a known housing status
- Percentage of Ryan White clients who are stably housed
- Percentage of PLWH who are homeless

STRATEGY G: Improve Availability of HIV Care

Although in many ways HIV care is highly specialized care, the passage of the ACA presents a new opportunity to integrate HIV care into regular primary care for all PLWH. This can include an HIV specialty physician also providing primary care to his/her HIV-infected patients, and a primary care provider learning about HIV to provide high-quality HIV care to his/her HIV-infected patients. This shift helps coordinate care and reduce the need for extra care visits for individual patients. However, many PLWH need care that

some primary care providers are not accustomed to providing. This necessitates activities to improve provider training and make structural changes to increase availability of HIV care within primary care services.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who are *engaged in care*, as well as the proportion who are *virally suppressed*.

Activity G1: Increase HIV-specific Training of Primary Care Providers in High-need Areas

This includes offering HIV-specific trainings and CBA to individual medical providers and full primary care clinics within underserved areas that have high HIV prevalence or incidence. It also includes offering more HIV/STD-specific Continuing Medical Education (CME) options throughout the state (see activity F3), including in high-need areas.

Targeted Populations:

- Primary care providers not already credentialed by the [American Academy of HIV Medicine](#)

Responsible Parties:

- PAETC
- Local health jurisdictions



Existing Resources Committed Toward Implementing the Activity:

- (Year 1) TA from the PAETC to identify areas that have high need for increased availability of HIV care within primary care services
- (Years 2-3) TA from the PAETC to offer HIV trainings to primary care providers
- (Years 3-5) TA from the PAETC to increase the number of HIV/STD-specific CMEs offered throughout the state, specifically in high-need areas

Metrics:

- Number of trainings provided
- Number of providers trained

Activity G2: Improve Use of Pharmacists as Providers



This includes identifying and applying best practices regarding the role of pharmacists in: a) HIV patient education about antiretroviral therapy, PEP, and PrEP; b) medication adherence support; c) rapid HIV and hepatitis C virus (HCV) testing; d), provision of naloxone and clean syringes; and (e) promotion of condoms, home test kits, and other HIV prevention-related items typically sold in pharmacies. This activity will include discussions with the California Board of Pharmacy to support increased role of pharmacists and assist with policy or structural changes as needed, including development of training or continuing education for pharmacists on these issues. It will also include utilization of ADAP's Pharmacy Benefits Manager to provide educational materials about HIV to pharmacy providers in the ADAP network.

Targeted Populations:

- Pharmacists
- Staff of specialty pharmacies

Responsible Parties:

- OA
- Local health jurisdictions
- PAETC
- ADAP Pharmacy Benefit Manager
- California Pharmacists Association

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B ADAP Funding
- (Years 1-2) TA from PAETC to identify the possible ways that pharmacists can be systematically integrated into HIV care and prevention efforts



Metrics:

- Percentage of ADAP pharmacies that provide HIV and/or HCV testing on site or make referrals to HIV/HCV testing
- Percentage of ADAP pharmacies that provide medication adherence support for PLWH
- Percentage of ADAP pharmacies that sell hypodermic needles and syringes without a prescription
- Percentage of ADAP pharmacies that dispense naloxone

Activity G3: Work with Clinics in Under-resourced Areas to Apply for Medical Federal Shortage Designation



This includes working with the Shortage Designation Program (SDP) of the Healthcare Workforce Development Division of the Office of Statewide Health Planning and Development (see <http://www.oshpd.ca.gov/HWDD/Shortage-Designation-Program.html>). This program is California's liaison to the federal Shortage Designation Branch of HRSA, and provides technical assistance to clinics and other primary care providers seeking recognition as a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area/Medically Underserved Population (MUA/MUP). The SDP includes not only primary care but mental health and dental health assessments. Shortage designations enable clinics to be eligible for assignment of National Health Services Corp personnel, apply for various clinic certifications and programs to improve capacity and resources, and receive higher reimbursement rates for services. For this activity, OA and local health jurisdictions will work to determine under-resourced areas and identify clinics in those areas that would benefit from application for HPSA or MUA/MUP designation.

Targeted Populations:

- Medical clinics in under-resourced areas of the state

Responsible Parties:

- OA
- Local health jurisdictions
- Office of Statewide Health Planning and Development

Existing Resources Committed Toward Implementing the Activity:

- HRSA Primary Care Services Resource Coordination and Development Program Funding to the Office of Statewide Health Planning and Development

Metrics:

- Number of Ryan White-funded clinics located within that hold a HPSA or MUA/MUP designation



STRATEGY H: Improve Integration of HIV Services with STD, TB, Dental, and Other Health Services

Especially since the passage of the ACA, strong efforts have been made to integrate the provision of health care in the United States. One major strategy is the Patient Centered Medical Home (PCMH) model, supported by the [U.S. Agency for Healthcare Research and Quality](#), the [American Academy of Family Physicians](#), the NQCA, and the HRSA HIV/AIDS Bureau. This model is

currently being evaluated for effectiveness with PLWH by [researchers funded by the California HIV/AIDS Research Program](#). Through the use of the PCMH model and other strategies, California is committed to integrating HIV testing and care services firmly with other health services, rather than continuing to support siloed, stand-alone programs that deal only with HIV.

Activity H1: Improve Integration of Behavioral Health and HIV/STD/Viral Hepatitis Programs



This includes supporting increased co-location of services for HIV and STD testing and care, hepatitis A and B vaccination, and hepatitis B and HCV testing and linkage to care with mental health services and substance use counseling. To do this, OA, DHCS, and local health jurisdiction staff will identify policy, program, and funding barriers around co-locating HIV, HCV, and STD testing with behavioral health programs, and develop strategies to address those barriers.

Targeted Populations:

- Behavioral health providers
- HIV/STD medical providers
- Health insurance plans and large health care providers

Responsible Parties:

- OA
- DHCS
- Local health jurisdictions
- Clinics and organizations that provide behavioral health and/or HIV/STD services

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (12-1201)
- HRSA Ryan White Part B Base

Metrics:

- Percentage of people with behavioral health diagnoses who have had an HIV test

**Activity H2: Increase Concurrent HIV/STD Testing**

This includes incentivizing and otherwise encouraging providers to offer both HIV and STD testing at the same time whenever possible. To implement this activity, CDPH's OA and STD Control Branch staff will identify structural and policy barriers to implementing concurrent HIV and STD testing, and work to implement changes necessary to address those barriers. Funds will be used for test kits, laboratory work, and/or incentives as needed to increase concurrent HIV/STD testing in targeted provider agencies.

Targeted Populations:

- Local health jurisdictions
- HIV testing providers not already offering STD testing
- STD testing providers not already offering HIV testing

Responsible Parties:

- OA
- CDPH STD Control Branch
- Local health jurisdictions
- CDC-funded CBA providers

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC STD Cooperative Agreement Funding
- State General Fund – STD Control Branch
- (Years 1-5) TA from CBA providers to train providers in the targeted provider agencies to be able to offer STD testing or HIV testing (whichever is not currently offered)

Metrics:

- Percentage of MSM, PWID, and high-risk heterosexuals (in Los Angeles, San Francisco, and San Diego) who were tested for both HIV and STDs in the previous 12 months

Activity H3: Coordinate and Integrate Data Systems to Identify and Track STD and TB Diagnoses Among PLWH

This includes data sharing and integration among HIV, STD, and TB surveillance programs, routine data sharing between CDPH and DHCS, to track HIV, STD, and TB diagnoses. (Also see related activity M3.) This activity will include work within the OA to integrate HIV, STD, and TB surveillance data collection systems, then train local health jurisdiction surveillance staff on effective data sharing and tracking processes for HIV, STD, and TB data. It will also require CDPH



and DHCS staff to work together to develop routine data sharing processes between Medi-Cal and CDPH surveillance systems; identify structural, policy, and funding barriers and facilitators for integrating HIV, STD, and TB tracking in to electronic health records (EHR) systems; and implement changes necessary to support further integration. CDPH and DHCS will collaboratively implement and maintain data sharing and integration processes.

Targeted Populations:

- CDPH and local health jurisdiction surveillance programs
- DHCS
- EHR developers and companies
- Major health care providers and insurance plans

Responsible Parties:

- OA
- CDPH STD Control Branch
- CDPH TB Control Branch
- CDPH Information Technology Services Division
- DHCS
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Surveillance Funding
- CDC STD Cooperative Agreement Funding
- CDC TB Cooperative Agreement Funding

Metrics:

- Number of data matches occurring annually between TB, STD, and HIV surveillance systems
- Number of joint reports on STD, TB, and HIV co-infections
- Rate of TB among PLWH

Activity H4: Incentivize Comprehensive Health Care Programs for PLWH (Including Dental, Vision, Mental Health, Substance Use, Acupuncture, and Chiropractic Along with Medical Care)



This includes incentivizing and otherwise encouraging medical providers to offer comprehensive health care services in one location through the use of the PCMH model. To do this, OA, local health jurisdictions, and other stakeholders will need to work together to determine an appropriate means of incentivizing comprehensive health care programs to encourage HIV medical providers to expand and collaborate to co-locate comprehensive health care services for PLWH.

Targeted Populations:

- Medical providers who care for PLWH

Responsible Parties:

- OA
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding

Metrics:

- Percentage of PLWH with an unmet need for mental health services
- Percentage of PLWH with an unmet need for substance use treatment services
- Percentage of PLWH with an unmet need for dental/oral health care
- Percentage of PLWH with an unmet need for vision services

STRATEGY I: Improve Case Management for PLWH with High Need



Case management is a service category under the Ryan White HIV/AIDS Program, and a well-recognized strategy for helping PLWH to stabilize their lives, stay engaged in medical care, and achieve viral suppression. While there are many robust case management programs for PLWH throughout California, there are still some areas in which improvement is needed, including for homeless and incarcerated PLWH, or those

at various stages of infection and illness. This strategy is designed to address some of these currently-existing gaps.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who are *engaged in care and retained in care*, as well as the proportion who are *virally suppressed*.

Activity I1: Increase Case Management Services for PLWH with Demonstrated Need from Diagnosis through Viral Suppression



This includes supporting case management positions in medical clinics and community organizations, and strengthening systems for linkage to medical and non-medical case managers at the time of diagnosis, at the time of linkage to care, and/or as part of treatment adherence programs. This will require that local health jurisdictions and planning councils allocate a larger percentage of available Ryan White Part A and B funding to case management services, to support increases in case management positions in areas where needed. OA, local health jurisdictions, or CBA providers will also provide technical assistance to community organizations to strengthen systems for linkage to case managers at the time of diagnosis and/or as part of treatment adherence programs.



Targeted Populations:

- HIV testing organizations, medical clinics, and community organizations that provide case management and/or treatment adherence.

Responsible Parties:

- OA
- Local health jurisdictions
- Community-based organizations that support administration of Ryan White HIV/AIDS Program funds and/or the AIDS Medi-Cal Waiver Program (MCWP)
- Community organizations that provide HIV testing
- California Statewide Training and Education Program (CSTEP) contractor

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- (Years 1-5) TA from the CSTEP contractor to provide CBA to medical clinics to establish in-house benefits counseling, or develop strong systems for linkage to such support

Metrics:

- Number of PLWH receiving case management services
- Number of PLWH receiving Ryan White-funded case management services within 30 days of diagnosis

Activity I2: Work with Transitional Case Management Programs for PLWH Leaving Correctional Facilities



This includes working with existing programs that provide case management and linkage to care for PLWH recently released from jails, prisons, and youth detention centers in California. It also includes training and education for HIV care providers on the unique needs of PLWH when they are transitioning into standard care settings after release from a correctional facility. OA, local health jurisdictions, and local correctional staff will work together to develop and establish effective data sharing mechanisms to facilitate communication around PLWH being released from correctional facilities.

Targeted Populations:

- Local health department staff, medical clinics, and/or community organizations that serve PLWH recently released from jail or prison
- Health care staff within correctional facilities



Responsible Parties:

- OA
- Local health jurisdictions
- California Correctional Health Care Services and CDCR

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding (Early Intervention Services category)
- HRSA Ryan White Part B Supplemental Funds

Metrics:

- Number of PLWH receiving transitional case management services
- Number of PLWH released from state prisons who are linked to care within 30 days of release (2012-13 baseline 36 percent; goal at least 85 percent)
- Number of jail health care providers using ARIES for coordination of care

Activity I3: Continue to Collaborate with DHCS to Administer MCWP



This includes conducting community outreach to potential MCWP agencies, potential service providers, and/or groups in the community who are institutionalized, and assisting them to recognize the opportunities to provide meaningful access to services for all eligible people. It also includes training medical and service providers to recognize opportunities for PLWH who are Medi-Cal eligible to receive comprehensive case management and direct/non-direct care services as an alternative to long-term care placement. Finally, it will involve increased collaboration with local agencies to support the establishment or growth of the number of MCWP providers within underserved local health jurisdictions.

Targeted Populations:

- Community-based organizations serving PLWH
- Faith-based organizations
- Existing Ryan White-funded providers
- Home health agencies
- County public health departments
- Hospital and skilled nursing facility discharge planners
- Primary medical care providers who serve PLWH



Responsible Parties:

- OA
- DHCS
- Local health jurisdictions
- Centers for Medicare and Medicaid Services (CMS)

Existing Resources Committed Toward Implementing the Activity:

- Existing State General Fund committed to MCWP
- CMS

Metrics:

- Number of local health jurisdictions with MCWP providers
- Number of eligible clients receiving MCWP case management services

Activity I4: Identify Homeless ADAP Clients for Referral to Housing Providers



This includes developing a system for routinely screening ADAP clients for unstable housing situations during annual ADAP re-enrollment when proof of residency is required, and supporting their immediate linkage to local housing providers when unstable housing is noted. Staff from ADAP and ADAP enrollment workers will work together to systematize the screening of clients for unstable housing and linkage to supportive housing services as indicated. Staff from the OA, local health jurisdictions, local housing providers, and/or HOPWA will continuously work to identify housing agencies that will provide immediate housing to people with unstable housing living with HIV.

Targeted Populations:

- ADAP clients
- ADAP enrollment workers
- HOPWA providers

Responsible Parties:

- OA

**Existing Resources Committed Toward Implementing the Activity:**

- HRSA Ryan White Part B ADAP Funding
- HRSA Ryan White Part B Base Funding
- HUD's HOPWA Funding
- HRSA Ryan White Part B ADAP Earmark Funding
- ADAP Rebate Fund

Metrics:

- Percentage of ADAP clients who are stably housed

STRATEGY J: Increase Rates of Insurance/Benefits Coverage for PLWH or on PrEP

In California, there is no reason that a PLWH should lack care or treatment because of financial reasons. Multiple programs are available to ensure that ability to pay is not a criterion for high-quality care. However, there are still PLWH in California who are uninsured, not enrolled in ADAP, or unable to pay their Covered California premiums or co-pays. The activities under this strategy are designed to increase the number of PLWH in California who have comprehensive health

insurance. In addition, this strategy will address gaps among those at highest risk of HIV infection in need of PEP or PrEP services.

This strategy will address gaps along the HIV Care Continuum in California by increasing the proportion of PLWH who are *engaged in care and retained in care*, as well as the proportion who are *virally suppressed*.

Activity J1: Require HIV Care Program Providers to Coordindate Timely Enrollment in Health Coverage and ADAP, if Applicable

This includes collaboration with OA, local Medi-Cal offices, Covered California enrollers, and providers to develop protocols, as well as a state-wide assessment of the location of enrollment sites, possible expansion of the capacity for OA to approve and certify new entities as ADAP enrollment sites, and an increase in trainings for staff to become certified enrollment/eligibility workers.

Targeted Populations:

- Ryan White-funded care providers that conduct enrollment and recertification for Ryan White HIV/AIDS Program services
- HIV targeted testing sites funded by OA

**Responsible Parties:**

- OA

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B ADAP Funding
- ADAP Rebate Fund

Metrics:

- Number of HIV Care Program providers that are ADAP enrollment sites
- Number of OA Prevention-funded targeted testing sites that are ADAP enrollment sites

Activity J2: Locate Culturally/Linguistically-appropriate ADAP Enrollment Sites in Affected Communities of Color


This includes identifying suitable sites for approval and certification as ADAP enrollment sites, and supporting them in successfully completing the approval and certification process. To do this, OA and local health jurisdictions will work together to conduct an assessment to determine suitable sites that provide culturally and linguistically-appropriate services for PLWH who are part of the most highly affected communities of color, and link them to local ADAP enrollment sites or contract with them to become ADAP enrollment sites. OA may also conduct site visits for potential new ADAP enrollment sites, develop contracts, and train staff to become certified enrollment workers.

Targeted Populations:

- Community-based organizations and medical clinics that provide culturally and linguistically-appropriate services for PLWH who are part of affected communities of color

Responsible Parties:

- OA
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B ADAP Funding
- ADAP Rebate Fund
- HRSA Ryan White Part B Minority AIDS Initiative Funding

Metrics:

- Number of ADAP enrollment sites located in census tracts with high rates of HIV among people of color

**Activity J3: Provide Incentives to ADAP Enrollment Sites for Enrolling Eligible Individuals into ADAP/OA-HIPP within a Week of Diagnosis**

This includes collaborative work between OA, local health jurisdictions, and medical/service provider stakeholders to determine an affordable incentive that is feasible to implement, then educating medical clinics and HIV test providers about the importance of early Medi-Cal and ADAP/OA-HIPP enrollment and the availability of incentives for enrollment that occurs within a week of diagnosis into ADAP and OA-HIPP. Individuals who are not eligible for ADAP due to meeting Medi-Cal eligibility criteria will be referred to Medi-Cal in order for the client to have access to life saving medications and to ensure ADAP is the payer of last resort.

Targeted Populations:

- HIV medical care providers
- HIV testing providers

Responsible Parties:

- OA
- Local health jurisdictions
- ADAP enrollment sites

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B ADAP Funding
- ADAP Rebate Fund
- (Years 3-5) TA from CBA providers to educate staff of medical clinics and HIV testing providers about the new system to incentivize enrollment within a week of diagnosis

Metrics:

- Number of PLWH enrolled into ADAP and OA-HIPP within a week of diagnosis

Activity J4: Develop a System to Assist PLWH Paying Initial Health Insurance Premiums for Individuals Enrolled in ADAP

This includes collaboration between the OA Insurance Benefits Manager contractor, Covered California, and insurance providers to explore a mechanism to make initial premium payments. It also includes discussion within OA, in collaboration with various stakeholders, to develop and implement updated policies and procedures for timely submission of health insurance documentation, as well as a statewide assessment of ADAP enrollment sites that also conduct Covered California enrollment.



Targeted Populations:

- Low-income PLWH who are eligible for OA-HIPP and newly enrolling in Covered California

Responsible Parties:

- OA
- Local health jurisdictions
- Covered California
- Community-based organizations who serve OA-HIPP clients
- Insurance providers

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B ADAP Funding
- ADAP Rebate Fund

Metrics:

- Number of PLWH enrolled in OA-HIPP

STRATEGY K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

People who inject drugs comprised approximately 14 percent of the PLWH in California with diagnosed HIV infection during 2014. However, many more people living with or at risk for HIV in California use drugs and do not inject them. California is steadfastly committed to a harm reduction approach to substance use, and emphasizes education and implementation of harm reduction models for all HIV prevention and care

providers funded by OA. Active drug users are frequently good candidates for PrEP, antiretroviral treatment, case management, and other services. They deserve excellent service and high-quality health care just like all PLWH. The activities within this strategy are intended to prevent HIV and further improve overall health for people who use drugs by increasing and improving HIV prevention and support services designed for this population.

Activity K1: Integrate Syringe Exchange into Existing HIV Programs



This includes providing training to HIV service providers about how to provide safe, effective, and culturally-competent syringe exchange programs as part of their regular services, and supporting them to purchase and distribute syringes and safer injection supplies. After developing an easily-replicated model for integration of syringe exchange services into existing HIV services, the model will be piloted and training for service providers will be developed out of the pilot.



Targeted Populations:

- HIV service providers not already offering syringe exchange services

Responsible Parties:

- OA
- Local health jurisdictions
- CBA providers

Existing Resources Committed Toward Implementing the Activity:

- State General Fund – Syringe Exchange Supply Clearinghouse
- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part B Base Funding to support staff and program infrastructure
- (Years 1-3) TA from CBA providers to develop an easily replicated model for integration of syringe exchange services into existing HIV services, including in clinical settings
- (Years 4-5) TA from CBA providers to develop educational materials and conduct trainings with staff of community-based HIV service providers who are not already offering syringe exchange services but serve clients who inject drugs

Metrics:

- Number of Ryan White-funded programs that offer syringe exchange services
- Number of OA prevention-funded programs that offer syringe exchange services

Activity K2: Fund New Syringe Exchange Programs



This includes identifying areas of unmet need for syringe exchange services, and allocation of funding granted by Senate Bill (SB) 75 as well as Assembly Bill (AB) 1605, Committee on Budget, Statutes of 2016 to support the establishment of new programs.

Targeted Populations:

- Community-based organizations and health departments who currently serve people who inject drugs in underserved areas within California

Responsible Parties:

- OA
- Local health jurisdictions
- CBA providers



Existing Resources Committed Toward Implementing the Activity:

- AB 1605 and SB 75 funding to support the establishment of new syringe exchange programs, including staff training and purchase and distribution of syringes and safer injection supplies
- (Years 2-3) TA from CBA providers to determine the greatest areas of unmet need
- HRSA Ryan White Part B Base Funding to support staff and program infrastructure

Metrics:

- Percentage of Californians living within 50 miles of a syringe exchange program or pharmacy that sells syringes without a prescription
- Number of counties with syringe exchange programs

Activity K3: Implement Harm Reduction-based Models of HIV Prevention and Care Services that Integrate Other Health Services Critical to People Who Use Drugs



This includes educating providers about the importance of maintaining opportunities for active drug users to access PrEP, case management, and antiretroviral treatment and encouraging the elimination or modification of sobriety requirements for services when possible. It also includes incorporating viral hepatitis vaccination, testing, and linkage services as well as STD testing and treatment into HIV prevention and care services when possible.

Targeted Populations:

- OA-funded HIV prevention and care providers

Responsible Parties:

- OA
- Local health jurisdictions
- CBA providers

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- (Years 1-5) TA from CBA providers to provide education and training to service providers about harm reduction and increasing access to prevention and care for people who use drugs

**Metrics:**

- Number of trainings provided
- Number of providers trained

Activity K4: Encourage Naloxone Programs throughout the State

This includes working with pharmacies and pharmacy corporations to understand and act upon the 2016 regulations by the California State Board of Pharmacy for pharmacists to furnish naloxone without a prescription. It also includes educating staff of community organizations to encourage the purchase and use of naloxone to prevent overdose, as well as routinely providing overdose awareness and prevention training for HIV prevention and care providers and clients at OA-funded sites. Finally, OA will work with the ADAP Medical Advisory Committee and other stakeholders to discuss adding naloxone and buprenorphine to the ADAP formulary to increase accessibility for PLWH.

Targeted Populations:

- Ryan White-funded care providers
- Community-based organizations that serve people who use drugs
- Pharmacies
- Clients of OA-funded programs
- ADAP Medical Advisory Committee

Responsible Parties:

- OA
- Local health jurisdictions
- CBA providers

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part B ADAP Earmark Funding
- (Years 1-5) TA from CBA providers to work with community-based organizations and Ryan White-funded care providers that serve people who use drugs, as well as clients of these organizations, to train them on the proper use of naloxone

Metrics:

- Number of naloxone trainings provided to service providers
- Number of naloxone trainings provided to clients of OA-funded programs
- Presence of absence of naloxone and buprenorphine on the ADAP formulary



Activity K5: Encourage Access to Syringes through Nonprescription Sale of Syringes in Pharmacies



This includes training and technical assistance efforts to pharmacists to encourage non-prescription syringe sale. As part of this activity, OA staff will work with the ADAP Pharmacy Benefit Manager to assess which ADAP pharmacies sell syringes without a prescription.

Targeted Populations:

- Pharmacies within the ADAP network, including large chain pharmacies
- California Pharmacists Association

Responsible Parties:

- OA
- Local health jurisdictions
- CBA providers

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (12-1201)
- (Years 1-5) TA from CBA providers to train pharmacists in the public health benefits of non-prescription syringe sale, and the requirements of the law governing its practice

Metrics:

- Percentage of ADAP pharmacies that sell syringes without a prescription

Activity K6: Encourage Access to Medication-assisted Treatment (Methadone and Buprenorphine/Suboxone) for People with Opioid Addiction

Medication-assisted treatment for opioid addiction has been shown to reduce injection frequency, improve health, and reduce the rate of death from overdose for people who use opioids. This activity includes collaborative work between OA, local health jurisdictions, DHCS, and CBA providers to increase the number or capacity of existing methadone treatment programs in California, particularly in underserved areas, as well as to encourage medical providers to become certified buprenorphine prescribers and prescribe the medication to their patients when indicated. More information on CDPH's efforts related to addressing opioid use is available in this [2016 report](#).



Targeted Populations:

- Methadone treatment programs
- Physicians who serve patients who are dependent on opioids

Responsible Parties:

- OA
- Local health jurisdictions
- DHCS
- CBA providers

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (12-1201)
- (Years 1-5) TA from CBA providers to support the expansion of medication-assisted treatment programs in California
- HRSA Ryan White Part B Base Funding

Metrics:

- Percentage of Californians living within 50 miles of a medication-assisted treatment provider (methadone treatment program or buprenorphine prescriber)

STRATEGY L: Increase General HIV Education and Awareness and Reduce Stigma Around HIV, Sexual Orientation, and Gender Identity

California has worked hard to target its public health-funded HIV education efforts and other HIV prevention interventions to those who are at highest risk for HIV infection, in order to maximize the use of limited public health resources. However, there remains a need to raise awareness and improve HIV knowledge in the

general population of California, both to prevent new HIV infections and to reduce HIV stigma. Stigma is a major challenge for PLWH, and research has shown that the more people know about HIV, the less likely they are to stigmatize people living with, or at risk for, the virus.

Activity L1: Work to Ensure that All California Pupils in Grades 7-12 Receive Comprehensive, Medically Accurate Sexual Health and HIV Prevention Education



Collaborate with the California Department of Education (CDE) and the CDPH STD Control Branch to fully implement the California Healthy Youth Act (Education Code Chapter 5.6), which became law on January 1, 2016, including the CDE's focus population of lesbian, gay, bisexual, and transgender (LGBT) youth as prescribed in the CDC Division of Adolescent and School Health (DASH) Grant. The California Healthy Youth Act requires that all school districts in the state



of California ensure that pupils grade 7-12 receive comprehensive, medically accurate sexual health education and HIV prevention education. This activity includes staff from CDE Coordinated Student Support Division reviewing curricula developed by outside entities for compliance with the California Health Youth Act, and posting this review information on CDE's website to allow local school districts to choose the most compliant curricula that meets the needs of their student population. It also includes OA staff participating in ongoing activities of the CDE's DASH funding opportunity initiative and the Adolescent Sexual Health Working Group.

Targeted Populations:

- California youth

Responsible Parties:

- CDE Coordinated Student Support Division
- CDPH STD Control Branch
- OA

Existing Resources Committed Toward Implementing the Activity:

- CDC DASH funding to CDE

Metrics:

- Percentage of the 13 priority school districts working with DASH and the 4 CDC independently-funded districts (San Diego Unified, Los Angeles Unified, Oakland Unified, and San Francisco Unified) which have become compliant with the California Healthy Youth Act
- Number of California Healthy Youth Act compliant curricula posted to the CDE website
- Percentage of LGBT youth experiencing bullying at school or electronically (from the Youth Risk Behavioral Survey)

Activity L2: Work with Service Providers to Develop Clear and Consistent Messaging around HIV Statewide



This includes determination of accurate, easy-to-understand messages that are culturally competent and reduce stigma whenever possible, for a wide variety of HIV-related issues, including transmission, testing, and treatment. It also includes the broad dissemination of these messages throughout all local health jurisdictions, to ensure consistency of use in multiple settings throughout the state.



Targeted Populations:

- HIV service providers
- Key populations at highest risk for HIV in California
- General public

Responsible Parties:

- OA
- Local health jurisdictions
- Key stakeholder community-based organizations

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC PrEP Funding (PS 15-1506)

Metrics:

- Development of a communications strategy

Activity L3: Continue Widespread Condom Promotion and Distribution

This includes the purchase and distribution of condoms to venues providing services to people at highest risk for acquiring HIV through sexual transmission. In addition, OA, local health jurisdictions, and community-based organizations will continue to provide education about the importance of condom use in decreasing HIV transmission.

Targeted Populations:

- Californians at risk of HIV through sexual transmission

Responsible Parties:

- OA
- Local health jurisdictions
- Community-based organizations

Existing Resources Committed Toward Implementing the Activity:

- Leverage federal cooperative agreement funding
- CDC HIV Prevention Funding (PS 12-1201)

**Metrics:**

- Annual number of condoms distributed statewide

Activity L4: Work to Ensure that HIV Infection is Decriminalized throughout California

This activity includes community partners working to modernize criminal laws to eliminate HIV-specific statutes, and ensure that any prosecution on the basis of HIV requires: 1) proof of an intent to harm; 2) conduct that is likely to result in that harm; 3) proof that the conduct of the accused in fact resulted in the alleged harm; and 4) punishment that is proportionate to the actual harm caused by the defendant's conduct.

Targeted Populations:

- Community advocates

Responsible Parties:

- Community advocates

Existing Resources Committed Toward Implementing the Activity:

- No state resources committed to advocacy. Staff time paid by State General Fund to analyze any introduced legislation.

Metrics:

- Number of HIV-specific criminal laws in California State Statute



STRATEGY M: Improve Usability of Collected Data

It is always important to collect data that allows us to measure, track, and better understand the populations served and the effectiveness of the work done in the field of HIV. However, sometimes data are collected that simply are not readily used to improve programs, either because there is not

sufficient capacity to analyze the data and modify work accordingly, or because the data collected are not quite right for proper analysis. The activities within this strategy are intended to help ensure that data collected by service providers are used to the best of everyone's ability.

Activity M1: Improve Tracking of HIV Prevention and Care Outcomes in Patients Enrolled in Medi-Cal, Covered California Qualified Health Plans, and Other Large Health Insurance Plans and Providers



This includes monitoring measures of the HIV care continuum by health plan, and tracking HIV testing and sexual health screening rates. To do this, CDPH, DHCS, and Covered California will work together with large health plans to develop monitoring metrics for HIV prevention and care activities, and implement routine reporting on monitoring metrics for Medi-Cal Managed Care Plans and Covered California Qualified Health Plans.

Targeted Populations:

- Medi-Cal providers
- Covered California Qualified Health Plans
- Large health insurance companies and providers

Responsible Parties:

- OA
- CDPH STD Control Branch
- DHCS
- Covered California

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Surveillance Funding
- Public and private health insurance

Metrics:

- Release of annual Continuums of HIV Care for Medi-Cal, Covered California Qualified Health Plans, and other large health insurance plans



Activity M2: Integrate HIV-related Interventions into the Major EHRs in Use in California



This includes working closely with major health systems and their EHR providers to achieve the addition of HIV-related interventions to their standard forms and data screens. (Also see related activity H3.)

Targeted Populations:

- Major health systems in California (e.g., Kaiser Permanente, Sutter Health, One Medical, key university hospital systems, etc.)
- EHR providers (e.g., NextGen, Epic, eClinicalWorks, McKesson, etc.)

Responsible Parties:

- OA
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- Public and private health systems and EHR provider resources

Metrics:

- Number of Ryan White Part B providers that are submitting data to OA using exports from EHR systems.

Activity M3: Coordinate Definitions and Data Related to HIV Prevention and Care Interventions Across State and Local Levels, Including Measures Related to Experiences of Stigma and Interventions to Address Stigma



This includes creating a crosswalk of federal, state, and local definitions and data variables related to HIV prevention and care interventions, then determining what adjustments can be made at the state and local levels to improve alignment and usability of data related to program delivery and outcomes throughout the state.

Targeted Populations:

- State and local data systems for capturing HIV prevention and care-related data

Responsible Parties:

- OA

**Existing Resources Committed Toward Implementing the Activity:**

- CDC HIV Prevention Funding (12-1201)
- CDC HIV Surveillance Funding

Metrics:

- Number of definitions for Partner Services and linkage to care variables in use in prevention, care, and surveillance databases
- HIV Adult Case Report Form updates to make form consistent with Partner Services and linkage to care variable definitions

Activity M4: Improve Completeness and Consistency of Data Collection for: a) Gender Identity; b) Sexual Orientation; c) Housing, d) Substance Use; and e) Mental Health Status

This includes the identification of the most appropriate standard measures for these categories through an assessment of definitions and data at various levels, along with work with federal partners when inconsistencies originate at the federal level. Then CDPH, in partnership with key stakeholders in each category, will improve consistency statewide through drafting and distributing guidance throughout state and local levels regarding the best data measures to use in each of these categories, and why that is recommended. Finally, OA will work in partnership with key stakeholders to make necessary changes to data collection systems and databases.

Targeted Populations:

- State and local data systems for capturing HIV prevention and care-related data

Responsible Parties:

- OA, in partnership with key stakeholders in each category

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Surveillance Funding
- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part B Base Funding
- HRSA Ryan White Part B ADAP Earmark Funding

Metrics:

- Percentage of PLWH receiving Ryan White services with a housing status recorded within the previous year

**Metrics (continued):**

- Percentage of ADAP clients with a housing status recorded within the previous year
- Development of processes and written guidance for using HIV prevention data to complete HIV surveillance data collection

Activity M5: Explore the Development of a System to Accurately Measure PLWH Moving Between Care Systems


This includes collaborative work between HIV surveillance, prevention, and care staff at the state and local levels to devise a data solution that will accurately capture the majority of PLWH who have chosen to seek care at a different location, but have *not* fallen out of care.

Targeted Populations:

- HIV care, prevention, and surveillance health department staff

Responsible Parties:

- OA
- Local health jurisdictions
- DHCS
- Private insurance providers

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding
- CDC HIV Surveillance Funding

Metrics:

- Development of communication strategies between providers looking for clients potentially out of care and local health department surveillance staff
- Proportion of clients in the statewide HIV surveillance system who are accurately classified as out of care



STRATEGY N: Enhance Collaborations and Community Involvement

PLWH and other key stakeholders within the community are absolutely critical to the success of HIV surveillance, prevention, and care in California. From the start of the HIV epidemic, the activism and caretaking of gay men, women, and others had a dramatic impact on HIV prevention and care. Involving the community in every aspect of HIV work from planning through implementation and evaluation is a major component of the work

that OA and local health jurisdictions do every day. Yet, especially when time or resources are limited, lack of communication, or unrealized opportunities for collaboration can increase redundancy and reduce efficiency and cost effectiveness of services. For this reason, the activities within this strategy are designed to help California enhance collaborations and community involvement even further.

Activity N1: Improve Utilization of Community Engagement Strategies at Both State and Local Levels, Especially Involving PLWH



This includes systematically examining representation of PLWH and other key populations on community planning councils and other advisory groups, and working with key stakeholders to devise strategies to balance representation as needed. It also includes working with key stakeholders to increase the quantity and quality of opportunities for community members to give direct input into strategies and activities at all phases of development, implementation, and evaluation. Finally, it includes an annual report-out on progress on meeting Integrated Plan objectives from OA to the CPG during an in-person CPG meeting. The CPG membership has representatives from each of the local HIV planning councils and groups in California, who are responsible for sharing information from OA with their local planning councils/groups.

Targeted Populations:

- PLWH and other key populations in the community

Responsible Parties:

- OA
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- HRSA Ryan White Part B Base Funding

Metrics:

- Number of OA documents where stakeholders had an opportunity to provide feedback before document was finalized



Activity N2: Enhance Direct Collaborations Between HIV/STD/Viral Hepatitis Prevention and Surveillance Programs at the State and Local Levels



This includes developing a written plan for integration of CDC HIV prevention and HIV surveillance grants, creating a single guidance document, and training on data security and confidentiality as well as concrete strategies for collaborative work between these programs.

Targeted Populations:

- HIV and STD prevention health department staff
- HIV and STD surveillance health department staff

Responsible Parties:

- OA
- CDPH STD Control Branch
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)
- CDC HIV Surveillance Funding

Metrics:

- Unified guidance on data security and confidentiality for use of HIV surveillance data at the state and local levels
- Number of local health jurisdiction staff who received training on the unified security and confidentiality guidance

Activity N3: Coordinate HIV Prevention and Care Activities for the Criminal Justice Population throughout California



This includes collaborative work between staff of OA, local health jurisdictions, CDCR, and others serving the criminal justice population in California to determine synergies and opportunities for new or enhanced programs that will benefit incarcerated PLWH and those at risk for HIV infection while incarcerated, PLWH who are newly arrested, and PLWH who are released from jail, prison, or juvenile detention facilities.

Targeted Populations:

- Incarcerated PLWH



Targeted Populations (*continued*):

- PLWH who are recently arrested, released, or paroled
- People at risk for HIV while incarcerated

Responsible Parties:

- OA
- CDCR
- Local health jurisdictions

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (12-1201)
- HRSA Ryan White Part A Funding
- HRSA Ryan White Part B Base Funding

Metrics:

- Percentage of PLWH released from state correctional facilities that are linked to care within 30 days of release
- Percentage of PLWH released from county jail facilities that are linked to care within 30 days of release
- Number of local correctional facilities using ARIES to coordinate care for PLWH

Activity N4: Work More Closely with Other Payers, Including Medi-Cal and Covered California Qualified Health Plans



This includes collaboration between staff of OA, DHCS, and Covered California to develop and implement new and modified strategies to improve coverage for HIV-related care following implementation of the ACA.

Targeted Populations:

- PLWH
- People at risk for HIV who receive HIV testing, PrEP, or other preventive care through medical providers

Responsible Parties:

- OA
- DHCS
- Covered California


Responsible Parties (continued):

- California Department of Insurance
- California Department of Managed Health Care

Existing Resources Committed Toward Implementing the Activity:

- Public and private health insurance

Metrics:

- Percentage of PLWH enrolled in Medi-Cal who are virally suppressed
- Percentage of PLWH enrolled in each Covered California Qualified Health Plan who are virally suppressed
- Percentage of Medi-Cal clients who have been screened for HIV

Activity N5: Improve Partnerships Between Local Health Departments and Primary Care Providers


This includes efforts to increase communication between local health department staff and primary care providers in the jurisdiction (both providers who work in local public health clinics and those who work in private settings). It also includes the development of concrete strategies for collaboration and information-sharing between local health departments and primary care providers.

Targeted Populations:

- Primary care providers

Responsible Parties:

- Local health jurisdictions
- California Primary Care Association

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (PS 12-1201)

Metrics:

- Number of out-of-care/linkage-to-care referrals received from non-Ryan White providers



STRATEGY O: Further Leverage Existing Resources to Better Meet the Needs of People at Risk for and Living with HIV in California

Overall budgets for HIV work are often fixed, and able to be increased only through successful applications for supplemental grant funding for particular activities. However, within existing allocations of funding, there are opportunities to make adjustments to maximize the ability of

service providers to meet the needs of PLWH and people at risk for HIV. The activities within this strategy are designed to address some specific ways that existing funding allocations can be modified to improve the effectiveness of service provision.

Activity O1: Ensure the Most Appropriate Distribution of Funds in Order to Best Meet the Needs of People at Risk for and Living with HIV in California



This includes reviewing current funding allocations to determine geographic gaps in funding, current expenditures, capacity to utilize funds, disproportionate funding as a result of local health department subcontracting, shifts from specialty services to general clinical services as a result of ACA implementation, and issues with funding disparities related to PLWH being diagnosed in one county but moving to another county. OA and CDPH's Office of Health Equity will work collaboratively to complete this review.

Targeted Populations:

- Local health jurisdictions
- HIV Care Program service providers

Responsible Parties:

- OA
- CDPH Office of Health Equity

Existing Resources Committed Toward Implementing the Activity:

- CDC HIV Prevention Funding (12-1201)
- CDC HIV Surveillance Funding
- HRSA Ryan White Part B Base Funding
- HUD's HOPWA Funding
- HRSA Ryan White Minority AIDS Initiative Funding

Metrics:

- New allocation funding formulas approved for use by CCLAD, CPG, and the OA Stakeholder Advisory Committee



Activity O2: Evaluate Statewide Need for MCWP Services Among Eligible PLWH



This involves close collaboration between OA and DHCS, with the involvement of key stakeholders as appropriate, to ensure that the client population service needs and sufficient resources are clearly identified. To do this, responsible parties may conduct an assessment of service needs, fully describe available resources, and determine the resources needed to meet the current needs.

Targeted Populations:

- PLWH who are Medi-Cal eligible, meet the nursing facility level of care, and have a Cognitive and Functional Ability Score of less than 60
- MCWP service providers

Responsible Parties:

- OA
- DHCS
- MCWP providers

Existing Resources Committed Toward Implementing the Activity:

- Existing State General Fund for MCWP
- CMS funding to DHCS

Metrics:

- Number of PLWH enrolled in Medi-Cal with a need for MCWP services

Activity O3: Transition at Least Some HIV Care Program Contracts from a Consortia Model (in which State Funding goes to a Local Health Jurisdiction to then Subcontract Out Services) to a Direct Services Model (in which State Funding goes Directly to Agencies Providing Services)



This will include an examination of the risks and benefits of shifting this model for funding allocation. Currently, all funds to consortia are considered support services by HRSA, a significant challenge given the Ryan White Care Act legislation requires grantees to spend no more than 25 percent on support services. To do this, OA will explore the development of a proposal to transition selected HIV Care Program contracts, and vet the proposal with CPG and CCLAD. If recommended, OA and local health jurisdictions will then work together to implement the changes in funding model.



Targeted Populations:

- Local health jurisdictions
- HIV Care Program service providers

Responsible Parties:

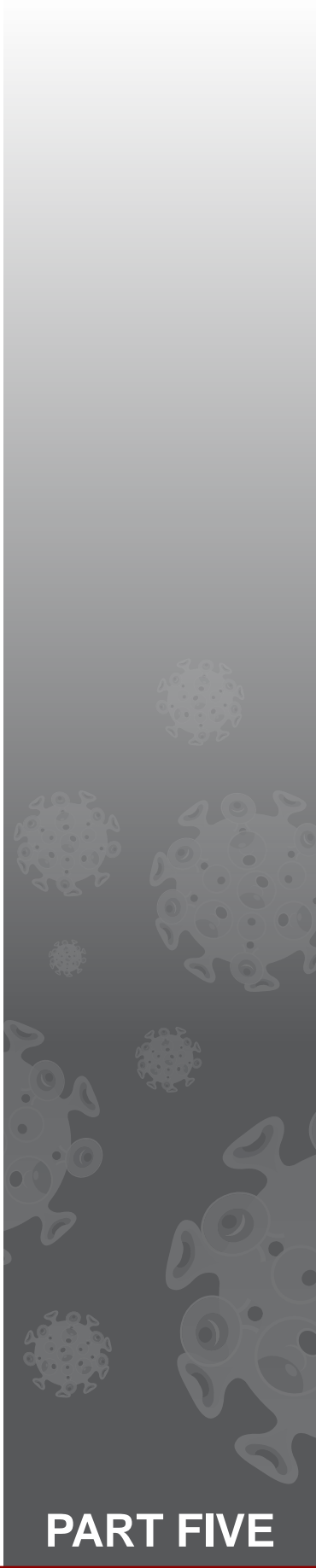
- OA

Existing Resources Committed Toward Implementing the Activity:

- HRSA Ryan White Part B Base Funding

Metrics:

- Percentage of HIV Care Program funds classified as direct services by HRSA



PART FIVE

Anticipated Challenges and Barriers



While the goals, objectives, strategies, and activities in this plan are intended to be realistic and achievable, there will inevitably be challenges in achieving this ambitious set of objectives. One of the keys to mitigating barriers and overcoming challenges is anticipating them beforehand and planning ahead; another is maintaining flexibility so that approaches can be modified as needed to maximize effectiveness.

Funding

One of the main challenges anticipated during the next five years is difficulties implementing new efforts given resource constraints, or provision of funds that are targeted at activities not covered by this Integrated Plan. There are a number of existing resources that can be leveraged to implement this plan.

Staff Time

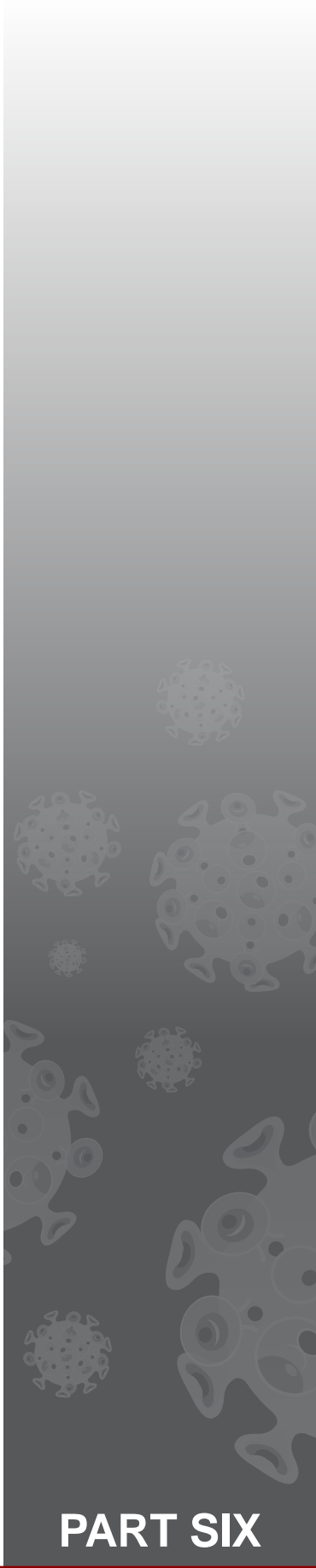
Similarly, many of the activities outlined in this plan, including those that do not require the allocation of additional funds, require a significant amount of staff time from OA, local health departments, and other state departments and organizations. In days of limited resources and often-sparse staffing, competing schedules and employees with too much on their plates can unwittingly become barriers to progress as time passes without action. Scheduling regular meetings at consistent times and working from concrete timelines and work plans when feasible will help keep activities on track as much as possible.

Differing Guidance from Federal Funders

Guidance related to different CDC-funded programs (i.e., Division of HIV/AIDS Prevention, Division of Sexually Transmitted Disease Prevention, Division of Viral Hepatitis) does not always align, and guidance on the same issues from CDC and HRSA sometimes conflict. This leads to situations where OA, local health jurisdictions, and community service providers must modify programs to meet grant requirements, in a manner that is not consistent with effective coordination and collaboration between programs (e.g., different definitions for homeless/unstably housed). Whenever possible, these conflicts will be addressed through conversation with federal funders and negotiation to mitigate conflicts or improve coordination.

Administrative Barriers

The diversity of resources available in California provide opportunities for collaboration and shared efforts that are not available in smaller states. However, some aspects of the governmental structures that accompany a large state government, as well as some large local governments, create challenges with getting resources to where they are needed in a timely fashion, and may make it difficult to respond to emerging issues quickly. We strive to use funding as effectively as possible given the constraints of local and state bureaucracies, and welcome further discussions among key stakeholders regarding how we can improve and streamline our administrative functions.



PART SIX

Collaborations, Partnerships, and Stakeholder Involvement



California is strongly committed to the involvement of stakeholders and other key partners in the planning and implementation of strategies to prevent HIV transmission and care for Californians living with HIV. We can achieve our collective vision of “Getting to Zero” in California only through collaboration with many partners and a determined effort to implement evidence-based strategies to prevent HIV and care for PLWH. To that end, we have developed this Integrated Plan through a joint effort between OA, local health jurisdictions, and HIV planning bodies in California, in collaboration with other state programs that serve PLWH, including DHCS, Covered California, CDE, and CDCR, as well as key stakeholders in the private and non-profit sectors. To develop the plan, we engaged our ongoing stakeholder groups, including the California Planning Group, the OA Stakeholder Advisory Committee, the California Conference of Local AIDS Directors, and local HIV planning bodies, and held special meetings including stakeholders from throughout the state specifically designed to gather input needed to develop the Integrated Plan. This process engaged people at higher risk for HIV infection, PLWH, service delivery providers, and other community stakeholders throughout the state, through a number of mechanisms to gather feedback.

CPG membership is comprised of 17-23 members who are appointed by OA following both a nomination process conducted by local planning bodies, and an open application process conducted by OA. The CPG membership includes one representative from each of the local HIV planning councils/groups who serves as a nominated CPG member, as well as at-large members representative of those involved in the prevention, care and treatment of HIV throughout the state, either as consumers or service providers. The selection process takes into consideration the knowledge, experience, and expertise of each prospective member and ensures that the CPG reflects the diversity of the HIV epidemic in California, based on HIV

status, age, gender identity, race/ethnicity, sexual orientation, and geographic/metropolitan statistical area distribution (e.g., urban and rural residence). Currently, all CPG members commit to a three-year term of service, with a new cohort of CPG members appointed every three years; members may apply for a second term if desired (revisions to the length of terms of service are planned for the CPG membership term that begins on March 1, 2017). The main function of CPG is to work with OA to develop a comprehensive HIV/AIDS surveillance, prevention, care, and treatment plan; to monitor the implementation of this plan; and to provide timely advice on emergent issues identified by the OA and other key stakeholder parties. CPG is committed to working openly in a group to make decisions and is guided by the principles of equity, fairness, and respectful engagement. CPG has had direct input into the development of this Integrated Plan by assisting OA in the development of the Needs Assessment, by providing input on prioritizing HIV services and subpopulations to assess, and identifying needs assessment questions, in addition to other input noted below.

The **OA Stakeholder Advisory Committee (SAC)**, organized by OA in partnership with DHCS, is a group of medical and non-medical providers, consumers, advocates, and county stakeholders. The purpose of OA SAC is to inform and provide input into policy decisions that impact the lives of Californians living with and impacted by HIV/AIDS whose wellness is impacted by federal and state HIV-funded programs.

CCLAD consists of the AIDS Directors from each of California's 61 local health jurisdictions. The purpose of CCLAD is to improve the quality and scope of health programs for HIV prevention and HIV-positive persons by promoting standards of excellence throughout the state of California. The CCLAD Executive Committee has monthly conference calls attended by the Chief of OA; the Executive Committee was updated during each conference call on progress being made on



the Needs Assessment and Integrated Plan and feedback was solicited.

California has three Eligible Metropolitan Areas (EMAs) and five TGAs that are funded by the Ryan White HIV/AIDS Program Part A, as well as two Metropolitan Statistical Areas which receive CDC HIV Prevention funding directly from CDC (San Francisco and Los Angeles). Each EMA and TGA has a **local HIV Planning Council**. OA participates in the council meetings and provides monthly written updates to the councils and other stakeholders. The updates provided regularly scheduled information to local planning council members about the development of the statewide Needs Assessment and Integrated Plan. The three Part A co-authors, Riverside/San Bernardino, Sacramento, and San Jose TGAs, worked more closely with their local planning councils on reviewing and providing input into the Needs Assessment and Integrated Plan.

In addition to these routine mechanisms for stakeholder engagement, OA held **two regional stakeholder meetings** to provide input into the development of the Integrated Plan. On April 11, 2016, a meeting was held in Sacramento (Northern California) in conjunction with our CPG meeting to begin brainstorming goals, objectives, strategies, and activities for the Integrated Plan. Seventy-four stakeholders attended from around the state, and after a series of presentations giving an overview of HIV in California, the Statewide Coordinated Statement of Need, and current strategies for 'Getting to Zero' in California, attendees split into four small groups to brainstorm ideas and prioritize strategies based on the four goals of the NHAS. A similar meeting, co-hosted by the Los Angeles Commission on HIV, was held on May 9, 2016, in Los Angeles (Southern California), to build on the work that was begun in Sacramento. At this meeting, 41 attendees broke up into four groups organized again around the goals of the NHAS, and worked to prioritize strategies generated by the group in Sacramento. The groups then discussed ways

to make the highest priority strategies more measurable, coming up with Specific, Measurable, Assignable, Realistic, and Time-related objectives when possible. Information from both of these groups strongly informed the development of the strategies and activities that appear in this Integrated Plan. These stakeholder meetings were attended by 116 people, including CPG and local planning council members, OA SAC members, and CCLAD members, including local health department representatives from all eight EMAs/TGAs and the two Metropolitan Statistical Areas which receive CDC HIV Prevention funding directly from CDC (San Francisco and Los Angeles). Ryan White HIV/AIDS Program Part C and F (PAETC) representatives were also included, as well as representatives from other state departments who serve PLWH. Also included were numerous PLWH and members of key populations, including gay men and other MSM, transgender men and women, Latino/as, African Americans, Asian/Pacific Islanders, and Native Americans. Twelve attendees were members of a California State department, 19 were representing a local health department, and 35 were representatives of community-based or health care organizations providing HIV-related services in California. Thirteen were academic/medical researchers, 9 were policy makers, 2 were pharmaceutical company representatives, 4 were independent consultants, and 22 were community advocates, and/or unaffiliated PLWH.

Finally, the Needs Assessment portion of this document was supported by collaboration with stakeholders through **three virtual Town Halls**. Co-sponsored by OA, the Ryan White HIV/AIDS Program Part A co-authors, and PAETC, these 90-minute Town Halls were held via an online Adobe Connect connection and conference call line. Invitations to the Town Halls were distributed widely to multiple stakeholder groups and were open to the public. Targeted outreach to the Native-American community and tribes was also performed. Each Town Hall focused on a particular



geographic area in California: one for Northern California; one for Southern California; and one for the Central Valley. A total of 178 people registered for one of the three virtual Town Halls. There was representation throughout California including nurses, program managers, administrative staff, case managers, advocates, public health professionals, and program managers from urban, suburban, and rural areas and from a variety of settings, including AIDS service organizations, local health jurisdictions, correctional facilities, hospitals, providers, community-based organizations, FQHCs, HIV specialty clinics, American Indian tribes, substance abuse services, faith-based settings, and HIV Planning Councils.

Health care partners, including Medi-Cal, Covered California, health insurance plans, and large health care providers, are critical partners necessary to improve outcomes along the HIV Care Continuum. Some partners have been involved in aspects of the Integrated Plan development process, including Kaiser Permanente San Francisco and DHCS, which attended the April 11, 2016, regional stakeholder meeting. Covered California has engaged with OA regarding quality initiatives,

which will provide an opportunity to implement some of the activities in this plan.

OA released two drafts of the Integrated Plan for public comment: an initial draft of the Goals and Objectives, and later, a more complete draft of the Needs Assessment and Integrated Plan. OA circulated the drafts widely to CPG, local planning councils, OA SAC, CCLAD members, other involved state departments, and all attendees of our stakeholder meetings. All comments received were thoughtfully considered and changes made to the Integrated Plan whenever possible and appropriate.

Letters of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan are available from the co-chairs of CPG and representatives of the health departments whose Ryan White HIV/AIDS Program Part A services are directly covered by this Integrated Plan (San Jose, Sacramento, and Riverside/San Bernardino TGAs). Other Part A programs were invited to provide letters of concurrence as well. See Appendix XII.



PART SEVEN

Community Engagement and People Living With HIV



As described above, impacted communities and consumers of HIV-related services were engaged in the development of the Integrated Plan in multiple ways. CPG was one main source of community engagement, because it most adequately represents consumers of HIV services in California. Ten out of the 22 CPG members (45.5 percent) are PLWH. Similar to the profile of Californians who are living with or most at risk for HIV in California, 59 percent of CPG members are male, 36 percent are female, and 5 percent are transgender. Eight out of the 22 members are MSM, with more than one-third of those being MSM of color. CPG members are White, Hispanic/Latino, African American, Native American, and Pacific Islander. Twelve are from Northern California, two from Central California, and eight from Southern California. Four come from rural areas and the rest come from urban areas.

In addition to the conscious efforts by OA to ensure that CPG members reflect the diversity of the HIV epidemic in California, members are also selected by carefully considering the knowledge, experience, and expertise of each prospective CPG member. CPG members are leaders in California's HIV planning processes, and one of their primary responsibilities is to provide critical insight into developing solutions to health problems. All CPG members attended at least one of the regional stakeholder meetings, in addition to other opportunities for review and feedback of the Integrated Plan. Involving CPG members in the Integrated Plan's development helped ensure that HIV surveillance, prevention, and care activities incorporated here would be responsive to the diverse needs of PLWH in California.

In addition to CPG members, the regional stakeholder meetings involved dozens of other professionals from the HIV/AIDS field and community advocates, many of whom are PLWH. The stakeholder meeting held in Southern California was organized by the Los Angeles County Commission on HIV, and involved intentional recruitment of PLWH who could provide input and feedback into the development of the Integrated Plan in its early stages. Furthermore, the community-based organizations present at these meetings served a large proportion of PLWH in California who are diverse in terms of race/ethnicity, gender identity, sexual orientation, and geography. Overall, the geographic reach of the participants at these meetings was extensive. Stakeholder meeting participants included representatives from clinical and non-clinical providers, local health jurisdictions, community-based organizations and universities throughout California.

Both during the stakeholder meetings and through numerous opportunities for public comment during the drafting of the Integrated Plan, PLWH and other critical stakeholders were specifically asked to evaluate whether the HIV prevention and care activities in Part 4 of this Integrated Plan were responsive to their needs, both state-wide and in their local health jurisdiction. This process helped us to ensure that the strategies and activities presented here were not only practical, but were likely to effectively lead to California toward our ultimate goal of "Getting to Zero."



Section III: Monitoring and Improvement

Monitoring and improvement activities will be conducted through multiple forums.

OA will release data annually summarizing statewide and local health jurisdiction progress on each objective and sub-objective in the Integrated Plan. These data will be released publically and posted on OA's website. These data will be shared with CPG during an in-person meeting and with the all local HIV planning councils. At these meetings, OA and Part A grantee representatives will present and discuss the findings and solicit feedback to identify ways the Integrated Plan efforts should be modified or improved. These data will also be shared with other stakeholder groups, including OA SAC and CCLAD, and feedback received will be reviewed and discussed with statewide and local planning councils for consideration.

OA has hired an Integrated Plan Implementation Specialist, who will oversee development of a monitoring and implementation plan for the Integrated Plan, which include developing an internal tracking system for monitoring progress made on Integrated Plan metrics. This tracking system will be updated at least every six months and summary data will be shared with OA and Part A grantee leadership. OA will also integrate relevant Integrated Plan objectives and metrics into contracts with local health jurisdictions and other entities, and will require annual reports from contractors on progress made in meeting these objectives. In the spirit of Continuous Quality Improvement, OA will work with contractors that are not meeting objectives in order to facilitate "Getting to Zero."

OA is strongly committed to using surveillance and program data to assess and improve health outcomes along the continuum. OA will use HIV surveillance data to develop annual reports on the HIV care continuum for the entire state and for the Ryan White Part A grant recipients. These reports will be posted publicly on the OA website. Data tables on the HIV care continuum will also be posted on the California Health and Human Services Open Data Portal (<https://chhs.data.ca.gov/>) in order to facilitate transparency and increase public access to data. In addition, OA will develop and release annual program reports on the OA's Prevention, Care, and ADAP programs. These reports will provide demographic and service summaries of persons accessing the programs and will report on relevant Integrated Plan metrics and objectives. OA will also develop a Continuum of HIV Care report in ARIES, the data system used by Ryan White providers, so that continuums can be run on demand and used to guide local program planning as needed.

OA will continue to develop robust Clinical Quality Management (CQM) activities at the state level which will focus on implementing data-driven CQM activities at the state and local levels. A CQM committee including OA leadership will continue to meet quarterly. Surveillance, program, and CQM reports will be reviewed at CPG and local planning council meetings. The objectives, sub-objectives, and metrics most relevant to the information being shared will also be presented, and OA and local health jurisdictions will solicit input on ways to improve progress toward attaining goals and objectives.



Appendix X: Acronyms

AB:	Assembly Bill
ACA:	Affordable Care Act
ADAP:	AIDS Drug Assistance Program
ARIES:	AIDS Regional Information and Evaluation System
CBA:	Capacity-Building Assistance
CCLAD:	California Conference of Local AIDS Directors
CDC:	Centers for Disease Control and Prevention
CDCR:	California Department of Corrections and Rehabilitation
CDE:	California Department of Education
CDPH:	California Department of Public Health
CHIS:	California Health Interview Survey
CME:	Continuing Medical Education
CMS:	Centers for Medicare and Medicaid Services
CPG:	California Planning Group
CQM:	Clinical Quality Management
CRIS:	CBA Request Information System
CSTEP:	California Statewide Training and Education Program
DASH:	Division of Adolescent and School Health
DHCS:	California Department of Health Care Services
DIS:	Disease Intervention Specialist
EHR:	Electronic Health Record
EMAs:	Eligible Metropolitan Areas
HCV:	Hepatitis C Virus
HEDIS:	Healthcare Effectiveness Data and Information Set
HOPWA:	Housing Opportunities for Persons With AIDS
HRSA:	Health Resources and Services Administration
HUD:	U.S. Housing and Urban Development
IPV:	Intimate Partner Violence
LGBT:	Lesbian, Gay, Bisexual, and Transgender
MAP:	Medication Assistance Program
MCWP:	AIDS Medi-Cal Waiver Program
MMP:	Medical Monitoring Project
MSM:	Men who have Sex with Men
MUA:	Medically Underserved Area
MUP:	Medically Underserved Population
NCQA:	National Committee for Quality Assurance
NHAS:	National HIV/AIDS Strategy
NHBS:	National HIV Behavioral Surveillance
OA:	Office of AIDS
OA-HIPP:	OA-Health Insurance Premium Payment
PAETC:	Pacific AIDS Education and Training Center
PCMH:	Patient Centered Medical Home
PEP:	Post-Exposure Prophylaxis
PLWH:	Person (People) Living With HIV
PrEP:	Pre-Exposure Prophylaxis
PWID:	People Who Inject Drugs
SAC:	Stakeholder Advisory Committee
SB:	Senate Bill
SDP:	Shortage Designation Program
STD:	Sexually Transmitted Disease (also known as STI; Sexually Transmitted Infection)
TA:	Technical Assistance
TB:	Tuberculosis
TGAs:	Transitional Grant Areas
UDS:	Uniform Data System
USPSTF:	U.S. Preventive Services Task Force



Appendix XI: CDC CBA Providers Information

Numerous times throughout this document, one of the “Responsible Parties” or “Resources” to carry out a specific activity included a CDC-funded CBA provider. There are a number of organizations funded by the CDC to build the capacity of health departments and community-based organizations to provide HIV prevention and care services. Any health departments or community-based organizations that receive direct funding from CDC can request CBA through [CRIS](#) (CBA Request Information

System). Any community-based organizations or health departments that are indirectly funded or not funded by CDC can ask the health department (including the OA) to submit a CRIS request on their behalf.

CRIS requests are assigned to an appropriate CDC-funded CBA provider, which then reaches out to provide CBA at no cost. The most updated list of CDC-funded CBA providers is available at <http://www.cbaproviders.org/providers/index.aspx>.

At the time of writing, the following agencies served as CDC-funded CBA providers:

Health Department CBA Providers

[AIDS Project Los Angeles \(APLA\)](#)
[Asian and Pacific Islander American Health Forum \(APIAHF\)](#)
[City and County of San Francisco](#)
[National Alliance of State and Territorial AIDS Directors \(NASTAD\)](#)
[New York City Department of Health and Mental Hygiene](#)
[The California Prevention Training Center \(CA PTC\)/PHFE](#)
[University of Rochester](#)
[University of Washington](#)

Community-Based Organization CBA Providers

[AIDS United](#)
[Asian and Pacific Islander American Health Forum \(APIAHF\)](#)
[Asian and Pacific Islander Wellness Center](#)
[ETR](#)
[JSI Research & Training Institute, Inc.](#)
[Latino Commission on AIDS \(LCOA\)](#)
[National Community Health Partners \(NCHP\)](#)
[National Minority AIDS Council \(NMAC\)](#)
[New York City Department of Health and Mental Hygiene](#)
[PROCEED, Inc.-National Center for Training, Support and Technical Assistance \(NCTSTA\)](#)
[UCSF Capacity Building Assistance Partnership \(CAPS, CoE, and AHP\)](#)

Health Care Organization CBA Providers

[Cicatelli Associates Inc. \(CAI\)](#)
[Denver Health and Hospital Authority](#)
[Primary Care Development Corporation \(PCDC\)](#)



Appendix XII: Letters of Concurrence



KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

State of California—Health and Human Services Agency
California Department of Public Health



EDMUND G. BROWN JR.
Governor

September 26, 2016

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Dear Ms. Richards and Mr. Ramos:

The California Planning Group concurs with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention and HRSA's HIV/AIDS Bureau for the development of an Integrated HIV Prevention and Care Plan.

The California Planning Group has reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan) for submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The California Planning Group concurs that the Integrated Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS-12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The California Planning Group provided input on the Integrated Plan through participation in surveys and stakeholder meetings and reviewing and commenting on draft version of the document.

Implementation of the Integrated Plan will be performed by the California Planning Group and CDPH/OA will oversee both prevention and care aspects of the Integrated Plan.

Office of AIDS, MS 7700 • P.O. Box 997426 • Sacramento, CA 95899-7426
(916) 449-5900 • (916) 449-5909 FAX
Internet Address: www.cdph.ca.gov





Appendix XII: Letters of Concurrence (*continued*)

Ms. Terri Richards
Mr. Kevin Ramos
Page 2
September 26, 2016

The signature(s) below confirms the concurrence of the planning body with the Integrated Plan.

Signature:

Date:

9/23/2016

Jena Adams
Community Co-Chair
California Planning Group

Signature:

Date:

9/23/2016

Michael Weiss
Community Co-Chair
California Planning Group

cc: Karen E. Mark, MD, PhD, Chief
Office of AIDS
Center for Infectious Diseases
California Department of Public Health
MS 7700
P.O. Box 997426
Sacramento, CA 95899-7426



Appendix XII: Letters of Concurrence (*continued*)



County of San Bernardino, Department of Public Health
351 Mt. View • San Bernardino, CA 92415-0100
(909) 693-0750
Website: www.iehpc.org

Riverside/San Bernardino California Transitional Grant Area

Cameron Kaiser, MD
County Health Officer Co-Chair

Shelia Cromwell-Nieve
Community Co-Chair

Terri Richards, MPH
California Project Officer/Public Health Analyst
Division of State HIV/AIDS Programs
HIV/AIDS Bureau
5600 Fishers Lane
Mail Stop 09SWH03
Rockville, MD 20857

Dear Ms. Richards:

The Inland Empire HIV Planning Council (Council) concur with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Council has reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan) for submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Council concur that the Integrated Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS-12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Council provided input on the Integrated Plan submission through our representatives on the California Planning Group, participation in surveys and stakeholder meetings, reviewing and commenting on draft version of the document, and providing input through planning body representatives who worked directly with CDPH/OA. Our Council representatives also wrote portions of the Integrated Plan. Care and prevention programs jointly provided input on the Integrated Plan through the above processes. Implementation of the Integrated Plan will be performed by the Inland Empire HIV Planning Council and will oversee both prevention and care aspects of the Integrated Plan.

The signature(s) below confirms the concurrence of the Council with the Integrated Plan.

Signature:  Date: September 9, 2016
Shelia Cromwell-Nieve, Community Co-Chair

Signature:  Date: September 9, 2016
Cameron Kaiser, MD, County Health Officer Co-Chair



Appendix XII: Letters of Concurrence (*continued*)



County of San Bernardino, Department of Public Health
351 Mt. View • San Bernardino, CA 92415-0100
(909) 693-0750
Website: www.iehpc.org

Riverside/San Bernardino California Transitional Grant Area

Cameron Kaiser, MD
County Health Officer Co-Chair

Shelia Cromwell-Nieve
Community Co-Chair

Terri Richards, MPH
California Project Officer/Public Health Analyst
Division of State HIV/AIDS Programs
HIV/AIDS Bureau
5600 Fishers Lane
Mail Stop 09SWH03
Rockville, MD 20857

Dear Ms. Richards:

The Inland Empire HIV Planning Council (Council) and Dr. Maxwell Ohikhuare, San Bernardino County Public Health Officer concur with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Council has reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan) for submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Council and the San Bernardino County Public Health Department concur that the Integrated Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS-12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Council provided input on the Integrated Plan submission through our representatives on the California Planning Group, participation in surveys and stakeholder meetings, reviewing and commenting on draft version of the document, and providing input through planning body representatives who worked directly with CDPH/OA. Our Council representatives also wrote portions of the Integrated Plan. Care and prevention programs jointly provided input on the Integrated Plan through the above processes. Implementation of the Integrated Plan will be performed by the Inland Empire HIV Planning Council and will oversee both prevention and care aspects of the Integrated Plan.

The signature below confirms the concurrence of the Council with the Integrated Plan.

Signature:  Date: September 16, 2016
Maxwell Ohikhuare, MD, San Bernardino County Health Officer



Appendix XII: Letters of Concurrence (*continued*)

HIV Health Services Planning Council

7001A East Parkway, Suite 600B
Sacramento, Ca 95823
(916) 875-5881
Fax (916) 875-5888



August 18, 2016

LCDR Jose A. Ortiz, MPH
Public Health Analyst
Western Branch, Division of Metropolitan HIV/AIDS Program
Health Resources & Services Administration/HRSA
5600 Fisher Lane, Room 09 W05A
Rockville, MD 20857

Dear Mr. Jose Ortiz:

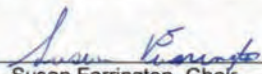
The Sacramento TGA's HIV Health Services Planning Council and Dr. Olivia Kasirye, Sacramento County Public Health Officer, *concur* with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Inland Empire, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Sacramento TGA's HIV Health Services Planning Council has reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan) for submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body and the Sacramento County Local Health Department *concur* that the Integrated Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS-12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The planning body provided input on the Integrated Plan submission through our representative on the California Planning Group, participation in surveys and stakeholder meetings, reviewing and commenting on draft versions of the document, and providing input through planning body representatives who worked directly with CDPH/OA. Planning body representatives also wrote portions of the Integrated Plan. Care and prevention programs jointly provided input on the Integrated Plan through the above processes. Implementation of the Integrated Plan will be performed by the Sacramento TGA's HIV Health Services Planning Council and the goals and objectives of the Plan will be incorporated into its Committee's annual Work Plans. The Council and the Sacramento County Local Health Department will oversee both prevention and care aspects of the Integrated Plan.

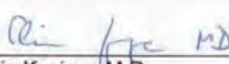
The signature(s) below confirms the *concurrence* of the planning body and the Sacramento County Local Health Department with the Integrated Plan.

Signature: _____


Susan Farrington, Chair
Sacramento TGA
HIV Health Services Planning Council

Date: August 18, 2016

Signature: _____


Olivia Kasirye, M.D.
Public Health Officer
Sacramento County Division of Public Health

Date: August 18, 2016



Appendix XII: Letters of Concurrence (continued)



Co-Chairs:
Robert Reed
Karim Kahwaji

976 Lenz Avenue, 2nd Floor
San Jose CA 95126
p- 408-792-5210 f- 408-792-5031
www.sccihvplanningcouncil.org

September 20, 2016

Jose A. Ortiz, MPH
Public Health Analyst
Western Branch, Division of Metropolitan HIV/AIDS Program
Health Resources & Services Administration/HRSA
5600 Fisher Lane, Room 09 W05A
Rockville, Md. 20857

Dear Mr. Ortiz,

The Santa Clara County HIV Planning Council for Prevention and Care (San Jose TGA) and Sara Cody, MD, Health Officer and Public Health Director concur with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Planning Council has reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan) for submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Planning Council and Santa Clara County Public Health Department concur that the Integrated Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS-12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Planning Council provided input on the Integrated Plan submission through our representative on the California Planning Group, participation in surveys and stakeholder meetings, reviewing and commenting on draft version of the document, and providing input through Planning Council representatives who worked directly with CDPH/OA. Planning Council representatives also wrote portions of the Integrated Plan. Care and prevention programs jointly provided input on the Integrated Plan through the above processes. Implementation of the Integrated Plan will be performed by the Santa Clara County HIV Planning Council for Prevention and Care and the Santa Clara County Public Health Department and will oversee both prevention and care aspects of the Integrated Plan.

The signatures below confirm the concurrence of the Planning Council and the Santa Clara County Public Health Department with the Integrated Plan.

Signature: Robert Reed Date: 9-20-16
Robert Reed, Co-Chair
San Jose TGA
Santa Clara County HIV Planning Council for Prevention and Care

Signature: Karim Kahwaji Date: 9-20-16
Karim Kahwaji, Co-Chair
San Jose TGA
Santa Clara County HIV Planning Council for Prevention and Care

Signature: Sara H. Cody Date: 9/20/16
Sara H. Cody, MD
Santa Clara County Health Officer and Public Health Director



Appendix XII: Letters of Concurrence (*continued*)



CYNTHIA A. HARDING, MPH
Interim Director

JEFFREY D. GUNZENHAUSER, MD, MPH
Interim Health Officer

Division of HIV and STD Programs
Mario J. Pérez, Director
600 South Commonwealth Avenue, 10th floor
Los Angeles, California 90005
TEL (213) 351-8000 • FAX (213) 387-0912

www.publichealth.lacounty.gov

September 15, 2016

Terri` Richards, MPH
California Project Officer/Public Health Analyst
Division of State HIV/AIDS Programs
HIV/AIDS Bureau
5600 Fishers Lane
Mail Stop 09SWH03
Rockville, MD 20857

Dear Ms. Richards:

CALIFORNIA'S INTEGRATED HIV SURVEILLANCE, PREVENTION AND CARE PLAN

The Los Angeles County Commission on HIV (COH) and the Division of HIV and STD Programs (DHSP), Department of Public Health *concur* with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body and health department have reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan). While COH and DHSP elected to do a separate integrated plan, we provided input on both the care and prevention aspects of the Integrated Plan through our representative on the California Planning Group, participation in surveys and stakeholder meetings, and review of draft versions of the document. The Los Angeles County Commission on HIV and the Department of Public Health's Division of HIV and STD Programs *concur* that the Integrated Plan describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease in California.

The signatures below confirm the *concurrence* of the planning body and health department with the Integrated Plan. We look forward to working with the Office of AIDS in meeting the needs of our diverse communities.



BOARD OF SUPERVISORS

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Shella Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District



Appendix XII: Letters of Concurrence (*continued*)

Terri` Richards
September 15, 2016
Page 2

If you have any questions or need additional information, please contact Pamela Ogata at (213) 351-8056.

Very truly yours,

Mario J. Pérez, Director
Division of HIV and STD Programs

9/19/16
Date

Bradley Land, Commission Co-Chair

9/15/16
Date

Ricky Rosales, Commission Co-Chair

9/15/16
Date

MJP:MG:po

c: Dr. Karen Mark, Chief, California Office of AIDS
Jose Ortiz, HRSA Project Officer
Monique Richards, HRSA Project Officer



Appendix XII: Letters of Concurrence (*continued*)



Terri Richards, MPH
California Project Officer/Public Health
Analyst
Division of State HIV/AIDS Programs
HIV/AIDS Bureau
5600 Fishers Lane
Mail Stop 09SWH03
Rockville, MD 20857

CDC Project Officer
California Project Officer


To Whom it May Concern:

The Orange County HIV Planning Council (Council) and County of Orange Health Care Agency (Health Care Agency) concur with the following submission by the California Department of Public Health Office of AIDS (CDPH/OA), in partnership with the Riverside/San Bernardino, Sacramento, and San Jose Transitional Grant Areas, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body and health department have reviewed *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention and Care Plan* (the Integrated Plan) for submission to the CDC and HRSA. While this planning and health department elected to do a separate integrated plan, we provided input on both the care and prevention aspects of the Integrated Plan through our representative on the California Planning Group, participation in surveys and stakeholder meetings, and reviewing and commenting on draft versions of the document. The planning body and local health department concur that the Integrated Plan describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.

The signature(s) below confirms the concurrence of the Council and Health Care Agency with the Integrated Plan.

Sincerely,


Bobby Avalos, Council Chair

9/14/16
Date



Appendix XII: Letters of Concurrence (*continued*)



T Jones

Tamarra Jones, AIDS Director

9/14/16

Date

cc:

Dr. Karen Mark, Chief, California Office of AIDS

HRSA Project Officer Jose Ortiz

HRSA Project Officer Monique Richards



California Department of Public Health
Office of AIDS
MS 7700
P.O. Box 997426
Sacramento, CA 95899-7426
www.cdph.ca.gov/programs/AIDS