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

California Department of Public Health, Center for Infectious Diseases, Office of AIDS

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In collaboration with the California Planning Group

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* Please refer to the goals, objectives, and activities for the Integrated Plan, which begin on page 7. Based on shared areas of priority, the goals, objectives, and activities of the Integrated Plan were developed in order to align goals for the Jurisdictional Plan, the SCSN, and the Comprehensive Plan with one another and with the NHAS.

In grateful recognition to the members of the California Planning Group:

The leadership, dedication, and expertise you so generously shared have informed every aspect of California's Integrated HIV Surveillance, Prevention, and Care Plan. Your collective voice will continue to shape HIV planning and services statewide as we move forward together to bring an end to the HIV epidemic.

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Foreword from the California Community Planning Group (CPG)

As this *Integrated HIV Surveillance, Prevention, and Care Plan (Integrated Plan)* is in its final review stages in the last weeks of July 2012, approximately 25,000 people are attending the International AIDS Conference in Washington, D.C. It is the first time the conference has been in the United States since the repeal of the Helms Amendment, which banned HIV-positive persons from entering the country. The theme of this conference is "Turning the Tide Together."

There are recent and significant changes in the world of HIV prevention and care that need to be addressed quickly. As of July 2010, the United States finally has a National HIV/AIDS Strategy (NHAS), with achievable goals and clear objectives to focus efforts on multiple levels. In July 2012, the U.S. Food and Drug Administration approved a rapid HIV antibody test for at-home use, and also approved the HIV medication Truvada to be used by HIV-negative individuals in conjunction with condom use, routine HIV testing, sexually transmitted diseases screening and treatment and behavioral counseling to reduce risk of acquiring HIV. In March 2012, new U.S. Department of Health and Human Services *Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents* recommended that antiretroviral therapy (ART) "be offered to patients who are at risk of transmitting HIV to sexual partners." In other words: Treatment is prevention. Never before in the history of the HIV epidemic have HIV prevention and HIV care been so obviously and naturally intertwined.

It is in this dynamic and optimistic environment, where the glimmer of hope for an end to the epidemic exists, that this *Integrated Plan* has been crafted. The *Integrated Plan* has been written by the California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) with significant input and direction from CPG and subsequent review by providers, consumers, and stakeholders through the OA Advisory Network (AN). This collaboration represents a new framework that resulted from an overhaul of how the OA works with community planning groups and solicits community advisory input.

In June 2008, at the behest of the 40 members of the California HIV Planning Group, OA launched a major restructuring process for its HIV planning group. It was clear even then that to be relevant and current, community input needed to be timely and objective-focused, and that a more streamlined model was needed.

> "Turning the Tide Together reflects a unique moment in time, emphasizing that the AIDS epidemic has reached a defining moment. By acting decisively on recent scientific advances in HIV treatment and biomedical prevention, the momentum for a cure, and the continuing evidence of the ability to scale-up key interventions in the most-needed settings, we now have the potential to change the course of HIV and AIDS."[1]

The new smaller CPG of 15-21 members was approved in September 2009. It focused on the following core responsibilities: taking an active role in the development of an integrated and comprehensive jurisdictional HIV surveillance, prevention, and care plan; engaging in activities designed to determine that the work of OA is effective in addressing the goals and objectives of those planning documents; and providing

[1] XIX International AIDS Conference Objectives - http://www.aids2012.org/default.aspx?pageId=434

periodic advice on emerging issues identified or generated by OA or the community.

CPG uses technology and virtual meetings to communicate, both because they are quick and efficient, and also because California HIV/AIDS programs are profoundly impacted by the devastating budget cuts enacted as a result of the State's massive budget deficit. In 2009, all State funding to OA – a total of more than $81 million – was eliminated. The cuts represented 80 percent of previous funding levels for HIV testing and prevention activities, and resulted overall in drastic reductions or outright elimination of many HIV prevention, education, and care and treatment programs and services.

Especially in an environment of diminishing resources for HIV prevention, care services, and community planning, the task of addressing the needs of California – a state whose population is greater than many countries in the world – is immense. California's rich diversity is one of its greatest assets, but social and cultural inequities, longstanding health inequalities, and geographic, institutional, and structural barriers continue to shadow the public health landscape. The array of individual and community behaviors, social and structural determinants, and psychosocial and environmental factors influencing those affected by and living with HIV are key issues to address in this fight in the prevention of HIV/AIDS.

This *Integrated Plan* is our effort to begin strategically addressing these complex issues, and provide direction for OA's future. The first step was to conceptually combine what used to be two separate plans of prevention and care into one consolidated plan, and to integrate surveillance as well. To consolidate our planning in this way is a clear demonstration of the importance of coordinating our efforts to fight the HIV epidemic, working together efficiently and effectively. We have also worked to ensure that the priorities and strategies, goals and objectives articulated in this *Integrated Plan* respond directly to the NHAS, which requires California to achieve high levels of engagement at every stage in the continuum of prevention and care. With this in mind, our work also emphasizes the central importance of reducing disparities in HIV prevention and care and in reducing the stigma and discrimination associated with HIV/AIDS.

HIV/AIDS is a complex epidemic that demands the application not only of our best efforts in medical science and public health policy, but which will require - if we are to genuinely confront the issues of stigma and disparity - the capacity to work together strategically, purposefully, and efficiently to address all aspects of HIV/AIDS. This *Integrated Plan* is intended as a major step towards achieving this capacity in the state of California.

Purpose of the Integrated Plan and Intended Users

California's *Integrated Plan* is meant to serve as a practical guide for OA in achieving the vision of the National HIV/AIDS Strategy (NHAS). The purpose of the *Integrated Plan* is to articulate the goals and objectives deemed to be of critical importance in addressing statewide HIV prevention and care and highlight service gaps and areas of greatest need, with particular focus on the populations determined to be at highest risk for HIV and individuals who are unaware of their HIV-positive status.

Activities associated with implementing the *Integrated Plan* will focus on strategic paths in order to achieve its goals, assure their scientific basis and community relevance, and identify the factors that will be utilized to assess progress. The *Integrated Plan* will also inform local health jurisdictions (LHJs) and community planners through describing the allocation methods, population priorities, and intervention strategies intended to address California's HIV prevention and care needs. Finally, the *Integrated Plan* is meant to ensure that the perspectives of local community planners and stakeholders inform OA.

The Jurisdictional HIV Prevention Plan, the HIV Care Comprehensive Plan, and the Statewide Coordinated Statement of Need (SCSN) have been merged within this document. Presenting these jointly underscores the priority that both the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) have placed on more robust integration of HIV prevention and care, and acknowledges the common ground shared in data, identification of service needs, and resource allocation and planning strategies.

Crosscutting issues and priority areas were identified in the Jurisdictional Plan, the SCSN, and the Comprehensive Plan. These parallel areas include the importance of integrating HIV prevention and care services; the emphasis on diagnosis, linkage, retention, and engagement in care; and the necessity of addressing the array of needs experienced by the communities and populations bearing the greatest burden of HIV disease. Short- and long-term goals, solutions, and activities identified in the *Integrated Plan* were crafted in direct response to these cross-cutting issues. The goals, solutions, and activities for each document are meant to align both with one another and with the NHAS.

Achieving positive outcomes in the tasks, goals, and objectives of this *Integrated Plan* will keep activities and resources aligned with priorities. Ultimately, it is meant to ensure that all Californians who have been affected by this epidemic will have access to a comprehensive continuum of HIV care that will allow them to lead healthy, productive, and fulfilling lives.

Informing the Integrated Plan: Other Stakeholders

The responsibility of the CPG, with support from OA, is to ensure complete and adequate stakeholder input into the Integrated Plan. As part of this process, the CPG assists OA in effectively defining the universe of stakeholders and identifying how to engage with unique stakeholder communities.

In a region as large and geographically diverse as California, it can be challenging to solicit stakeholder input on a statewide basis. The OA Advisory Network (AN), a specialized component of the OA website, will be further developed throughout the life of this document in order to facilitate the community input which is so important in supporting HIV planning. Currently, AN users can send direct requests or questions to OA, and can opt to receive e-mail updates on specific topics including funding opportunities, trainings, resources for providers, researchers, and consumers, and OA news. They may also initiate or join discussion groups, respond to questions put forward by OA, or respond to surveys such as the statewide community needs assessment that helped to inform this plan.

As part of enhancing and documenting the engagement process associated with jurisdictional planning, CPG and OA will work together to increase awareness of the AN. The goal is to expand the AN's capacity and reach so that its various functions may be effectively utilized to engage with stakeholders, solicit input, and provide a source for timely and relevant feedback and exchanges between OA, consumers, providers, and others.

The Integrated Plan - A Living Document

As a living document, this *Integrated Plan* is subject to revision based on shifts in the epidemic, updated data, emerging populations and newly-identified community priorities. This *Integrated Plan* aims to establish an ongoing and dynamic process for assessing the effectiveness of OA's work and to strengthen or re-establish priorities and direction as needed.

There are multiple levels of assessment involved with the ongoing review, revision, and updating of the *Integrated Plan*. These levels include assessing the jurisdictional planning process itself, to ensure that it continues to meet the needs and requirements of the *Integrated Plan*. Also important is consideration of whether the strategies included in implementation of the *Integrated Plan* are in alignment with the goals set forth in the NHAS, and whether they meet the goals of High Impact Prevention,[2] CDC's approach for reducing HIV infections in the United States.

CPG will collaborate with OA in reviewing the community planning process and strategies, will assist in updating the community and stakeholder engagement process, and will inform OA regarding any updates or revisions that may need to be incorporated into the *Integrated Plan*.

Upon review and assessment, any revisions will be included with updates to the *Integrated Plan* and submitted to CDC as part of its monitoring documentation. This review and revision process, as a shared responsibility between CDC, OA, and CPG, will be conducted on an annual basis.

The California Planning Group

The CPG is dedicated to meaningful community involvement in HIV testing, prevention, care, and treatment planning. The CPG's goal is to improve the effectiveness of California's HIV prevention and care programs by strengthening the scientific basis, relevance, and focus of strategies and interventions, and to assist in targeting resources to those communities at highest risk for HIV.

The CPG is one important facet of a more far-reaching approach to obtaining statewide community input and implementing community-focused advisory functions. The membership of CPG makes recommendations aimed at facilitating, and assisting in, the solicitation of broad community feedback on statewide planning documents, implementation plans, policy development, emerging issues, and other matters that are relevant to the providers and stakeholders who partner with OA.

The CPG may provide timely advice on emergent issues identified by OA, the AN, and other key stakeholder parties. The CPG is committed to working collaboratively to make decisions and is guided by the principles of equity, fairness, and respectful engagement.

For more information on CPG membership, governance, and opportunities to get involved, please access OA's website link below:

http://www.cdph.ca.gov/programs/aids/Pages/OACPG.aspx

Vision for the National HIV/AIDS Strategy

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

[2] http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf

California Planning Group Recommendations

Implementing HIV Planning: Goals, Objectives, and Activities

Priorities reflecting joint OA/CPG recommendations for the *Integrated Plan* were developed based on the approach put forward in the NHAS, and informed by CPG's guiding principles that "wherever possible, goals and objectives should be based on data that is derived from California jurisdictions, data that is current, and data that has received stakeholder and OA review." The resulting goals are meant to support the practical and sustainable implementation of the *Integrated Plan* as well as provide a foundation for effective monitoring and assessment of progress:

1. Reduce HIV incidence;
2. Increase access to care and optimize health outcomes;
3. Reduce HIV-related health disparities;
4. Achieve a more coordinated response to the HIV epidemic in California, including promoting and enhancing the integration of HIV care and prevention across programs and services;
5. Maximize resources through efficacy of planning and allocation, flexibility, and effective program fiscal management; and
6. Monitor the HIV epidemic by using OA HIV and AIDS surveillance data to support and direct program and policy decisions.

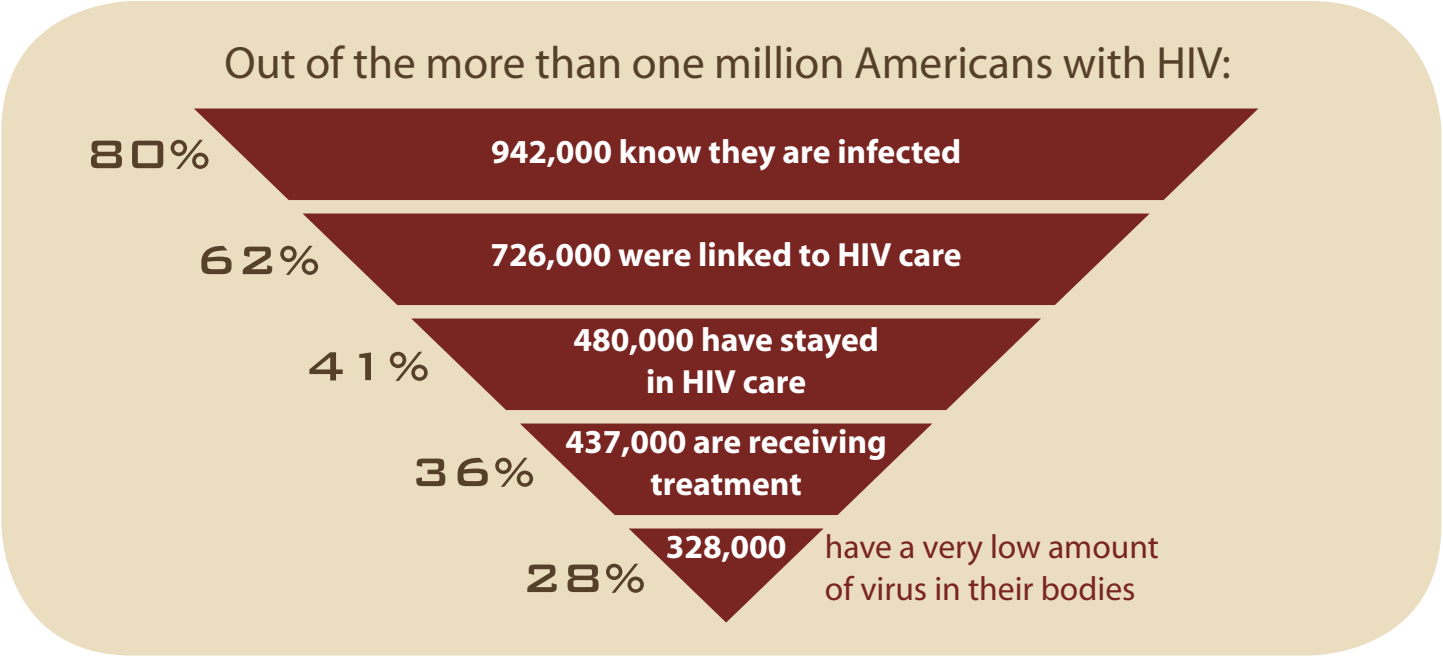
The goals of California's *Integrated Plan* include objectives and activities developed by the CPG in collaboration with OA. They are linked to concrete strategies that reflect the CPG's priorities and aspirations for ending the HIV epidemic and ensuring that precious and limited HIV resources are directed to the populations and areas which are most profoundly affected.

The CPG's process is evidence-based, using both qualitative and quantitative sources such as epidemiological data, program utilization statistics, surveys, and narrative reports. Based on this process, each element of the priorities and decisions related to this *Integrated Plan* are chronicled and supported with data. It is understood that given California's diversity in geography and race/ethnicity, goals and objectives must be crafted in consideration of the wide range of needs of the people of California. While data from other sources may be used to enhance or strengthen the *Integrated Plan*, the document is meant for California, and as such, data from California is prioritized.

In order to ensure that the *Integrated Plan* identifies those populations with the greatest burden of the epidemic, and assist in ensuring that prevention and care resources are allocated and disseminated based on the geographic burden within the state, the CPG has developed a set of goals, objectives, and activities which are guided by fundamental principles. As a whole, these goals, objectives, and activities represent a path forward for California reflecting the continuum of HIV services from prevention and testing to linkage and retention in care. They are intended to prioritize the most effective interventions and approaches and contribute to the refocusing, as needed, of existing strategies. The overall emphasis is on targeting efforts to populations and communities bearing the greatest disease burden, and achieving results with the greatest impact on the epidemic.

A model for the strategies presented in this document designed to meet the goals of NHAS and ensure that HIV-positive persons have access across the entire spectrum of HIV services, from diagnosis of HIV to retention in treatment to achieving viral suppression, is represented in a recent CDC fact sheet[3]:

[3] http://www.cdc.gov/nchhstp/newsroom/docs/HIVFactSheets/TodaysEpidemic-508.pdf



The above illustrates a cascade model of the overall number of HIV-infected persons who are currently immunologically suppressed. The "Treatment Cascade" concept was developed in an analysis of the number of HIV-positive persons in the United States who fully benefit from engagement with the various steps comprising the spectrum of HIV care. In late 2011, the CDC estimated that "only 28 percent of the more than one million individuals in the United States who are living with HIV/AIDS are getting the full benefits of the treatment they need to manage their disease and keep the virus under control"(1). Informed by this model and guided by the goals and objectives put forward in this document, the CPG and OA will collaborate in assessing the spectrum of engagement on a statewide basis in order to ensure effective targeting of programs and resources.

In totality, this approach represents new paradigms for planning, strengthened by improved surveillance tools and supported by access to comprehensive and mature data sets. As a result, the goals are grounded in contemporary evidence-based strategies such as high-impact intervention planning, the "treatment as prevention" concept, early identification activities, and the fusion of prevention and care through retention, engagement, re-engagement, and treatment adherence activities. Finally, the importance of structural change and policy-focused work is acknowledged within this goal set.

California's Integrated Plan - Goals & Objectives

Goal 1: Reducing New Infections

Objective 1:

Lower the annual number of new infections by 25%.

Activities:

Shift HIV prevention efforts to emphasize HIV testing, both routine testing in medical settings and targeted testing in non-medical settings, to increase the identification of HIV-positive individuals.

Use targeted efforts to prevent HIV infection using a combination of effective, evidence-based interventions.

Support the use of syringe access services.

Target HIV prevention efforts in the communities where HIV is most heavily concentrated, with a focus on high-risk negative and HIV-positive persons.

Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30%.

Adopt community-level approaches to reduce HIV infection in high-risk communities.
Reduce stigma and discrimination around HIV testing and against PLWH to encourage testing, treatment, and decrease transmission.

Objective 2:

Reduce the number who do not know their status by 10%.

Activities:

Emphasize partner services at the time of testing and ongoing through provision of care and treatment to identify those who may have been infected and provide appropriate follow-up testing for those who are at risk.

Support innovative testing activities that increase identification of undiagnosed HIV infections and/or improve the cost effectiveness of HIV testing activities to identify new cases of HIV.

Objective 3:

Increase the proportion of HIV positive persons with an undetectable viral load.

Activities:

Ensure that every person in California who is HIV-positive is eligible for treatment and has access to treatment.

Emphasize linkage to care activities and other services for newly identified HIV positive individuals so that HIV positive persons may receive medications.

Emphasize engagement and retention in care activities in PWP and HIV primary care settings.

Emphasize adherence activities in PWP and HIV primary care settings.

Fully implement AB 2541, which allows use of HIV surveillance data to assist in identifying HIV-positive individuals not receiving HIV care and link them into needed services.

Allocate sufficient resources to map the HIV epidemic in all funded jurisdictions and increase capacity to monitor community viral load.

Increase the use of surveillance and field services to engage HIV-infected persons in care and treatment and re-engage those who have fallen out of care.

Goal 2: Increase Access to Care and Optimize Health Outcomes

Objective 1:

100% of HIV-infected individuals will receive appropriate and continuous medical care and support services as measured by HIV care and support services usage data.

Activities:

Define "appropriate care" as:

- Receives viral load test 2x per year;
- Includes strong, authentic linkage to auxiliary support services; and
- Addresses HIV related co-morbidities such as STDs, and hepatitis B and C.

Increase the proportion of Ryan White Part B clients who are in continuous care.

Definition of "continuous care"—at least 2 visits for routine HIV medical care in 12 months at least 3 months apart— as an evaluation element.

Monitor existing data for HIV medical care and support service usage.

Establish service and care system to engage people diagnosed with HIV who have never been in care or to reengage people who have fallen out of care.

Support or develop strategies to maintain high levels of adherence to antiretroviral treatment.

Provide continual assessment and improvement of HIV data collection system(s) with input from end users to enhance/create compatibility and accessibility.

Objective 2:

100% of OA funded HIV testing sites will provide seamless, on-site linkage to care services.

Activities:

Develop definition of "seamless, on-site linkage-to-care" to allow for meaningful monitoring and assessment activities.

Develop monitoring and assessment tool for use with OA funded contractors providing HIV screening to assess linkage to care capabilities and efficiencies.

Require OA funded contractors to administer and collect annual client survey data regarding linkage to care services.

Provide on-going monitoring and annual assessments of OA funded contractors to evaluate seamless linkage to care services.

Objective 3:

Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis by 25%.

Activities:

Improve/develop capacity of OA data reporting systems to measure linkage to care.

California's Integrated Plan - Goals & Objectives (Cont.)

Goal 3: Reduce HIV-Related Health Disparities

Objective 1:
Decrease the number of new infections in gay and bisexual men, African Americans, and Latinos by 25% as measured by HIV surveillance systems.

Activities:
Use available data and existing research to identify populations experiencing HIV-related health disparities.

Identify and disseminate effective interventions and approaches that reduce the risk of infection in high prevalence communities.

Develop strategies to reduce stigma and discrimination about HIV in communities disproportionally impacted by HIV.

Objective 2:
Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20% as measured by ARIES and eHARS.

Activities:
Increase the proportion of HIV diagnosed gay and bisexual men who meet the Group 1 HRSA HIV/AIDS Bureau (HAB) indicators as measured by ARIES data.

Objective 3:
Increase the proportion of HIV diagnosed African Americans with undetectable viral load by 20% as measured by ARIES and eHARS.

Activities:
Increase the proportion of HIV diagnosed African Americans who meet the Group 1 HAB indicators as measured by ARIES data.

Objective 4:
Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20% as measured by ARIES and eHARS.

Activities:
Increase the proportion of HIV diagnosed Latinos who meet the Group 1 HAB indicators as measured by ARIES data.

Objective 5:
Address social determinants of heath and cofactors that contribute to disease progression among HIV-positive individuals.

Activities:
Increase the number of Ryan White clients with permanent housing by 25% as measured by ARIES data.

Goal 4: Achieve a Coordinated Response to the HIV Epidemic in California

Objective 1:
OA will develop and enhance data collection systems to support a coordinated response to HIV.

Activities:
Streamline data collection requirements among providers including creating standardized data collection forms where possible (which may consider unique identifiers for funded providers).

Create a database/matrix of funded providers that provide HIV and viral load testing activities with State and Federal funds.

Develop a monitoring tool to establish baseline report format; report progress to key stakeholders on an annual basis.

Objective 2:
OA will develop and/or enhance internal and external planning and collaboration activities in support of a coordinated response to HIV.

Activities:
INTERNAL:
Develop measurable definition of "coordinated response to HIV".

Strengthen collaboration between OA, STD, other communicable disease programs, DCHS, HBEX, and other relevant CDPH divisions.

Convene regular meetings between key staff from each branch in order to enhance planning and collaboration.
Convene workgroups as needed to address issues regarding developing a coordinated response to HIV prevention and care planning.
Share data regarding emerging trends in HIV/AIDS with internal and external partners; LHJs/ providers and other stakeholders.

EXTERNAL:
Share data regarding emerging trends in HIV/AIDS with internal and external partners; LHJs/ providers and other stakeholders.

Require LHJs to establish active collaborations between HIV prevention and care services and related services and pactivities as measured by LEO, EHARS, ARIES reports.

Increase collaboration among hospitals, clinics, pharmacies, ASO, DPHs, CBO, and testing services, mental health, corrections, AOD programs, primary care association, family planning, housing and support services.
CPCA (FQHC testing).

Conduct rigorous monitoring and evaluation of funded programs as measured by review of standardized monitoring and/or evaluation forms and reporting to CPG and other stakeholders.

Objective 3:
OA will develop and support policy initiatives that enhance a coordinated response to HIV.

Activities:
Identify potential HIV-related issues associated with full implementation of ACA in 2014 and beyond.

Provide technical assistance for medical care, support, testing, and prevention service delivery systems and providers .

Goal 5: Maximizing Resources Through Efficacy of Planning and Allocation, Flexibility, and Effective Program Fiscal Management

Objective 1:
Engage in a statewide community planning process as measured by OA staff participation on or communication with local, regional, and statewide planning bodies to provide an opportunity for LHJs, CBOs, and stakeholders to offer their expertise in allocation processes, ensure coordination and minimize duplication and overlap.

Activities:
OA will commit to participate in relevant planning bodies in order to coordinate HIV/AIDS planning efforts.

Objective 2:
Engage in fiscal management best practices.

Activities:
Regularly review current practices for grant and contract oversight.

Provide technical assistance to funded LHJs.

Adequately monitor service delivery to assure quality services are being delivered, and that billing is appropriate.

Objective 3:
Identify and disseminate information about the availability of fiscal/grant resources to stakeholders.

Activities:
Conduct periodic reviews of applicable grant funding websites.

Provide routine communications via electronic sources or email blasts to stakeholders.

Ensure that the State OA applies for all possible grant opportunities.

Review all staffing methods for efficiencies and make most efficient use of contractors and OA staff.

Objective 4:
Support and collaborate with OA-funded providers in the process of HCR implementation.

Activities:
Lead a collaborative statewide process to explore and define HIV-related issues in HCR.

Assess the capacity of LHJs to screen clients for appropriate public and private health insurance.

Objective 5:
Address legislative, policy, and procedural barriers.

Activities:
Keep abreast of state and federal legislation regarding HIV prevention, care, surveillance, syringe services, ADAP, and other relevant programs and activities.

Inform planning groups and other stakeholders of changes.

California's Integrated Plan - Goals & Objectives (Cont.)

Goal 6: Monitoring the HIV Epidemic Through Using OA HIV and AIDS Surveillance Data to Support and Direct Program and Policy Decisions

Objective 1:

On an annual basis, evaluate HIV and AIDS surveillance, HIV testing, hepatitis and other data sources to determine the state of the epidemic and emerging trends in order to:

- **Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated;**
- **Allocate public funding to geographic areas consistent with the epidemic;**
- **Target high-risk populations; and**
- **Reduce HIV-related mortality in communities at high risk for HIV infection.**

Activities:

At a minimum, the following epidemiologic variables will be evaluated for each population of interest in order to understand the relative magnitude of HIV/AIDS:

Cumulative HIV and AIDS cases ever reported.

Current HIV/AIDS disease burden measured by:

- Number of persons living with HIV and AIDS;
- Rate of persons per 100,000 population living with HIV and AIDS;
- Estimated rate of new infections; and
- Mortality rate per 100,000 population due to HIV disease.

Annual HIV/AIDS diagnoses since names-based HIV reporting (2006) measured by:

- Number of persons diagnosed with HIV annually; and
- Annual rate of HIV/AIDS diagnoses per 100,000 population.

Annual AIDS diagnoses measured by:

- Number of persons diagnosed with AIDS annually; and
- Annual rate of AIDS diagnoses per 100,000 population.

Pertinent data provided by supplemental surveillance sources, e.g.:

- National HIV Behavioral Surveillance; and
- Medical Monitoring Project.

Objective 2:

Concentrate HIV prevention efforts in geographic areas and populations consistent with the epidemic, i.e., in the highest risk and emerging target populations.

Activities:

Use transparent priority setting processes to allocate funding to LHJs, CBOs and stakeholder populations in the communities across California most heavily impacted by HIV.

Objective 3:

Provide opportunities for the general public as well as affected communities to review the State OA's progress in meeting the Goals and Objectives of this plan as well as its required quality assurance measures.

Activities:

Provide regular public reporting on the OA website including an annual report tailored for public consumption. Disseminate new, pertinent epi profile data to jurisdictions as it becomes available.

Objective 4:

Provide opportunities for the general public as well as affected communities to review the State OA's progress in meeting the Goals and Objectives of this plan as well as its required quality assurance measures.

Activities:

Provide regular public reporting on the OA website including an annual report tailored for public consumption. Disseminate new, pertinent epi profile data to jurisdictions as it becomes available.

Objective 5:

Design and evaluate innovative preventions strategies and combination approaches for preventing HIV in high-risk communities.

Activities:

Review prevention interventions from LEO database and supplemental data: Outreach Services, Individual-level Interventions, Group-level Interventions; CDC's effective behavioral interventions; Prevention with Positives; and Partner Services.

Objective 6:

Enhance funded program accountability and evaluate current programs for effectiveness at reducing new HIV infections and reducing HIV-related mortality.

Activities:

Review HIV detection interventions from the LEO database and supplemental data: For rapid and conventional HIV testing, the number of tests, the number who report previous testing, number of positive tests, number who receive results, and the number of those with positive tests referred for medical services and for Partner Services.

Objective 7:

Redirect resources to the most effective prevention and care programs.

Activities:

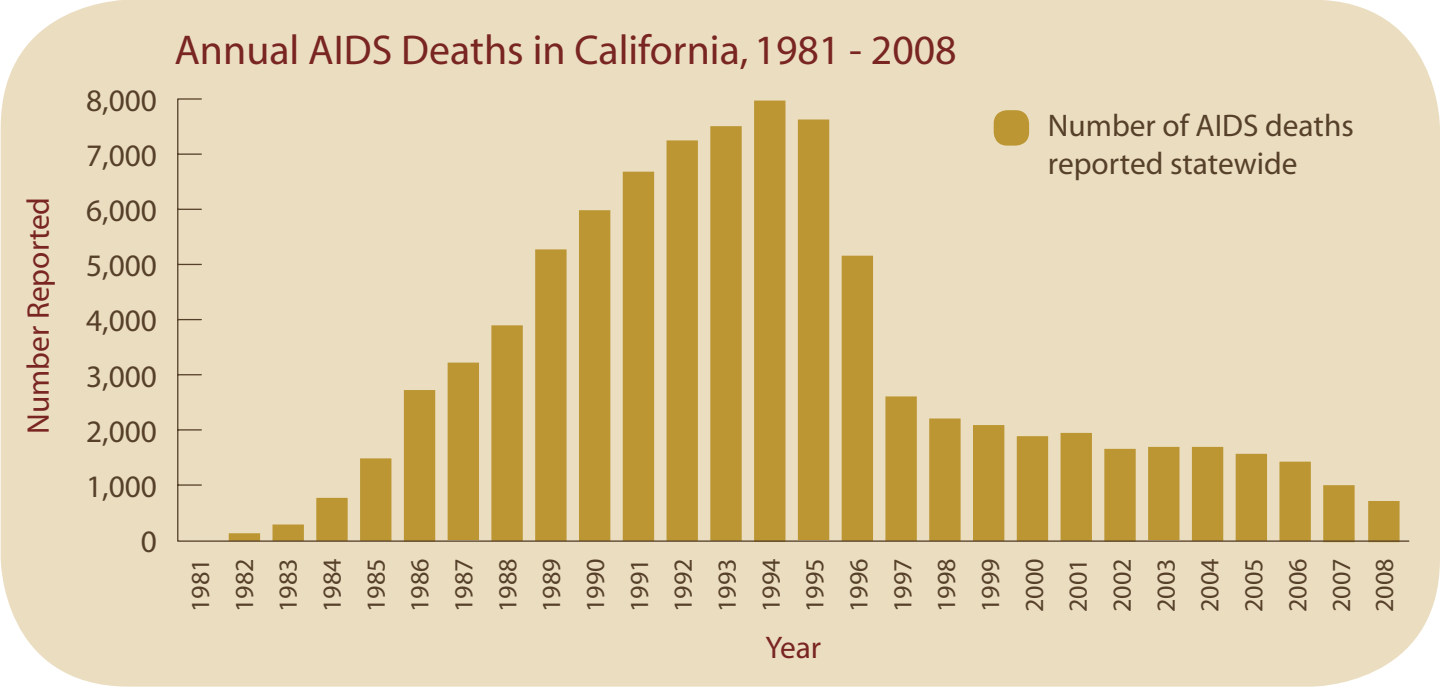
Review HIV care/treatment interventions from ARIES database and supplemental data: Each Ryan White/OA HIV Care Program Service category; ADAP; HOPWA; Medi-Cal Waiver and CARE-HIPP.

History of the HIV Epidemic in California[4]

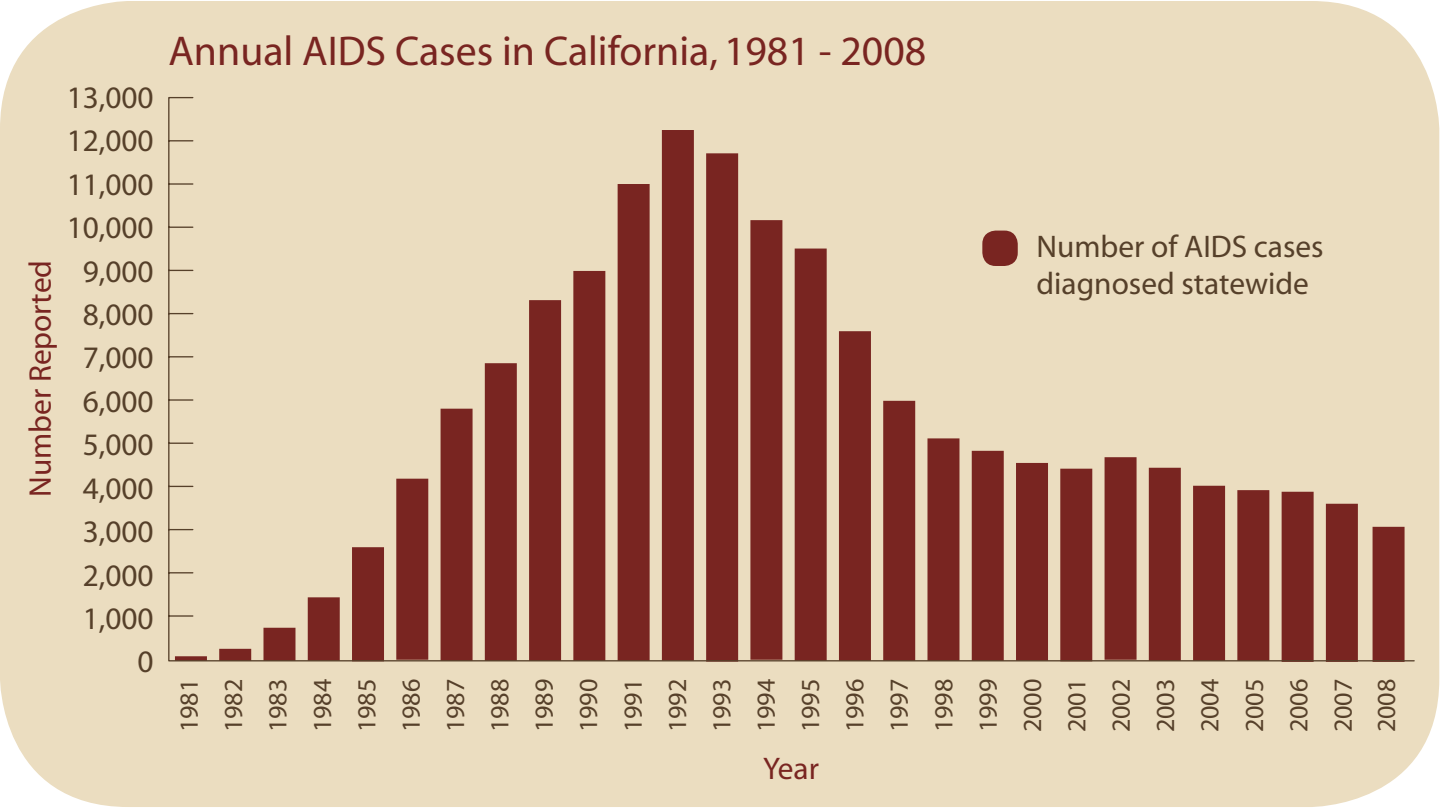
California reported its first AIDS case in 1981. Annual AIDS deaths increased rapidly throughout the 1980s and peaked in 1994, fell dramatically with widespread HIV testing and effective antiretroviral treatment which became available in 1996-1997, and continued with a slight downward trend over the past ten years. AIDS deaths dropped from 7,966 in 1994 to less than 1,710 each year since 2002. The death rate has held despite the number of persons living with AIDS (PLWA) rising from 52,416 in 2002 to 67,505 currently (data through April 30, 2009). Thus, the proportion of people dying continues to decrease.

The availability of highly active antiretroviral therapy (HAART) and statewide efforts to link HIV-positive persons to HIV care in California markedly improved survival across all racial/ethnic groups in the state. This dramatic improvement in survival was naturally linked to a corresponding increase in the number of PLWA residing in California. PLWA more than doubled among the Hispanic/Latino and Asian/Pacific Islander (API) populations during the first ten years of the HAART era, while the death rate due to HIV/AIDS fell by over 82 percent for both groups.

The combination of accessible HIV testing, HIV education and prevention programs, and effective treatment have also had a significant impact on the numbers of new AIDS cases diagnosed annually in California.



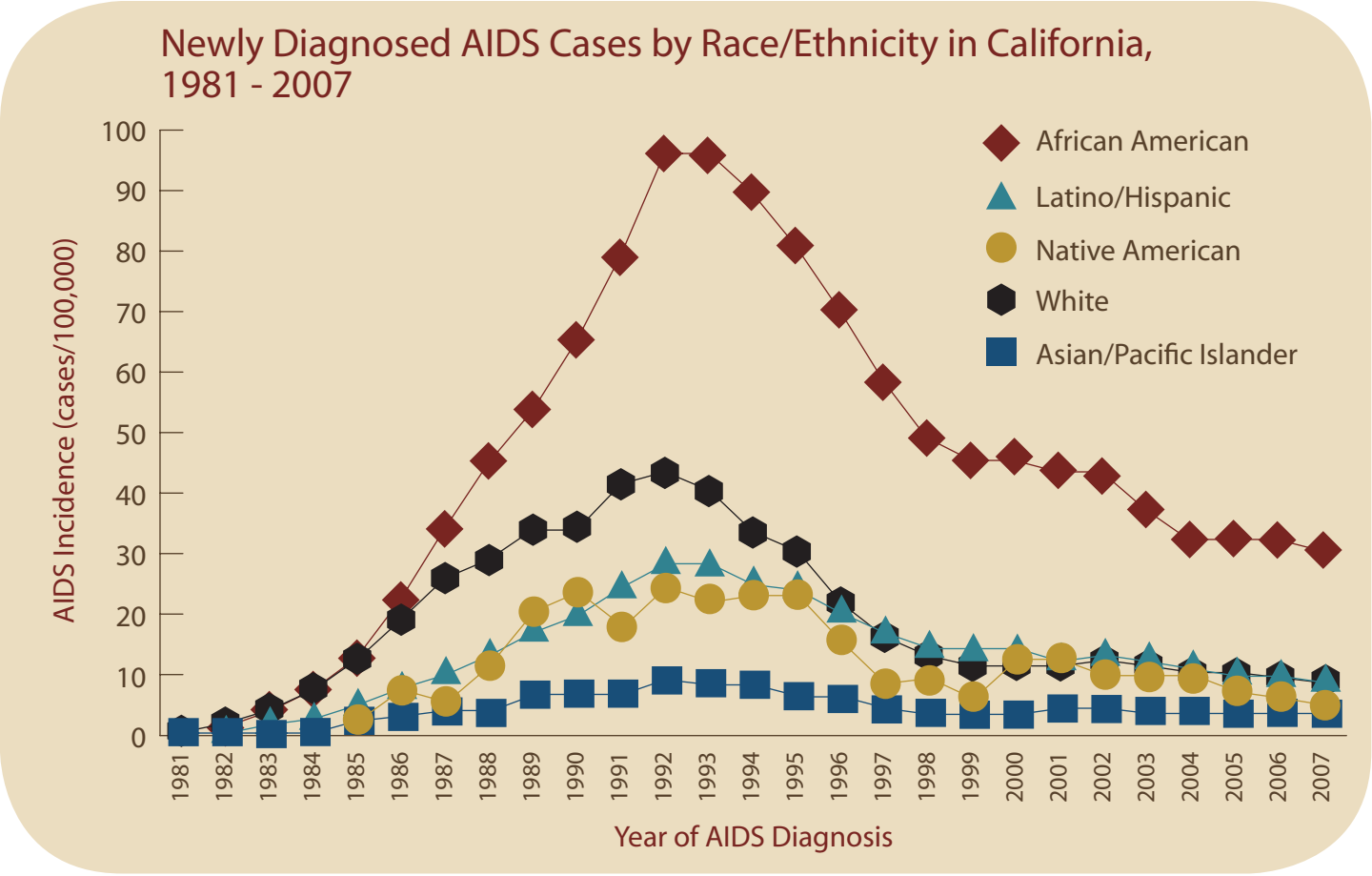
[4] http://www.cdph.ca.gov/programs/aids/Documents/EvolutionofAIDS.pdf



The number of AIDS cases diagnosed within the men who have sex with men (MSM), injection drug users (IDUs), and (MSM/IDUs) populations each fell by more than 75 percent in the 15 years between 1992 and 2007. However, the drop statewide was 70.7 percent, reflecting the expansion of the epidemic into the female non-IDUs population.

The fastest growing populations in California still show relative decreases in the number of AIDS cases diagnosed annually. During the 15-year period between 1992 and 2007, the Hispanic/ Latino population grew by over 64 percent, and yet the number of AIDS cases diagnosed still decreased by nearly one-half. Similarly, the API population grew by over 48 percent, yet the number of AIDS cases diagnosed within it decreased by over one-third.

A yearly trend of the AIDS burden on racial/ ethnic groups in California can be measured by annual newly-diagnosed AIDS cases, which indicates the rise and fall of AIDS rates as well as the disproportionate AIDS burden on the African American population in California.

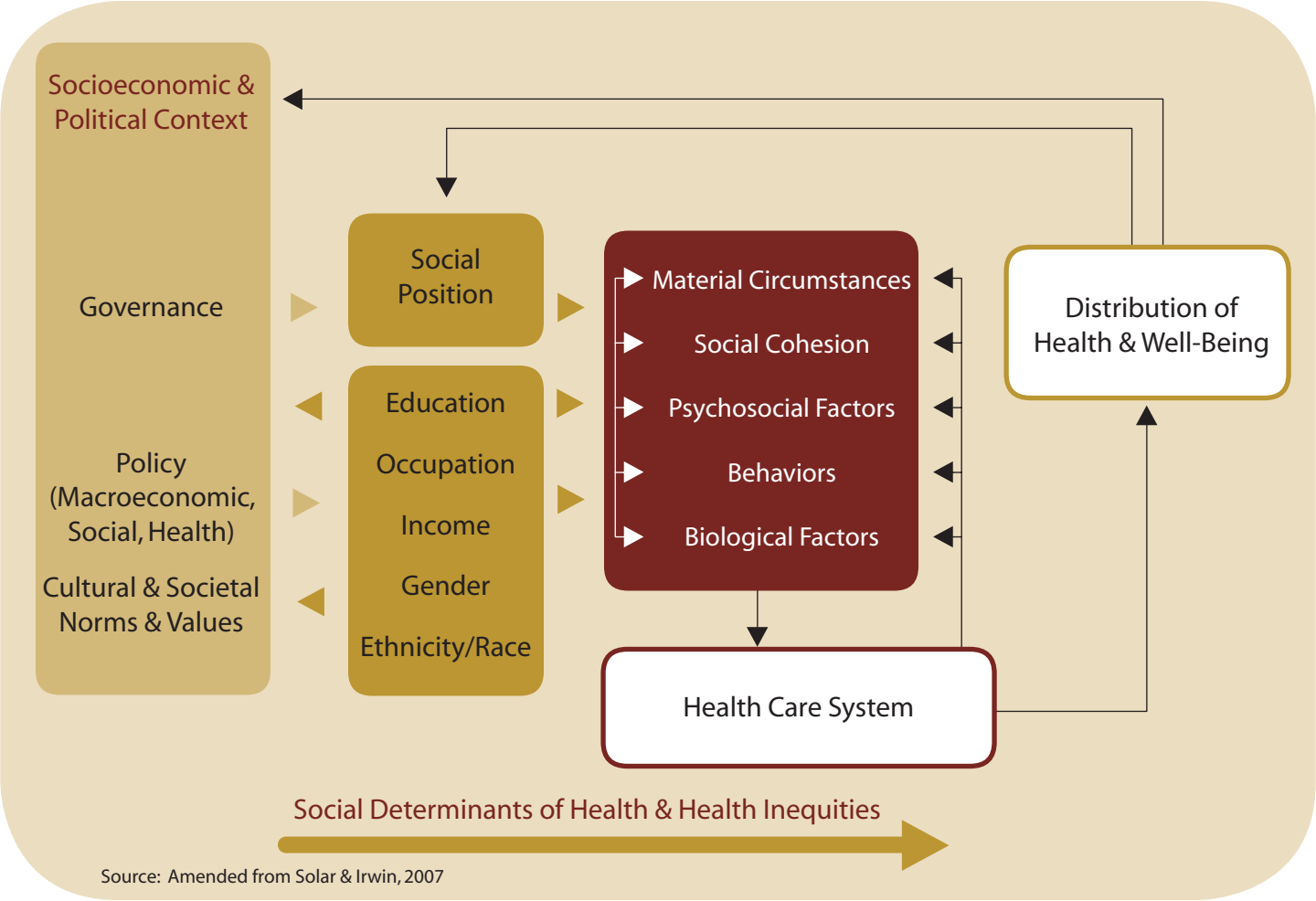


HIV infection became reportable in 2002 upon the implementation of HIV reporting by non-name code, and this system remained in effect until early 2006 after reporting over 41,000 cases. In April 2006, the code-based HIV reporting system was replaced by a name-based HIV reporting system.

April 30, 2009 marked the end of 36 full months of this reporting system, and 36,412 HIV (non-AIDS) cases have been reported.

Health Disparities

Since the advent of effective antiretroviral medications, encouraging successes have been achieved in reducing the incidence of HIV and improving health outcomes for HIV-positive persons. The traditional medical model is based on the idea that biological factors and individual health behaviors shape the risk of HIV disease, but a real understanding of the factors that influence health behaviors and outcomes requires a broader view. Powerful, complex relationships exist between health and biology, genetics, and individual behavior. These relationships are influenced by equally powerful and complex relationships between health services, socioeconomic status, the physical environment, discrimination, literacy levels, and legislative policies. These social and structural factors are known as determinants of health (2).



Source: Amended from Solar & Irwin, 2007

The model above, developed by the World Health Organization, provides a framework for understanding the array of determinants that influence health inequities.

Social and structural determinants are influenced in turn by the distribution of wealth and resources as directed through politics and policies. Ultimately, inequities tied to determinants lead to health disparities. While OA's policies and programs are guided by the commitment to reduce HIV-related disparities, as reflected in the development of the *OA Health Disparities Framework*,[5] these disparities continue to exert a powerful influence on quality of life and health outcomes for HIV-positive Californians.

Disparities and Age

Youth

In California, the age of new HIV diagnoses has shifted since 2000. The proportion of newly diagnosed cases in the 20-29 year old age group has increased significantly, and a greater proportion of youth newly diagnosed with HIV in California are persons of color. While teens 13-19 years of age comprise 22 percent of new HIV diagnoses overall, this age group makes up a distressingly high proportion of new HIV diagnoses in African Americans, representing up to 44 percent of new HIV cases within that population.

Analysis conducted by CDC found that nearly one-half of young people 13-24 years old and living with HIV were undiagnosed (47.8

[5] http://www.cdph.ca.gov/programs/aids/Documents/OAHDFramework.pdf

percent). The high percentage of undiagnosed youth is likely due to lack of knowledge and misperceptions about risk in this group, as well as the lower likelihood that younger people would have been infected long enough to exhibit symptoms of the disease that may prompt an HIV test (3).

In addition to elevated rates of HIV, acquisition and transmission and engagement in high-risk sexual behaviors, youth aged 15-24 years have the lowest utilization of medical office visits of any age group. Among those aged 20-29 years, men have lower rates of utilization of ambulatory and preventative care compared to women. Moreover, for both males and females, African American and Hispanic youth have lower utilization rates than Whites (4).

Elders

Current CDC data indicates that 31 percent of those living with HIV in the United States are age 50 and older, and 15 percent of new HIV infections are found in this age group. A national study in 2011, focused on lesbian, gay, bisexual, and transgender (LGBT) older adults, found that those who are HIV positive face disparities across a wide range of key indicators.[6] Regardless of socio-demographic differences, older LGBT individuals living with HIV are also more likely to have experienced victimization and employment discrimination than their HIV-negative counterparts.

Fifty-nine percent of LGBT older persons living with HIV are sexually active, and report that they are more likely than those who are HIV negative to engage in at least one HIV risk behavior. In addition, those with HIV are more likely to smoke and to use non-prescribed drugs than those who are HIV negative (5).

[6] http://caringandaging.org/

Nearly 40% of African Americans in California are low income, and are more likely to live in communities with limited access to essential services.

Disparities and Race/Ethnicity

African Americans

In general, African Americans suffer greatly disproportionate rates of negative sexual health outcomes, and reported differences in HIV and other sexually transmitted disease-related infection (STD) rates cannot be explained solely by differences in individual risk behaviors. Research in fact suggests that African American young adults are at very high risk for STDs, even when their behavior is normative rather than reflecting high-risk categories (6).

Nearly 40 percent of African Americans in California are low income, and are more likely to live in communities with limited access to essential services (7). African Americans in California were strongly affected by the recession in 2009 – the number of uninsured African Americans jumped from 16.8 percent in 2007 to 23.6 percent in 2009 (8). Multiple other factors also influence disparities among African Americans, including the targeted marketing of illegal drugs in low-income communities, distrust of the medical establishment, and high rates of incarceration.

The disproportionate incarceration of African Americans renders this social force a major part of the life experience of many families. For the same crime, the risk of incarceration is substantially greater for African American men than for White men, and the resulting incarceration disparity is enormous. As of 2010, African American men had an imprisonment rate that was seven times higher than that of any other race or ethnicity, and 7.3 percent of African American men ages 30-34 were in state or federal prison (9).

The NHAS points out that the gender imbalance that occurs in communities with high rates of incarceration also results in an "increased likelihood that the remaining men will have multiple, concurrent relationships with female sex partners," and an increased risk that a single male will transmit HIV to multiple female partners (10).

The likelihood of involvement with drug abuse and having sex with an infected sexual partner are increased if a person lives in an area where those risk factors are concentrated. The CDC refers to this disparity as "residential segregation", reporting that it partly explains the disproportionately high level of STDs, including HIV, among African Americans (11). High HIV prevalence and incidence within the sexual networks of African American MSM also places them at increased risk of HIV (12), and the population-level influence of community viral load appears to play a significant role as well (13).

In circumstances such as these, where the evidence clearly demonstrates that individual differences and risk behaviors do not fully account for differences in infection rates, traditional individual interventions may not be the most effective approach. Population-level and structural interventions should always be considered when conducting HIV prevention and care planning.

Latino/as

California is second only to New York among states with the largest HIV-positive Latino/a population. Between 1996 and 2006, the number of Latino/as with AIDS in California increased by 128 percent -- the largest increase of any ethnic group in the state. Latino/as are less likely to test for HIV than other ethnic groups, and are more likely to test later in the course of their infection than any other ethnic group (14).

The causes of the disproportionately high rate of HIV/AIDS in the Latino/a community are complex – as varied as the diverse cultures and nationalities that make up the Latino/a population as a whole. However, there are common factors that contribute to HIV-related health disparities among its members, including high mobility, immigration-related issues, isolation from family and country of origin, stigma, discrimination, and marginalized status (15).

Between 1996 and 2006, the number of Latino/as with AIDS in California increased by 128%.

Participants in Spanish-speaking focus groups conducted by OA-funded providers indicated that language barriers make it difficult to access prevention and care services. In addition, language barriers contributed to feelings of isolation, stigma, and increased fears regarding their HIV diagnosis and receiving care (16).

Latino/as are less likely to have health insurance than any other ethnicity in California. A total of 28.7 percent Latino/as were uninsured in 2007, increasing to 30.1 percent during the 2009 recession. Latino/as are more likely to work in industries that do not provide health care as a job benefit, experiencing the lowest rate of any ethnic group in the state for job-based insurance coverage, and they more frequently experience barriers to coverage due to immigration status. Twenty-seven percent of Latino/as have no regular source of medical care, corresponding to their lower levels of health insurance coverage, and comprise a barrier to identifying and treating potentially serious conditions (17).

Asian and Pacific Islander (API) Populations

The API population in California is diverse and growing rapidly. Although HIV/AIDS prevalence and incidence have remained relatively low among API, lack of disaggregated data by national origin masks the differential impact of HIV/AIDS on the distinct sub-groups making up the API population.

CDC's Behavioral Risk Factor Surveillance System found that APIs are significantly less likely than members of other races/ethnicities to report having been tested for HIV (18). Data from an HIV testing survey in Seattle, Washington, indicated that of the APIs surveyed, 90 percent perceived themselves at some risk for HIV infection, yet only 47 percent had been tested during the past year (19).

API populations experience a number of socio-economic, cultural, and linguistic barriers to access to HIV/AIDS services. These barriers are compounded by the diversity of the API population in California in terms of languages spoken, ethnicity, national origin, culture, immigrant status, literacy levels, health beliefs, socio-economic status, health care coverage, and geographic distribution across both urban and rural settings (20).

Health coverage varies widely across API communities. However, as a group, APIs are more likely to be uninsured than non-Hispanic Whites (21). In some API communities, HIV is not acknowledged due to cultural beliefs and norms related to health and disease, sexuality, and homophobia. Access is also influenced by cultural norms stressing self-reliance and handling problems in private. Finally, API immigrants may view some HIV risk behaviors as attributable to mainstream culture or to other minority groups, and therefore distance themselves from HIV-related concerns (22).

Disparities and Sexual Identity/Sexual Orientation

Significant negative health outcomes for LGBT people result from the combined influence of three primary factors: lack of cultural competence in the health care system, reduced access to employer-provided health insurance, and social stigma against LGBT persons. These factors are amplified among LGBT persons of color, increasing the likelihood of disparities and negative health outcomes (23).

Among adult Californians, LGBT individuals are less likely to have health insurance than their heterosexual counterparts, based in part on employment gaps related to workplace discrimination and on a lack of domestic partner benefits. LGBT Latino/as are the least likely to have health insurance, and the least likely to have any regular source of basic health care. LGBT African American adults are the most likely to delay or fail to get needed prescription medications, and LGBT adults from all communities of color are more likely to delay or fail to seek out basic health care (24).

Up to 39% of transgender people face some type of harassment or discrimination when seeking routine health care.

Stigma may lead LGBT individuals to avoid disclosing their sexual or gender identity to health care providers, who as a result remain unaware of their LGBT patients' specific physical or mental health concerns. Some LGBT persons face outright hostility from providers: one of the few existing studies of the transgender community shows that up to 39 percent of transgender people face some type of harassment or discrimination when seeking routine health care (25).

In order to fully understand the HIV prevention and care needs of transgender persons, better surveillance data is needed. Currently, there are no national estimates of the prevalence of HIV among transgender populations, due to lack of data collection at the national level. The information that is currently available paints a disturbing picture in terms of HIV-related disparities in this community. Data from CDC-funded testing programs shows high percentages of newly identified HIV infections among transgender people: 2.6 percent compared with 0.9 percent for males and 0.3 percent for females. Among transgender persons, the

highest percentage of newly identified HIV infection is among African Americans (4.4 percent) and Latino/as (2.5 percent) (26).

Even transgender people with access to health care face substantial obstacles in obtaining appropriate care. The 2008 *State of Transgender California Report*, a statewide survey of transgender adults, found that 30 percent of respondents postponed care for illness or preventive care due to discrimination from physicians or other health care providers, and 11 percent had a care provider flatly refuse to treat them because they were transgender or gender non-conforming. Thirty-five percent reported having to teach their physician or provider about transgender people in order to get appropriate care (27).

Transgender Californians report alarmingly high rates of denial for basic health care services by providers or insurance companies, including denials for surgery, hormones, counseling and mental health services, and even primary health care. Financial barriers and denials of coverage result in many transgender people putting off all health care needs. Even when covered by insurance, 42 percent of respondents delayed seeking care because they could not afford it, and of these, 26 percent reported health conditions that worsened because they postponed care (28).

Disparities and Geographic Location

Border Regions

While there are only two border counties in California (San Diego and Imperial), the California-Mexico border region is home to one-half of the total U.S.-Mexico border population on the U.S. side, and its communities represent a distinctive region with unique social, political, and economic relationships. The U.S.-Mexico border region is predominantly rural with 73 percent of the border counties designated as Medically Underserved Areas and 63 percent designated as Health Professional Shortage Areas for primary medical care (29).

Poverty, undocumented status, and marginalization of the Latino/a communtiy are contributors to limited and inadequate health care access among border residents. More than 58 percent of newly enrolled clients in border HIV clinics report that it has been more than one year since their HIV diagnosis (30). Some of the most common barriers to HIV care among border residents include stigma, general concerns about HIV medications, and related concerns about HIV medication side effects.

Regional cross-border mobility is a significant factor in binational public health. More than 60 million yearly border crossings occur in the San Diego County and Baja California region alone (31). Health care bureaucracy in the United States, transportation issues, and language barriers also impact access. For many Latino/a families, seeking health care services means crossing the international border – low cost, less bureaucracy, and a common language make seeking health care or purchasing medications in Tijuana or Mexicali the preferred option (32). This, however, complicates issues of adherence and treatment management. Smaller but still significant numbers of clients report seeking out traditional medications or herbs in Mexico, and/or utilizing traditional healers in Mexico or in the United States (33).

California border populations include distinct groups with high levels of HIV risk that tend to be unique to U.S. Southwest border regions, and as a result may not be fully recognized at the national level. These include Latino/a farm workers, Latino/a sex workers, trans-border Latino/as, and newly immigrated Latino MSM.

Despite the differing political, social, economic, and cultural characteristics that define the United States and Mexico, Southern California's proximity to the border demands that border and binational health be ongoing considerations in HIV prevention and care. However, organizations in the region face institutional and structural barriers in securing enough support to build the infrastructure needed for binational work. Highly mobile border populations mean that gathering

surveillance data, implementing prevention interventions, ensuring access to care, and providing the necessary continuum of HIV care is extremely challenging.

> More than two-thirds of California's rural counties do not have the minimum number of primary care physicians considered adequate to meet demand.

Rural Regions

In much of the United States, little is known about HIV care among rural populations. A recent California study assessing the health care needs of HIV-positive women in rural areas found that the most commonly cited barriers to accessing care included physical health problems that prevented travel to care (32.8 percent), lack of transportation (31.2 percent), and lack of ability to navigate the health care system (25.0 percent). The women also expressed strong concerns about perceived provider bias and experiences with HIV-related stigma (34).

As reported in the Rural Think Tank hosted by OA in 2009,[7] rural areas attract few hospitals or specialists, and transportation and weather conditions can add to difficulties in getting health care needs met for a population that has higher rates of poverty than cities. In general, rural counties tend to have far fewer physicians per capita than urban counties, and more than two-thirds of California's rural counties do not have the minimum number of primary care physicians considered adequate to meet the demand (35).

Rural Think Tank participants also reported that rural areas struggle with high numbers of uninsured patients, lack of bilingual/bicultural providers, and insufficient numbers of providers who are familiar with HIV-related care. Fear of unwanted disclosure may create significant barriers for HIV-positive rural residents seeking care and treatment. Even if care is accessed, adherence may be a struggle, with some individuals so fearful of being publicly identified through their medications that they stop taking medication or drop out of care altogether (36).

For those living in sparsely populated areas, there is little community infrastructure for mobilizing or leveraging resources. Finally, given limited funding for HIV prevention and care services, rural areas typically do not have access to the resources available to urban centers.

Social and Structural Determinants of HIV-Related Health

The NHAS reminds us that social and structural determinants are critical influences on individual and community health. While the macroeconomic and social influences that shape the HIV epidemic are complex, structural interventions such as expanded syringe access for drug users, increased access to health care, and availability of stable housing can influence these determinants in positive ways. In order to develop and implement structural interventions, it is important to note the predominant social and structural determinants of HIV-related health in California.

Poverty

Wealth status determines the likelihood of HIV infection in America. A study by CDC in 2010 showed that in America's poorest urban neighborhoods HIV prevalence was more than four times the national average. Higher HIV risk within poor urban areas was attributed to high HIV prevalence, limited access to health care and other basic services, and high rates of substance abuse and incarceration. Socioeconomic status and HIV prevalence are also linked among MSM (37).

[7] http://www.cdph.ca.gov/programs/aids/Documents/RPTRuralThinkTankMarToSep2009.pdf

Census data indicates that the number of Californians living in poverty grew for the fourth straight year in 2010. An estimated 6 million Californians had incomes below the federal poverty line of $22,113 for a family of four. This represents 16.3 percent of the population, increased from 15.3 percent in 2009. The national poverty rate is 14.9 percent. Statewide, 11 percent of children grow up in communities where 30 percent or more of the residents live in poverty. Unofficial poverty rates are even higher when California's high cost of living is accounted for (38).

OA has utilized the integration of hardware, software, and data provided through Geographic Information Systems technology to develop poverty maps within California jurisdictions. Poverty mapping, as the spatial representation and analysis of indicators of well-being and poverty within a region, is useful in a variety of ways. Surveillance data combined with poverty analysis provides a powerful tool for presenting complex information in a visual format that is easy to understand, and can summarize multiple factors in a simple display that is very difficult to achieve otherwise. This clarity and detail can contribute to more effective design of interventions and targeting of resources (39).

Migration/Immigration

Immigrants have always played a vital role in California's economy and culture, and the state continues to experience dramatic demographic shifts influenced in part by immigration. Between 1970 and 2009, the number of California residents born abroad increased more than fivefold, from 1.8 million to almost 10 million. California has more immigrants in its population than the United States as a whole (27 percent versus 13 percent) or any other state. Another 22 percent of Californians have at least one immigrant parent (40).

The vast majority of California's immigrants (90 percent) are from Latin America (55 percent) or Asia (35 percent). Their leading countries of origin are Mexico (4.3 million), the Philippines (783,000), and China (681,000) (41). Because Mexico so definitively represents the largest source of immigration to California, most discussion in this section will focus on Mexican immigrants. However, it is important to note that California jurisdictions are working to address the distinct HIV prevention and care needs of immigrant communities representing many other countries, including the Philippines, Korea, China, Vietnam, and Africa (42).

IMMIGRANTS ARE MORE LIKELY TO PRESENT WITH LOWER INITIAL CD4 COUNTS AND ARE MORE LIKELY TO HAVE CONCURRENT OPPORTUNISTIC INFECTIONS AT THE TIME OF HIV DIAGNOSIS THAN US-BORN HIV-INFECTED PERSONS.

Studies of risk factors for delayed access to care in California demonstrate that immigrants are more likely to present with lower initial CD4 counts and are more likely to have concurrent opportunistic infections, at the time of HIV diagnosis than U.S.-born HIV-infected persons. Interviews conducted through the course of one study with Latino/a immigrant patients with newly diagnosed HIV infection indicated that "…lack of knowledge regarding HIV risk, social stigma, secrecy, and symptom-driven health-seeking behavior all contribute to delayed clinical presentation and poor engagement with the medical system" (43).

Over 25 percent of Mexican immigrants who are farm workers have been in the United States for less than one year (44). Customs and behaviors common in the United States are thus foreign and may be confusing to them. Even when they have been in the United States for a few years, isolation and separation from local communities lead to continued low acculturation overall, and this directly and indirectly influences a number of HIV-related risk factors.

One California clinic providing HIV care to Mexican immigrants assessed 92 percent of their more than 300 clients as having low to very low levels of acculturation (45). Both married and unmarried Latino men with low levels of acculturation are more likely to have multiple sex partners, and less acculturated Latina women have lower rates of condom use. Another California study found that low levels of acculturation were significantly associated with having fewer HIV tests, no hepatitis C tests, testing positive for HIV, and low levels of access to care (46).

Complicating the issue of access is the fact that in the wake of severe budget cuts associated with the 2009 recession, many California counties decreased clinic hours or even closed clinics, while some eliminated nonemergency health services for undocumented immigrants.

For migrant and seasonal farm workers, health care reform offers few viable solutions. With the implementation of the Affordable Care Act (ACA), many lawfully present immigrants will remain ineligible or be required to wait for years to enroll in Medi-Cal, California's federally subsidized Medicaid program (47). While they can buy health insurance and apply for tax credits in insurance exchanges, this option may still be unaffordable for very low-income immigrant families.

Undocumented immigrants, children as well as adults, are not recognized in any way in the health care reform law. Undocumented immigrants are not eligible for federal health care programs, and are specifically excluded from the health insurance exchange provisions of the ACA that help people get insurance coverage (48).

Health Literacy

The California Health Literacy Initiative reports that half of all adults have difficulty understanding health information such as medication labels, how to interpret laboratory results, or even the meaning of nutritional information provided on food products (49).

Literacy skills are a stronger predictor of an individual's health status than age, income, employment status, educational level, or racial/ethnic group (50). Limited health literacy is more prevalent among older adult minority populations, those who are poor, and medically underserved people (51).

Among HIV-positive persons at risk for receiving suboptimal health care due to histories of substance abuse, incarceration, mental illness, and unstable housing or homelessness, those with lower levels of health literacy were more likely to be African American or Latino, speak Spanish as their primary language, and have less than a high school education (52). In HIV care, clients with lower health literacy demonstrate poorer adherence compared to those with higher health literacy, and in multiple studies, health literacy predicts adherence over and above all other factors (53).

Drivers and Cofactors of the HIV Epidemic

The most pervasive elements affecting HIV risk act as driving forces to continue and expand the epidemic. These are conditions that influence not just individuals or communities, but which act to amplify the factors that increase susceptibility to HIV on a scale that fuels the continuation of the epidemic as a whole (54). There has not yet been sufficient research to enable full characterization of the drivers of the HIV epidemic in California on a statewide basis, but some jurisdictions have identified drivers associated with their locales. Regional drivers identified to date include specific substance use patterns, particularly use of methamphetamine, cocaine/crack, and heavy drinking; prevalence of specific sexually transmitted infections (STIs) such as syphilis or gonorrhea; and the presence of specific sexual activity patterns, particularly multiple partners when combined with unsafe sexual activities.

Cofactors are factors that more generally affect risk for acquisition, transmission, or disease progression of HIV, but which may not produce the marked amplifying effect of drivers. Cofactors

can be behavioral, environmental, genetic, or biological, and when conducting prevention or care planning, it is important to remember that a cofactor in one jurisdiction or within one population may be a driver in another.

Drivers and Cofactors: Substance Use

If HIV resources are to be targeted to the communities and populations at greatest risk and with the greatest disease burden, it is essential to consider not just substance use in general, but rather the constellations of substance use patterns that drive the HIV epidemic. For California, the substance use categories that currently appear to have the greatest influence on HIV acquisition/transmission include cocaine/crack, methamphetamine (alone and in association with other drugs), and heavy drinking.

> Cocaine/crack users with HIV are less likely than HIV+ non-users to have access to basic medical services, and more likely never to have been in HIV primary care.

Cocaine and Crack

The National HIV Behavioral Surveillance System (NHBS), which includes three cities in Northern and Southern California, reports that as of 2008, 25 percent of MSM participants had used cocaine in the past 12 months (55), and 20 percent of cocaine-using IDUs injected crack, 55 percent used non-injection crack, 34 percent injected cocaine, and 18 percent used non-injected cocaine in the previous 12 months (56).

Recent treatment studies find that up to one-third of cocaine dependent participants in treatment, had traded sex for drugs and/or money three or more times and had more than ten sexual partners in one year, and reported a past STD diagnosis (57).

Cocaine users, especially those with a dependence diagnosis, are more likely to miss regular medical appointments and have less access to a regular health care provider and support services (58). Crack-cocaine use facilitates HIV disease progression by reducing adherence in those on HAART, and appears to accelerate disease progression independently of HAART (59).

Cocaine/crack users with HIV are less likely than HIV-positive non-users to have access to basic medical services, and more likely never to have been in HIV primary care. They are also less likely to have a regular health care provider and to initiate medical care and treatment (60). Lack of medical care and/or reduced adherence, combined with the fact that HIV-positive crack users are more likely than HIV-positive non-users to continue to engage in high-risk sexual behaviors with HIV-negative or unknown-status partners, leads to increased HIV transmission risk for this population (61).

Methamphetamine and Associated Drugs

The use of methamphetamine has exerted a formidable influence on the public health landscape in California. A variety of studies in the United States have demonstrated a clear association between methamphetamine use and risk for HIV among MSM (62), and this is considered to account in part for the increased incidence of HIV in MSM populations in particular. Among heterosexuals, methamphetamine users are more likely to engage in unprotected sex, unprotected sex with casual partners, and sex while high (63).

California studies found that HIV-positive MSM methamphetamine users were less likely to use condoms and had higher depression scores than MSM in general, and were more likely to have ten or more sexual partners in the previous 12 months (64). One Los Angeles study found that among a sample of older, low income men, there was higher HIV prevalence and higher risk sexual behaviors than found in crack cocaine users (65). Among HIV-positive persons,

methamphetamine use is also known to interfere with HIV treatment adherence, and to negatively impact cognitive functioning. Methamphetamine appears to accelerate HIV disease progression and may independently exert immunosuppressive effects (66, 67).

In MSM and young MSM in particular, the need to understand the links between methamphetamine use and HIV risk has led to consideration of methamphetamine use associated with sex clubs, circuit parties, bathhouses, and use of the Internet and social media to initiate contact with sexual partners. Young MSM who use methamphetamine have been found to be more likely than older MSM to report unprotected anal intercourse, multiple anal sex partners, and sex in a bathhouse or sex club with a partner they met via the Internet or in exchange for resources (68).

Two primary patterns of polydrug use within these contexts have been identified: drug combinations motivated by sexual performance and enhancement (methamphetamine, poppers, Viagra) and "party drug" combinations with socially disinhibiting and mood elevating qualities (methamphetamine, GHB, ketamine) (69).

The links between methamphetamine use, HIV, STDs, sexual risk taking, and a wide range of related psychosocial and health problems have been acknowledged for over a decade. However, if prevention and care resources are to be focused in order to most effectively curb the HIV epidemic, the specific drug combinations and associated social/environmental settings most likely to contribute to HIV seroconversion must be identified and understood.

Heavy Drinking

Throughout the HIV epidemic, alcohol use has been recognized as a risk factor for HIV transmission/acquisition (70). The literature related to alcohol use and HIV points to three main areas of concern: alcohol's influence on the spread of HIV, the contribution of alcohol to the development of HIV disease, and the reduction of the effects of HIV medication resulting from alcohol use (71).

Research over the past ten years has provided a more nuanced understanding of alcohol and HIV risk, pointing more specifically to heavy drinking as a potential driver of the HIV epidemic and as an influence that compromises HIV health outcomes. Alcohol use is common among persons with HIV infection, with rates of heavy drinking twice that found in the general population (72). The use of alcohol before sex and heavy alcohol use are independent predictors of seroconversion (73). Heavy alcohol use increases HIV risk behaviors, including having unprotected sex, unprotected sex with multiple sex partners, and high-risk injection behaviors (74).

Alcohol is an immunosuppressant, and alcohol abuse after contracting HIV seems to accelerate disease progression through a direct effect on CD4 cells. Consuming more than five drinks a week is a predictor for not being on HAART and for having an unsuppressed viral load (75). Even intermittent use of alcohol can complicate HIV-related health outcomes by diminishing adherence, increasing side effects, or changing the pharmacokinetics of prescribed medications (76).

Drivers and Cofactors: STIs

That STIs drive HIV infection is well documented (77, 78, 79), though the influence of specific STIs varies across and between jurisdictions. In 2010, the California STD Surveillance Graph Set[8] summarizes trends of the last few decades (80). Chlamydia rates have steadily risen over the last decade, and remain concentrated in younger Californians, aged 15-29 years old. The rate of chlamydia among African Americans and Latino/as is notably higher than the rate of chlamydia among Whites. While gonorrhea has decreased over the last ten years, resistant gonorrhea has increased, starting at less than 5 percent of isolates in 2000, peaking in 2006 at about 35 percent of isolates, and still remains high at around 20 percent of isolates in 2010. There has been a significant increase in the rate of detected syphilis in California over the last ten

[8] http://www.cdph.ca.gov/data/statistics/pages/STDData.aspx

years, mostly in MSM, of whom 54 percent were also living with HIV. Seeking sexual partners on the Internet was a driver of syphilis infection within MSM, beginning at about 15 percent of MSM, primary and secondary syphilis cases in 2001, and increasing to 40 percent in 2010. Methamphetamine use was also associated with both MSM and female syphilis cases throughout the last decade. Most of the syphilis cases were found in ages 25-44 years old, and a disparity of more cases among African American men is identified.

It is noteworthy that social determinants that impact co-infection within California include health services and behavioral influences. HIV and STI testing are not fully integrated, leading to those diagnosed with an STI not always being tested for HIV and vice versa. One of OA's goals is to continue to integrate STI, hepatitis, tuberculosis (TB), and HIV testing so that comprehensive screening becomes routine when indicated.

Drivers and Cofactors: Mental Disorders

Mental disorders are common among HIV-positive individuals, and OA provider surveys as well as statewide and national studies indicate that HIV-positive persons in public health care are likely to have high rates of acute and posttraumatic stress disorders (PTSD) and depression. One California study examined the prevalence of three stress-related psychiatric diagnoses: depression, PTSD, and acute stress disorder (ASD) among a population of HIV-positive persons attending two county-based HIV primary care clinics. High percentages met the screening criteria for depression (38 percent), PTSD (34 percent), and ASD (43 percent), and 38 percent screened positively for two or more disorders. Of the patients with at least one of these disorders, 43 percent reported receiving no concurrent mental health treatment (81).

In addition to the negative impact on quality of life, mental disorders are associated with increased HIV risk behavior as well as decreased access and adherence to HIV treatment (82). The additive relationship between substance abuse and mental disorders can magnify the risk of a particular population for HIV disease and other negative health outcomes. Data from a large-scale sample of urban MSM, including men in Los Angeles and San Francisco, assessed whether an amplifying relationship between depression, polydrug use, childhood sexual abuse, and partner violence may be driving the HIV epidemic among MSM. Results indicated that all four of these psychosocial health problems were independently related to a greater likelihood of high-risk sexual behavior and of having HIV (83).

OA Prevention and Care Services: Funding

Resource Allocation Strategies

Effective allocation of resources provides the foundation for maximizing the effect of strategies and interventions intended to achieve the goal of reducing HIV infections and improving health outcomes for those who are HIV positive. The resource allocation strategies recommended by CPG are intended to assist OA in the creation and review of a comprehensive and cohesive implementation plan that will address the goals and objectives of NHAS, inform the goals and objectives of the Integrated Plan, and guide its monitoring and evaluation.

The statewide resource allocation strategies recommended by CPG are as follows:

1. Provide support to facilitate the relationship between Prevention and Care;
2. Identify the most effective models of supporting Prevention and Care collaboration;
3. Provide technical assistance as a major component of the Integrated Plan;
4. Provide capacity building in traditional or newly imagined formats based on best practices;

5. Ensure that linkage and retention goals are shared across prevention and care LHJ grantees; and
6. Identify current drivers of HIV incidence in priority populations and use this information to design and target interventions and strategies for maximum impact.

Prevention Funding and Services

The CDC funding that supports OA's prevention activities (CDC PS12-1201- Comprehensive HIV Prevention Programs for Health Departments) established three distinct funding areas in California: the Los Angeles and San Francisco Metropolitan Statistical Areas (MSAs), and the California Project Area (CPA). Consistent with CDC's direction, OA does not provide prevention funding to Los Angeles and San Francisco's MSAs as of January 1, 2012.

The OA allocation formulas are consistent in principle with the NHAS disease-burden-based allocations, especially in the context of the NHAS recognition that all resources within the state need to be considered. Application of the OA allocation formula has resulted in the provision of local assistance funding to LHJs in the CPA representing the highest burden of HIV cases (95.08 percent). The remaining 40 LHJs do not receive local assistance funding from OA for HIV prevention activities, but can access educational materials, condoms, and materials related to syringe services and prevention for IDUs.

OA distributed its CDC PS12-1201 allocation to 19 LHJs based on a weighted funding allocation proposed by OA and approved by CPG. The formula is based on the following criteria and weights:

- 75 percent: percentage of people living with HIV and AIDS, excluding prison cases;
- 15 percent: percentage of African Americans;
- 5 percent: percentage of Latinos; and
- 5 percent: people living below poverty.

The percentages represent the proportion of each criterion within each LHJ out of the total number in all eligible (OA-funded) LHJs. Each criterion is then weighted and totaled. For example, if an LHJ has 18 percent of all living HIV and AIDS cases out of all cases in the eligible LHJs, 21 percent of all African American people in the eligible LHJs, 14 percent of all Latinos, and 9 percent of people living below poverty then the following formula would be applied to determine the percentage of their allocation: (.18 x .75) + (.21 X .15) + (.14 X .05) + (.09 X .05) = 0.135 + 0.0314 + 0.007 + 0.0045 = 0.178. This LHJ's allocation would be 17.8 percent.[9]

OA allocates CDC funding directly to LHJs to support Partner Services (PS) activities. Eighteen LHJs receive PS using an updated formula determined and based on a tiered approach that assesses the level at which an LHJ may need technical and capacity building assistance, as well as help from the California Department of Public Health, STD Control Branch, to perform elicitation, third-party notification, and other PS-related activities.

In the response to the CDC PS12-1201,[10] OA proposed and CPG approved the following areas of primary emphasis:

- Routine opt-out HIV testing in health care settings and targeted HIV testing and screening in both health care and non-health care settings, in order to increase the identification of HIV-positive individuals;
- Linkage to care (LTC) and other services for newly identified HIV-positive individuals;
- PS at the time of testing and ongoing throughout the provision of care and treatment;
- Retention in care, treatment adherence, and re-engaging HIV-positive individuals who have fallen out of care;

[9] http://www.cdph.ca.gov/programs/aids/Documents/11MAD5aPrevAllocation.pdf
[10] http://www.cdph.ca.gov/programs/aids/Documents/PREVCDC2012PrevAppNarr.pdf

- Condom distribution to HIV-positive and HIV-negative individuals engaging in high-risk behaviors;
- Structural and policy issues related to HIV prevention, specifically planning for implementation of the Affordable Care Act, state and local implementation of Assembly Bill 2541 (Authors Portantino and Fletcher, Statutes of 2010, Chapter 470) addressing the public health use of surveillance data, and considerations related to the Alcohol and Drug Program-administered Substance Abuse and Mental Health Services Administration HIV set-aside funding; and
- Syringe access and related activities where authorized but no longer supported by Federal funds.

After determining allocations, OA requires funded jurisdictions to utilize a two-tiered system of prioritized activities. Through requiring these specific activities, OA is responding to the priorities represented by NHAS, CDC's 'High Impact Prevention' strategy, OA Goals and Strategies Framework,[11] and the principles and goals put forward by CPG. A wide array of technical assistance will be made available to the funded LHJs in order to build capacity to achieve these priorities and goals.

Funded LHJs must use their allocation to provide services designated by OA as Tier I. Tier I services include HIV testing in health care and non-health care settings; linkage, engagement, and retention in care activities, PS, risk assessment and linkage to behavioral interventions and other services for HIV-positive persons in care settings; integrated hepatitis, TB, and STD screening; treatment adherence support; syringe services; Affordable Care Act implementation planning, and condom distribution and marketing.

If a given LHJ can demonstrate that all Tier I services are being provided, using any funding sources or resources available to that LHJ, then they may opt to use OA funding to provide services in Tier II. Tier II prevention activities include hepatitis C testing; integrated HIV, hepatitis, TB, and STD screening with PS for persons of unknown HIV status; behavioral interventions for high-risk HIV-negative persons; social marketing, media, and mobilization campaigns, and pre-exposure prophylaxis (PrEP) planning and/or delivery.

Because PrEP is a new HIV prevention method, OA will follow the results of demonstration projects currently being conducted in San Francisco, San Diego, Long Beach, and Los Angeles that are designed to test the effectiveness of PrEP in real-world situations, outside of clinical trials. In addition, pilot PrEP implementation strategies are planned for young MSM of color in Oakland, Richmond, Berkeley, and other East Bay area locations.

The demonstration projects will consider the costs and feasibility of expanding access to PrEP, the settings in which PrEP should be offered, whether PrEP can be offered in a way that helps reduce HIV-related health disparities, and what can be done to support adherence among young MSM of color since PrEP success is dependent upon medication adherence.

Finally, during 2010-2011, OA developed three key policy initiatives that are aligned with CPG recommendations and are critical to OA's prevention work that will be supported and expanded under PS12-1201:

- Encouraging state and local coordination of the HIV Early Intervention Services (EIS) funds disbursed by Alcohol and Drug Program as part of the HIV Set-Aside portion of the Federal Substance Abuse Prevention and Treatment Block Grant;
- Addressing legislative, policy, and procedural barriers to using HIV surveillance data to assist in identifying HIV-positive individuals not receiving HIV care and linking them into needed services; and

[11] http://www.cdph.ca.gov/programs/aids/Documents/OAGoalsStrategies122409.pdf

- Leading a collaborative statewide process to explore and define the HIV-related issues, resources, and unanswered questions associated with health care reform in the 2014 implementation of ACA.

Care Funding and Services

OA is a Ryan White HIV/AIDS Part B HIV Care Program (RWHAP) grantee. The RW program serves as wrap-around services to pay for outpatient medical care, support and treatment that are not covered by other funding sources. CA's RW funded care programs include: HIV Care Program (HCP), Minority AIDS Initiative (MAI) and AIDS Drug Assistance Program (ADAP) who do not qualify for other programs.

OA care services and collaborative partnerships with prevention and other HIV providers are intended to address each category illustrated in HRSA's representation of the continuum of engagement in HIV care:

OA's continuum of HIV care emphasizes early entry and retention in care, a comprehensive array of core medical services, and support services focused on increasing the probability that HIV-positive persons can access and remain in care. This continuum has evolved in response to significant changes in the field of HIV, reflecting new approaches described in the NHAS and in HRSA and CDC guidelines. Achieving the vision of the NHAS will succeed in part through operationalizing the concept of treatment as prevention, prioritizing diagnosis, linkage, retention, and engagement in care, and advocating more robust integration of HIV prevention and care services.

In order to prevent duplication of services, OA supports its funded jurisdictions in working collaboratively to integrate Ryan White, CDC-funded providers, and other HIV-related providers within the overall system of HIV prevention and care. This is meant to create seamless access and continuity of care as well as ensuring that RW Part B is the payer of last resort.

Ryan White Program Funding in California for 2012:

Source	Amount	Services
RW Part A	$99,580,179	Core Medical and Support Services
RW Part B Base	$34,684,816	Core Medical and Support Services
RW Part B ADAP	$106,356,976	AIDS Pharmaceutical Assistance
RW Part C	$19,643,580	Outpatient, Early Intervention Services
RW Part D	$6,595,975	Women, Infant, Children and Youth affected family members AIDS Health Care
RW Part F: SPNS	$3,158,888	Innovative models of HIV care to respond to the emerging needs of RW clients
RW Part F: AETC	$6,034,071	Education and Training
RW Part F: Dental Programs	$1,442,381	Oral health

The RW Part B grant is administered with funding through a single allocation model, which is administratively streamlined through HCP for HIV medical care, treatment, and support services. OA allocates funding to 43 LHJs and community-based organizations (CBOs) based on specific needs and capacity at the county level.[12] For HIV care services, OA proposed and CPG approved an allocation formula that includes the following elements:

- Living HIV and AIDS Cases (Prevalence and Incidence Data);
- Census Data;
- Persons per Square Mile;
- Non-English Speaking;
- Persons Below Poverty Level;
- People of Color;
- Medi-Cal HIV-Positive Beneficiaries with One or More Claims for HIV-Specific Medications; and
- ADAP Clients.

Based on surveillance and unmet needs data, MAI funds are allocated to 19 of the 43 contractors in order to provide linkage to medical services and ADAP in communities of color with a disproportionately high HIV burden. Additionally, in order to achieve the goals of the NHAS, OA is utilizing HRSA's Early Identification of Individuals with HIV/AIDS (EIIHA) initiative to specifically target priority populations at disproportionate risk of becoming infected with HIV and link them to care, treatment and support services.

ADAP funding is composed primarily of RW Part B earmarked funds, State General Funds and statutorily mandated drug manufacturer rebates. ADAP funds provide a continuum of

[12] http://www.cdph.ca.gov/programs/aids/Documents/OAHCPAllocProc.pdf

access to life-saving medications for ADAP eligible individuals. ADAP supports the OA mission to "assure high-quality preventive, early intervention, and care services that are appropriate, accessible, and cost effective." ADAP has been providing life-saving and life-enhancing medications for over 20 years to Californians who cannot afford them or do not qualify for no-cost Medi-Cal. ADAP has seen a steady escalation of costs due to several factors: ADAP clients are living longer and therefore staying on the program for longer periods of time; client caseload continues to increase; and drug costs continue to rise as drug prices increase and new medications are added to the formulary.

ADAP has more than 180 enrollment sites statewide, which ensure accurate and confidential ADAP client eligibility documentation for the initial enrollment and subsequent recertification. For clients enrolled in ADAP, HIV medication is accessible through 4,000 participating California ADAP pharmacies, and there are 182 drugs covered by ADAP in the ADAP Formulary.[13] In addition, the ADAP Branch administers the Pharmacy Benefits Management contract, oversees drug expenditures and revenue and develops an ADAP Estimate Package for California's Legislature to project annual funding needs.

California continues to prioritize the HRSA service category, Outpatient/Ambulatory Medical Care services, as the first service priority (Tier I Services) for all RW Part B (non-MAI) funding. LHJs are required to ensure that outpatient medical services are met for PLWH/A in their jurisdiction regardless of funding sources before allocating other funds for support services or Tier II service categories. Following is a list of all Tier I and Tier II service categories (see footnote for service category definitions).[14]

Tier I – Core Medical Services

- Outpatient and ambulatory health services
- ADAP treatments and pharmaceutical assistance
- Oral health care
- Early intervention services
- Health insurance premium and cost sharing assistance for low-income individuals
- Home health care
- Medical nutrition therapy
- Hospice services
- Home- and community-based health services
- Mental health services
- Medical nutrition therapy
- Medical case management services (including case management)
- Substance abuse services (outpatient)

Tier II - Support Services

- Case management (non-medical)
- Emergency financial assistance
- Food bank/home-delivered meals
- Health education/risk reduction
- Housing services
- Legal services
- Linguistic services
- Medical transportation services
- Outreach services
- Psychosocial services
- Referral for health care/supportive services
- Rehabilitation services
- Respite care
- Substance abuse services (residential)
- Treatment adherence counseling

Interaction between RW and Non-RW Funded Services

California's HIV care continuum relies on close collaboration with federal, state, and local governments and strongly emphasizes evidence-based prevention and care strategies. Non-Ryan White Part B funds for HIV care are made available through a variety of funding sources, including those described below. Potential RW clients are routinely screened for eligibility for

[13] http://www.cdph.ca.gov/programs/aids/Pages/tOAADAPindiv.aspx
[14] For definitions/descriptions of all service categories, see: http://www.cdph.ca.gov/programs/aids/Documents/HCPMAIBudgetOperationsGuidance.pdf

each program in compliance with the payer of last resort mandate.

California's Medi-Cal program provides medical services for eligible low income individuals. It is funded in part through the federal government and in part through the state. Medi-Cal offers full Outpatient Ambulatory Medical Care (OAMC) services to those who qualify (eligibility includes a residence requirement). Clients must apply for Medi-Cal and show verification of ineligibility in Medi-Cal before they can either enroll in ADAP or receive HCP services.

Medicare provides OAMC services for individuals age 65 years and older and/or with selected disabilities. Persons who do not meet the California residency requirements are not eligible.

California Children's Services (CCS) is a state program for children with CCS-eligible medical conditions. These include, but are not limited to, chronic medical conditions, traumatic injuries, and infectious diseases producing major sequelae. Children up to 21 years old are eligible to access health care and other services.

The Low Income Health Program (LIHP) was established to help California prepare for health care reform. It is an optional, county Medi-Cal-like program that expands primary medical coverage to eligible uninsured, low-income adults. Eligibility for LIHP includes residency requirements.

Many HIV-positive individuals who receive RW and/or ADAP services are eligible for LIHP. OA collaborated with partners at the California Department of Health Care Services (DHCS) to facilitate stakeholder calls, webinars, LIHP training teleconferences for ADAP enrollment workers and RW case managers/benefits counselors, develop Frequently Asked Questions (FAQs), and implement changes to the ADAP and RW Part B client enrollment and recertification process to require LIHP eligibility screening.

OA and DHCS jointly established the LIHP Stakeholder Advisory Committee (SAC) that meets with OA and DHCS weekly and now (since LIHP is implemented in each contracted county) twice monthly. The purpose of the SAC is to develop the Office of AIDS policy as LIHP was implemented to assist with development of operational plans and provide community input on policy that ensures that transitioning clients are not lost to care.

OA has begun analysis of the impact of LIHP on RW client caseloads and service utilization in counties that provide outpatient ambulatory services and that have a county run LIHP program. Preliminary data indicate that there are increasing numbers of clients migrating to LIHP and increased need for wrap-around support services.

California's Health Insurance Marketplace: Covered California (CC) will provide a mechanism for access to health insurance for low-income individuals and small businesses. OA has collaborated with Covered California to explore ways to assist with marketing the "insurance marketplace" to RW clients and their providers. In supporting that effort, OA established regular conferencing with CC and HIV/AIDS stakeholders for the purpose of regular updates and input/feedback.

California's Pre-Existing Condition Insurance Plan (PCIP) provides health insurance coverage to individuals who have been uninsured for six months due to a pre-existing condition. PCIP is a federally-funded program administered by the Managed Risk Medical Insurance Board (MRMIB). OA created the OA-PCIP to pay PCIP insurance premiums for HIV-positive individuals, thereby helping ensure a continuum of care for those living with HIV/AIDS during federal Affordable Care Act (ACA) implementation.

The Transitional Case Management Program (TCMP) administered by the California Department of Corrections and Rehabilitation provides case management and links HIV-positive parolees to HIV care and support services. TCMP is in the process of establishing

one point of contact with LHJs for each regional jurisdiction in order to work with RW Program and case managers and outreach workers in developing transitional plans to link parolees to local HIV services. TCMP also serves as an access point for minority populations for provision of MAI services.

The HIV Care Branch of OA operates the Housing Opportunities for People with HIV (HOPWA) program, which provides housing assistance designed to alleviate or prevent homelessness for HIV-positive persons and to improve access to HIV care, treatment, and support. HOPWA serves counties that do not receive Ryan White Part A funding, and when possible, HOPWA and Ryan White Part B-funded services are provided by the same HIV/AIDS service agency. RW Service Delivery plans identify collaboration among HOPWA and Ryan White providers. To support this collaboration, OA performs combined RW Part B/HOPWA monitoring site reviews, and HCP and HOPWA advisors case conference regarding any monitoring concerns or other issues that arise in jurisdictions that provide both HOPWA and RW Part B only services.

HOPWA contractors are required to ensure that all clients have access to supportive HIV services, such as RW Part B funded services, and OA is working towards providing technical assistance to Ryan White Part B counties to develop needs assessments that include a more detailed housing component in order to identify specific housing service needs. Additionally, HOPWA data is included in ARIES to identify clients who are receiving both HOPWA and RW services, and track health outcomes as a result of improved housing stability and access to care. Starting in 2013, OA will require that contractors develop a work plan emphasizing community planning and collaboration with all HIV and mainstream housing and service agencies.

The Medi-Cal Waiver Program (MCWP) is funded by the Centers for Medicare and Medicaid Services to the California Department of Health Care Services (DHCS). The Department of Public Health, OA provides oversight and monitoring of MCWP providers through a service contract with DHCS. The MCWP provides an array of home and community-based services that assist HIV-positive persons to remain in their homes and stabilize their health, thus improving quality of life and avoiding costly hospital or nursing facility admission. RW educates Case Managers on the services provided through the MCWP to encourage collaboration and ensure that clients are appropriately transitioned between programs as they become eligible.

Non-Ryan White HIV Services Funding in California for 2012:

Program	Amount	Services
Department of Health Care Services: Medicaid/Medicare Low Income Health Program (LIHP) AIDS Medi-Cal Waiver Program	$233,311	Outpatient Medical Care, In Home Case Management
Department of Corrections & Rehabilitation: TCMP AIDS Treatment and AIDS Facilities Juvenile Healthcare AIDS Screening	 $2,258 $54,634 $251	Case Management, Outpatient Medical Care, HIV Testing
Department of Social Services: Residential Care for Chronically Ill Perinatal Substance Abuse/HIV Infants	 $63 $209	Medical Care, HIV Testing

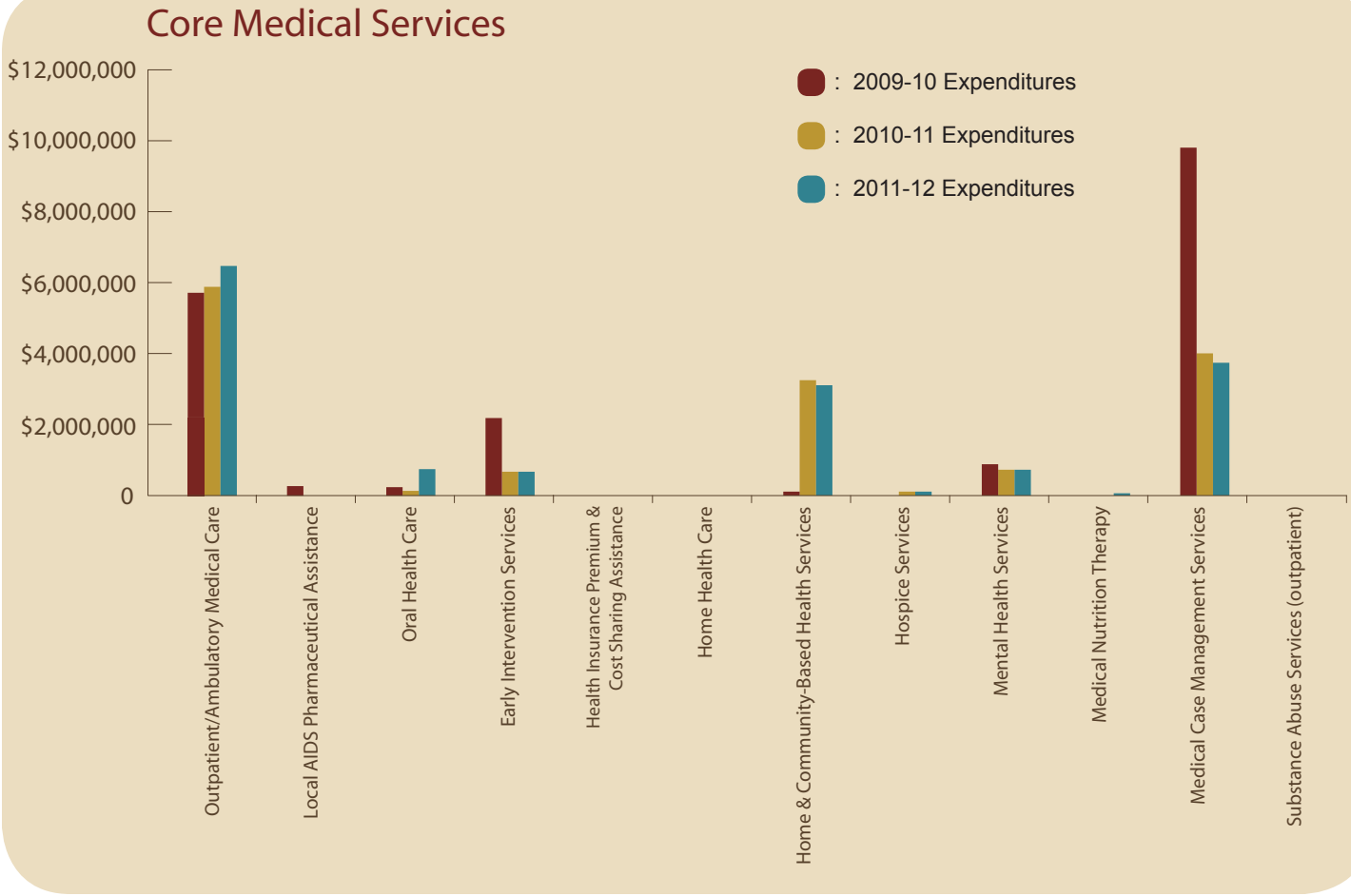
Continued on Next Page...

Non-Ryan White HIV Services Funding in California for 2012 *(continued from previous page)*:

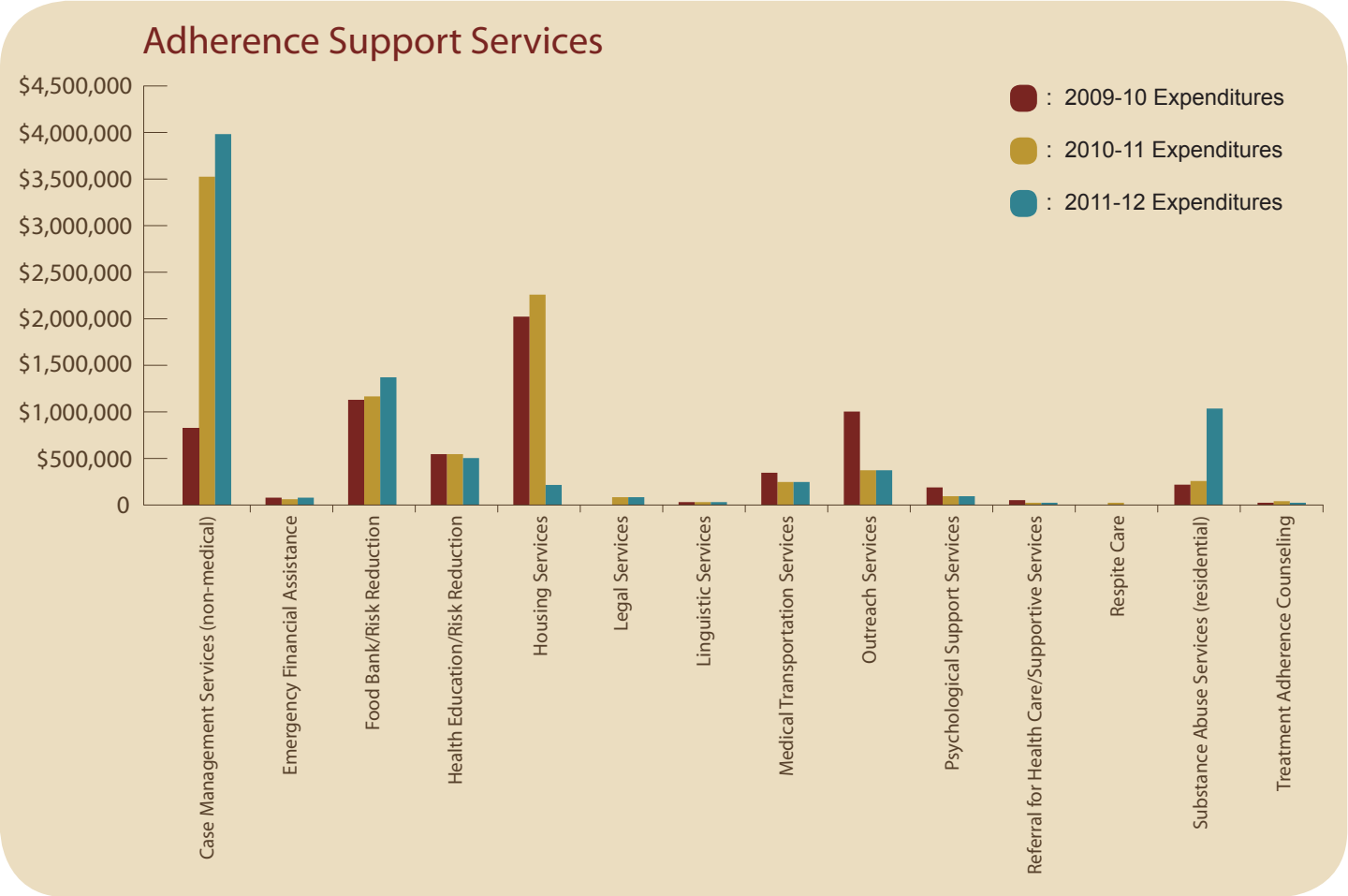
Program	Amount	Services
Department of Alcohol & Drug Programs: HIV Counseling/Testing/Early Intervention	$12,445	HIV Testing, Linkage to Care, Case Management
Department of Public Health: Housing Opportunities for People with AIDS	$3,260	Housing and Supportive Services

State of California AIDS/HIV Program Funding Detail, Department of Public Health (DPH) and Department of Health Care Services (DHCS), 2013-14 Governor's Budget

Ryan White Part B Services Inventory by Service Category:



Ryan White Part B Services Inventory by Service Category *(continued from previous page)*:



Other OA Collaborations

OA and the CDPH STD Control Branch have been actively increasing the scope and depth of their collaboration and considering how joint programming can address co-morbidities most effectively. The overall intent is to move toward more effective integration of STI, HIV, TB and Hepatitis prevention, treatment and care. In addition, the OA Prevention Branch's Local Implementation Groups (i.e. local prevention planning bodies), Partner Services, Counseling and Testing and California's STD/HIV Prevention Training Center overlap OA's (EIIHA) efforts and EIIHA-relevant training.

OA contracts directly with the Chicano Federation of San Diego County to implement protocols associated with the NHBS, a CDC-directed national health survey that collects information on sexual risk, drug use, HIV testing behaviors, and HIV seroprevalence from populations at highest risk for HIV infection. In addition, California is 1 of 26 sites funded by CDC to conduct the Medical Monitoring Project, a supplemental HIV/AIDS surveillance system that yields population estimates of characteristics of persons with HIV infection, who are in care and live in California (excluding Los Angeles and San Francisco, which are funded separately). The project captures the experiences of those in care, describes met and unmet needs, and further assists OA in targeting funding allocations and prevention and care programming.

Collaboration with Enhanced Comprehensive HIV Prevention Planning (ECHPP)

The Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project is a 3-year (2010-2013) demonstration project funded by CDC's Division of HIV/AIDS Prevention (DHAP) for the 12 municipalities with the highest number of people living with AIDS in the United States. The project aims to maximize the impact of HIV prevention in these municipalities, which include two directly-funded health departments in California (Los Angeles and San Francisco) and to achieve an optimal combination of activities to meet NHAS goals.

The goals of ECHPP are aligned with those of NHAS: 1) reduce new infections; 2) increase access to care and improve health outcomes for persons living with HIV through linkage, retention, and adherence to care; 3) reduce HIV-related disparities through decreasing community viral load among MSM, African American and Hispanics; and 4) more coordinated national response.

Specific objectives of ECHPP that are supported via collaboration throughout California's RW Part B programs include: 1) develop a plan that aligns with LHJ's prevention activities and NHAS; 2) increase resources for biggest impact on HIV incidence; 3) identify and address gaps in prevention activities among priority populations; 4) enhance coordination between prevention, care, and treatment; 5) identify the optimal combination of prevention, care, and treatment activities to maximally reduce new infections; 6) assure that the most effective biomedical and community/structural interventions are prioritized; and 7) assure that interventions are going to populations/communities in such a way that the level of investment matches the level of risk.

Goals and objectives for this *Integrated HIV Surveillance, Prevention, and Care Plan* have been aligned with many of the required and recommended ECHPP interventions intended for implementation by California's ECHPP participants. OA maintains regular communication with these jurisdictions as they evaluate the effectiveness of their ECHPP models, and will modify or update this document as needed to reflect any significant shifts in implementation.

Impact of State and Local Budget Cuts on Care and Prevention Programs

In response to California's budget crisis in fiscal year 2009-10, Governor Arnold Schwarzenegger eliminated more than $59 million in state funds from OA, removing support for HIV-related services and programs and bringing the total reduction in funding to OA to approximately $82 million – about half the allocation of $167 million in 2008-09. Although cuts to ADAP were backfilled with Special Fund (pharmaceutical manufacturer rebate funds), funds for surveillance, HIV testing, early intervention programs, outreach to care/ADAP, home and community-based care, therapeutic blood monitoring, and prevention and education services were drastically reduced or eliminated. Approximately 80% of the funding for prevention was cut, leaving that as the hardest hit programmatic area. Care services faced cuts of about 61%. The only remaining funding for HIV prevention and care (with the exception of ADAP) was federal dollars – all state General Fund allocations for HIV/AIDS prevention and care (with the exception of ADAP) were eliminated. None of that state funding has been restored to date.

Based on unmet need data, OA continues to fund as many LHJs with MAI funding as is possible to reach HIV+ persons of color in order to provide linkage to medical services and ADAP. Additional augments are in place for OA data systems to track clients through the continuum of services from outreach to engagement into care, treatment and support services.

In California's continuing difficult budget climate, the advent of policies and strategies such as those outlined in the NHAS and in HRSA's

Early Identification of Individuals with HIV/AIDS (EIIHA) Initiative have been powerful tools in allowing the OA to continue to support and encourage programs and services that blend care and prevention activities and allow the development of a clear service continuum from identifying and testing the unaware to linking and maintaining HIV-positive persons in care and treatment. Although California's budget cuts have been extremely difficult, the elimination of state-funded programs has forced a beneficial re-assessment of OA goals and strategies and a more targeted and focused services strategy.

Loss of Santa Rosa Transitional Grant Award and Ensuring Continuity of Care

The Sonoma County Department of Health and Human Services (SCHHS) lost its TGA status in 2011. The county health department did not have the capacity to continue being the fiscal agent for HIV primary and specialty care services and engaged in a comprehensive transition of services to a local community clinic. That process included public hearings throughout their geographical region to solicit input and educate their clients and stakeholders (including Kaiser) to a new and different approach to service provision; community forums; hiring a consultant to facilitate and address potential barriers to clients and ensuring that clients made the transition to the Santa Rosa Community Health Center (SRCHC).

During the transition period, SRCHC co-located services at the county health department in order to gain consumer familiarity and comfort with staff. Barriers to care were minimized during this transition in part because HIV-trained and experienced staff from the Sonoma County HIV Clinic were hired by SRCHC.

While continuity of care was maintained, reduced funding resulted in the loss of several HIV/AIDS positions in this community. However, most clients were allowed to keep the same nurses and doctors they were familiar with at the County level. The Outreach services rendered during this time were the key to the success of this transition. Mental health services and services provided to women, children and youth were reduced due to the loss of the TGA funds.

HIV Prevention and Care: Legislative and Regulatory Context

California laws directly and indirectly affect HIV prevention and care programs and services. These laws include areas such as HIV testing, partner services, harm reduction, and HIV/AIDS case management.

OA has authority to establish HIV Counseling and Testing (C&T) training programs (conducted by community-based, non-profit HIV organizations) for HIV counselors. California law authorizes HIV counselors, working in both OA-funded and non-OA funded C&T sites to perform rapid HIV, HCV, or combination HIV/HCV tests if certain requirements are met. In these non-medical C&T sites the law requires written consent for HIV testing.

California law does not require written consent for HIV testing in medical settings. Before ordering an HIV test, medical providers must inform the patient about the HIV test and provide information on HIV treatment options and routine HIV testing for HIV-negative patients. A medical provider must document if a patient declines an HIV test. Health insurance plans are required to provide coverage for HIV testing in medical settings regardless of whether the testing is related to the primary diagnosis.

In 2011, California enacted laws to encourage physicians to work more closely with local health department Partner Services (PS) staff. Physicians may disclose to PS staff that they have an HIV positive patient but cannot disclose any patient identifying information without the written consent of the patient. PS staff are authorized to notify persons believed to have been exposed to HIV, without threat of criminal or civil liability, when no identifying information about the HIV-positive individual or reporting physician is disclosed.

Also, in 2011, California enacted landmark harm reduction laws that allow OA to authorize syringe exchange programs (SEPs) in addition to local government SEP authorization. Over the counter syringe sale laws were expanded to permit pharmacists to sell or furnish up to 30 syringes without a prescription to customers (18 years and older), and allows these customers to purchase and possess up to 30 syringes when acquired from an authorized source. Additionally pharmacists, physicians, and SEPs are now authorized sources of nonprescription syringes for disease prevention purposes.

Another pivotal and recent law allows OA to share HIV/AIDS surveillance data with local health department (non-HIV/AIDS surveillance) staff, who may then use the data to contact an HIV-positive person or that person's HIV provider to offer HIV care, treatment, and/or case management services. Local TB and STD staff can also use HIV/AIDS surveillance data to facilitate HIV/TB/syphilis, gonorrhea, and chlamydia co-infection case management.

California like other states has HIV criminalization laws which may create barriers to HIV testing. Any person who exposes another person to HIV by engaging in unprotected sexual activity is guilty of a felony, when the infected person: knows he or she is infected; has not disclosed his or her HIV-positive status; and acts with the intent to infect the other person with HIV. Evidence that the person had knowledge of his or her HIV-positive status, without additional evidence, is not sufficient to prove intent.

Heath Care Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act (HCERA). These bills represent the most sweeping changes in American health care since Medicare and Medicaid were created.

Given the complexities of federal and state financing of medical services for people living with HIV infection and the need for HIV treatment expertise in an expanding universe of health care settings, it is critical to consider HIV-specific issues for health service delivery associated with the implementation of ACA. It is also important to consider the HIV testing and prevention issues and opportunities associated with ACA. In response to these needs, OA convened a stakeholder input process between May and August 2011 in order to identify key HIV-specific issues in the areas of health care delivery systems, provider and workforce readiness, patient needs, and financing. This section includes highlights resulting from that input process. It also represents some of the areas of greatest concern, as well as the areas in which OA, in collaboration with state and federal partners, intends to develop and deliver Technical Assistance (TA) for California providers.[15]

Much HIV-related and primary medical care for people living with HIV infection is currently provided by clinics funded through the Federal Ryan White program. Funding is provided through the State (Part B), to highly impacted counties (Part A), or directly to clinics (Parts C and D). Medi-Cal and Medicare are also significant payers of HIV-related medical care. In addition, there are HIV-specific pharmacies and pharmacy reimbursement concerns.

[15] http://www.cdph.ca.gov/programs/aids/Documents/PlanningforHCROASummary.pdf

HRSA is supporting conversions of some RW clinics to Federally Qualified Health Center (FQHC) status through its TA providers. In addition, HRSA-supported community clinics will face the burden of caring for many more people with HIV infection than ever before, and it is important that those who have experience in this work understand and offer assistance, when possible, with their challenges.

Many HIV-focused clinics in California may not have the information, education or TA support they need to prepare to participate in the Exchange-associated health plans associated with ACA. If RW clinics do not contract with Exchange providers, their patient population will contain more disenfranchised, resource-poor, higher needs individuals. RW clinics will need to assess if they will be able to survive financially with a smaller patient load, covered only by Medi-Cal (for the documented) and RW (for the undocumented).

To qualify to become a FQHC, clinics have to demonstrate that the need exists and that they can meet this need completely. Clinics applying for FQHC status will need to know how to demonstrate the need to see HIV-positive patients in community clinics. This will be especially challenging for clinics that do not have HIV medical expertise and would therefore need to refer out all other patients.

Many HRSA-supported Community Health Centers (CHC)s may not be prepared to care for people living with HIV infection. CHCs will need to provide regular access to HIV-knowledgeable specialty medical services (e.g., psychiatry) and psychosocial support services within and/or external to the CHC. Some CHCs will need training in areas such as recognizing and addressing substance use, providing care to injection drug users, and providing care to transgender persons.

Some people living with HIV infection will enter the health care system because they have developed co-morbidities such as concurrent tuberculosis, viral hepatitis, or another sexually transmitted disease. Given the history of categorical CDC funding and resulting public health care system structures, it may be challenging to shift the future care of these populations from a disease-focused approach to one that is more holistic and includes some of the "wrap around" services many clients will require. Relative reimbursement rates across Medi-Cal, Medicare, and Exchange products may impact provider choices about how many patients they will accept with each payer type including Medi-Cal, Medicare, and private insurance, and thus impact access to care for consumers living with HIV.

Some CHCs and managed care providers will need HIV-specific cultural competency and stigma reduction training. They will need to be aware that some consumers transitioning to CHCs may be uncomfortable in a "blended", rather than in an HIV-specific, clinic setting. Clinics will also need to be able to integrate prevention strategies like behavioral risk assessment and counseling, prevention with positives, partner services, and adherence assessment and support tailored to HIV treatment protocols.

It is not known what kinds of HIV-specific outcomes or performance measures new providers will be expected to meet, who will develop and monitor them, and if it will be possible to incorporate the reporting requirements for RW and CDC into existing clinic databases. It is also not known how data collection and reporting will occur in CHCs not funded by RW or if there will be any access to client-level data from these sites. If not, this may

Although full implementation of Health Care Reform is scheduled for 2014, changes to HIV services are being implemented now through California's Section 1115 Medicaid demonstration waiver "Bridge to Reform."

adversely impact OA's ability to monitor trends, particularly if OA does not have access to non-OA-funded clinical service data.

California is a multicultural state, and race and ethnicity in California are strongly linked with citizenship status, so the fact that the ACA contains citizenship requirements for its coverage expansions carries significant impact for Californians. The exclusions embedded in ACA will likely increase health insurance disparities between U.S. citizens and noncitizens over time. California runs the risk of increasing racial/ethnic inequities in health care access and outcomes if these issues remain unaddressed.

Although full implementation of Health Care Reform (HCR) is scheduled for 2014, changes to HIV services are being implemented now through California's Section 1115 Medicaid demonstration waiver "Bridge to Reform." New third party programs that provide HIV care services and treatment are available, and these programs must be considered in routine screening for RW clients. Under the current law, the RW HIV/AIDS Program must serve as the "payer of last resort," meaning RW funds cannot be used to pay for services that could otherwise be paid for by another source. One example of an emerging third party program is the Low Income Health Program (LIHP) currently implemented in certain counties, although scheduled for state-wide implementation by the end of 2012.[16]

Most counties have an on-site eligibility worker available to assist clients with understanding the benefits available to them while transitioning from RW to LIHP, but clients may struggle with understanding some of these changes. Further, changes to the provision of care for many HIV positive individuals who are comfortable with their RW White clinicians can be daunting, especially if their new LIHP network clinician is not experienced in providing HIV care.

The system of care for people living with HIV/AIDS is changing as clients transition to other third party programs. The need for RW wrap around support services, such as food bank /home delivery, health insurance premiums, housing, mental health and substance abuse services will become crucial in sustaining the continuum of care.

In these first years of scaling up to full implementation of the ACA, there have already been some notable successes. The "ADAP as TrOOP (True Out Of Pocket expenses)" provision in the ACA has greatly enhanced the ability of state AIDS Drug Assistance Programs to help individuals living with HIV on Medicare meet their Medicare Part D co-payment obligations. This has both enhanced Medicare beneficiaries' prescription drug access through the Medicare Part D program and reduced these beneficiaries' dependence on ADAP (84).

The PCIPs created by the ACA are now available to people living with HIV who have traditionally been excluded from the individual insurance market because of discrimination based on their health status. In addition, premium assistance programs have been developed to further assist these individuals.

Addressing Healthy People 2020 Objectives

The Healthy People 2020 Initiative represents a broad set of goals and objectives for the nation's health. Two of its four overarching goals align directly with the goals and objectives of California's *Integrated HIV Surveillance, Prevention, and Care Plan*:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups

[16] http://www.cdph.ca.gov/programs/aids/Pages/OARyanWhiteDHCSLowIncomeHealthProgram.aspx

Healthy People 2020 and the *Integrated Plan* share a strong emphasis on the importance of social determinants of health, and recognize the impact of health disparities. The overall intent of the *Integrated Plan* is to strengthen the delivery of critical HIV medical care and services to newly diagnosed individuals and those currently out of care. This intent is supported by the following objectives, put forward by the Public Health Advisory Committee to the California Department of Public Health as part of the effort to achieve the vision of Healthy People 2020:

- Increase the proportion of persons who receive appropriate evidence-based clinical preventive services
- Reduce preventable hospitalization rates for ambulatory-care-sensitive conditions
- Increase the proportion of persons who receive primary and coordinated care
- Reduce the proportion of individuals that experience difficulties or delays in obtaining necessary medical care, dental care, or prescription medicines

Data Collection Systems

For RW Part B recipients, OA utilizes the AIDS Regional Information and Evaluation System (ARIES),[17] which is a web-based HIV/AIDS client management system. While ARIES is required for all RW Part B providers throughout the state, certain directly-funded metropolitan Part A providers also adopted the system: San Francisco, Orange County, San Diego, Riverside, San Bernardino, and Santa Clara. ARIES provides a single point of entry for clients, allows for coordination of client services among providers, meets both HRSA and Housing and Urban Development reporting requirements, and provides comprehensive data for program monitoring, quality assessments and scientific evaluations.

Local Evaluation Online (LEO)[18] is the online system for tracking information about OA-funded prevention programs. OA is currently developing a process to link prevention information from LEO with other information systems at OA, including the Enhanced HIV/AIDS Reporting System, which contains HIV surveillance data, and ARIES.

Informing the Integrated Plan: Quantitative and Qualitative Data

California's Epidemiologic Profile, along with qualitative and quantitative analysis of statewide responses to community assessments, enables OA and CPG to work together more effectively in establishing data-driven linkages between epidemiology and planning recommendations. These linkages inform the structuring of long-term goals, objectives, and strategies for delivering services. Critical elements include consideration of whether resources are being expended to populations most in need and to emerging populations, whether HIV+ people can effectively obtain and maintain HIV health care, and whether HIV care is being efficiently delivered given limited resources.

Informing the Integrated Plan: California's 2009 Epidemiologic Profile Update

This 2009 update utilizes recent HIV/AIDS surveillance data to describe the scope of HIV/AIDS in California by selected demographics and is meant as a supplemental update to the five-year *Integrated Epidemiologic Profile of HIV/AIDS for California, 2001-2005*[19].

A primary focus of this update is California's 2009 confidential name-based HIV infection data, reflecting the first time these name reported data have been analyzed in an epidemiological profile. The subsequent five-year *Integrated Epidemiologic Profile of HIV/AIDS for California, 2006-2010* is expected to be published in 2013.

Key Highlights of the California HIV/AIDS Epidemiologic Profile, 2009 Update

Overall

- There were a total of 206,793 HIV-positive

[17] http://www.projectaries.org
[18] http://www.cdph.ca.gov/programs/aids/Pages/tOAPrevData.aspx
[19] http://www.cdph.ca.gov/programs/aids/Documents/EPIProfile.pdf

persons reported to California's surveillance system from 1983 to 2009. Of these cumulative cases, 110,966 (53.7 percent) were presumed to be living at the end of 2009.

- Among the 110,966 individuals living with HIV infection at the end of 2009, 38,659 cases (35 percent) were classified as HIV cases and 72,307 cases (65 percent) were classified as AIDS cases.

- In 2009, there were 5,380 persons newly diagnosed with HIV infection in California. This figure represents all cases diagnosed in 2009 and reported to California's HIV/AIDS surveillance system by February 22, 2012.

- California's epidemic differs from the national epidemic in terms of gender and race/ethnicity. Nationally, African Americans make up the largest number of new HIV/AIDS cases while in California the largest number is among Latino/as. National figures also show that women constitute almost one-third of new cases annually, whereas in California that figure is less than 13 percent.

- While the proportion of California's newly diagnosed HIV cases that are Hispanic is double that of the CDC national statistics, the rate of new diagnoses among Hispanics appears to be lower in California than nationwide (14.5 per 100,000 population versus 22.8 per 100,0000 population, respectively).

- The proportion of newly diagnosed cases in California that are African American is less than one-half that of the national figure (20.3 percent versus 51.5 percent, respectively). The rate of infection among African Americans in California is also lower than the rate nationwide (47.9 per 100,000 versus 66.6 per 100,000, respectively).

- The number of persons living with HIV infection continues to steadily increase every year. The increase is primarily due to the fact that individuals are living longer with HIV infection as a result of improved treatment and medical care.

- The proportion of individuals newly diagnosed with HIV who were late testers (i.e., diagnosed with AIDS at the same time or within a year of first testing positive for HIV) has steadily decreased from 50 percent in 2009 to just under 35 percent in 2009.

Who

Gender

- Males represented the overwhelming majority (87 percent) of persons living with HIV infection in California as well as those newly diagnosed in 2009 (86 percent). The rates of both new diagnoses and persons living with HIV infection were seven times greater among males than females.

Race/Ethnicity

- HIV infection continues to disproportionately impact African American Californians. The rate of newly diagnosed HIV infection cases in 2009 was about five times greater among African Americans than Whites. The rate of HIV infection diagnoses among African American males was three times that of White males. This disparity was markedly greater among African American females whose rate of HIV infection diagnosis was 11 times that of their White female counterparts. While African American females represented only 6 percent of California's female population, African American females accounted for more than one-third (35 percent) of new female HIV diagnoses in 2009.

- Hispanics/Latino/as constitute the largest racial/ethnic group newly diagnosed with HIV infection in 2009 (2,050 versus 1,880 Whites and 1,091 African Americans).

Hispanics/Latino/as made up 38.1 percent of all newly diagnosed HIV infection cases in 2009, a greater proportion than the 30.8 percent of living cases. Newly diagnosed Hispanics were significantly more likely to be simultaneously diagnosed with AIDS than other races. Although the newly diagnosed HIV infection rate is higher than Whites (14.5 per 100,000 versus 11.54 per 100,000), it is still significantly lower than African Americans (47.9 per 100,000).

- Whites are the largest racial/ethnic group currently living with HIV/AIDS, constituting 46 percent of all living cases. Latino/as constitute 31 percent and African Americans 18 percent of living cases while other race/ethnicities constitute 5 percent.

Age

- Across all cumulative cases, individuals diagnosed in their thirties (30-39 year olds) constituted the largest proportion of cases (40 percent).

- Almost three-quarters (73 percent) of all individuals living with HIV infection at the end of 2009 were over 40 years of age and 34 percent were over 50 years old.

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

- A greater proportion of individuals diagnosed in older age groups (40+ years old) are concurrently diagnosed with AIDS (44 percent versus 28 percent among those under 40 years old). This would indicate that late testing is a greater factor than recent infection among this older age group.

- African Americans make up 43 percent of all newly diagnosed 13-19 year olds, a significantly greater percentage than their proportion of cases 20 years and older (43 percent versus 20 percent, $p<0.01$).

How

Exposure Category

- The overwhelming majority of both living cases (74 percent) and new diagnoses (69 percent) continue to be among men who have sex with men (MSM).

- About 8 percent of living and 6 percent of newly diagnosed cases report injection drug use as their primary risk. IDUs who also report MSM activity account for about 8 percent of living and 5 percent of newly diagnosed cases.

- MSM (including MSM/IDUs) were significantly less likely ($P<0.01$) than all other transmission groups to be diagnosed with AIDS at the same time or within one year of first testing positive for HIV (30.9 percent versus 42.8 percent, respectively).

Where

Epidemiological Profile Regions

- HIV infection disproportionately impacts the state's major metropolitan areas (San Francisco, Greater Bay Area, Los Angeles, and other southern areas). The highest rates of new diagnoses and persons living with HIV infection, as well as the largest numbers of cases, were found in these areas.

- Los Angeles County continues to contribute the largest number of new cases, with 2,133 of the 5,380 total cases diagnosed in 2009 (39.6 percent).

- The number of new cases in the San Francisco MSA is almost one-fourth that in Los Angeles (553 cases). Yet, due to its smaller population, the rate of newly diagnosed HIV infection in San Francisco is significantly higher than that in Los Angeles (30 per 100,000 versus 20 per 100,000).

- The proportion of California cases diagnosed in San Francisco has decreased significantly since 2000, from 16 percent in 2000 to 10 percent in 2009.

- The proportions of California cases newly diagnosed in 2009 from the Greater Bay Area, Central/San Joaquin Valley, and other southern (non-Los Angeles) areas have significantly increased since 2000.

Informing the Integrated Plan: The CPG/OA Community Assessment Survey

As part of the process of developing California's first Integrated HIV Surveillance, Prevention and Care Plan, the CPG Community Assessment Workgroup was formed and tasked with gathering information from HIV care and prevention service providers across the State. The workgroup developed and distributed a survey to all current and prior HIV prevention and care contractors of the OA. These data have been compiled into a statewide inventory of current local service needs, gaps and barriers, and public/private-funded service delivery and utilization, to support the development of the Integrated Plan. Survey results and discussion may be found here: http://www.cdph.ca.gov/programs/aids/documents/cpgcommunityassessmentsurvey.pdf. The survey tool may be found here: http://www.cdph.ca.gov/programs/aids/documents/cpgcommunityassessmentsurveyinstrument.pdf

As with any survey, it is important to acknowledge the limitations of the methodology. First, the data presented in the survey is not generalizable to the needs and services accessible to all people living with HIV/AIDS in the State of California. Because the survey was sent only to current and prior OA HIV prevention and care contractors, responses were limited mainly to health departments. Secondly, individual survey responses were not weighted by the prevalence of HIV disease in their particular area. Consequently, the results reflect some overrepresentation of service providers in rural areas.

While these data may not be representative of all California service providers, the information as a whole is extremely important in that this survey constitutes the first statewide assessment of OA-funded and previously funded prevention and care providers since the funding cuts of 2009. The responses collected were rich and diverse, and as a whole were instrumental in informing the development of the Integrated Plan.

CPG/OA Community Assessment Survey Highlights

Respondent Demographics

- Approximately one-third of respondents provide care, prevention or both types of HIV/AIDS services.

- The majority of respondents represent public health departments, followed by service providers in Eligible Metropolitan or Transitional Grant Areas. One respondent noted their status as a FWHC.

- The majority of respondents represent rural areas of California, followed by suburban and urban areas. Some providers serve up to 8 different counties, while others consider their service area to be highly diverse, including urban, rural and remote desert towns and cities.

- Respondents' planning groups are primarily care, or they represent both prevention and care.

- Most providers completed an HIV/AIDS epidemiological profile as recently as 2010.

Over one-third were unaware as to when or if a profile had been completed.

- In 2011, approximately one-third (27.7%) of respondents completed a care and prevention needs assessment, an increase over the 23% who did so in 2010.

Care Clients and Services Provided

- A majority of programs target HIV positive clients, including MSM, IDU and sex partners of HIV positive clients. Greater than half target people of color (primarily Latinos [79%] and African Americans [52%]), homeless and heterosexual male and female clients. Other population groups include transgender people, the incarcerated and newly paroled, migrant workers, and non-IDU substance users.

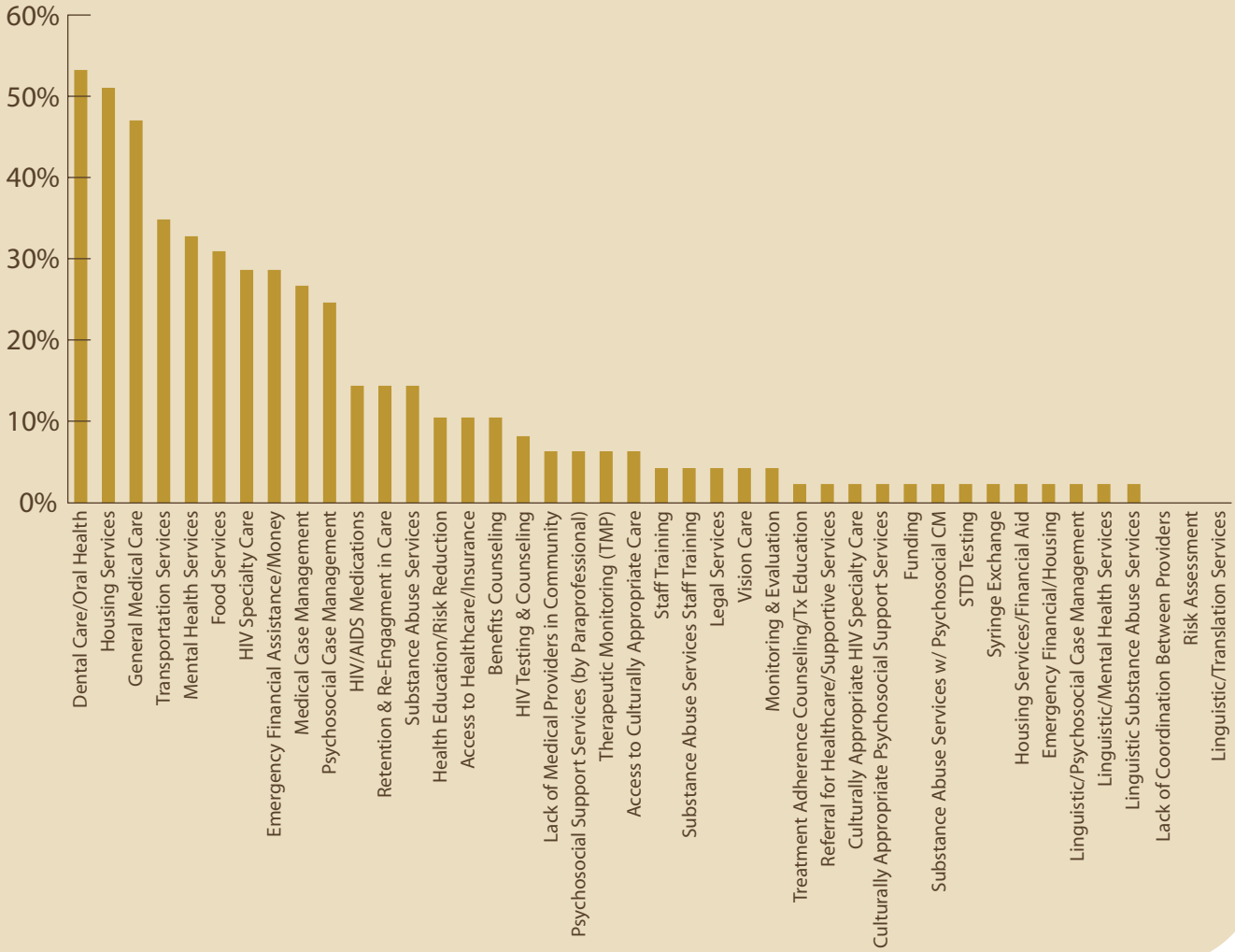
- Population groups actually served are similar to those targeted. A small minority also serve children, rural populations and/or Native Americans.

- Case management services represent the most frequently-provided services among a broad range of possible services currently provided. Greater than 60% of respondents provide ambulatory care, health education, food bank, financial assistance and medical transportation services. Over half also provide oral and mental health services and housing assistance.

Care Service Needs, Barriers, and Gaps

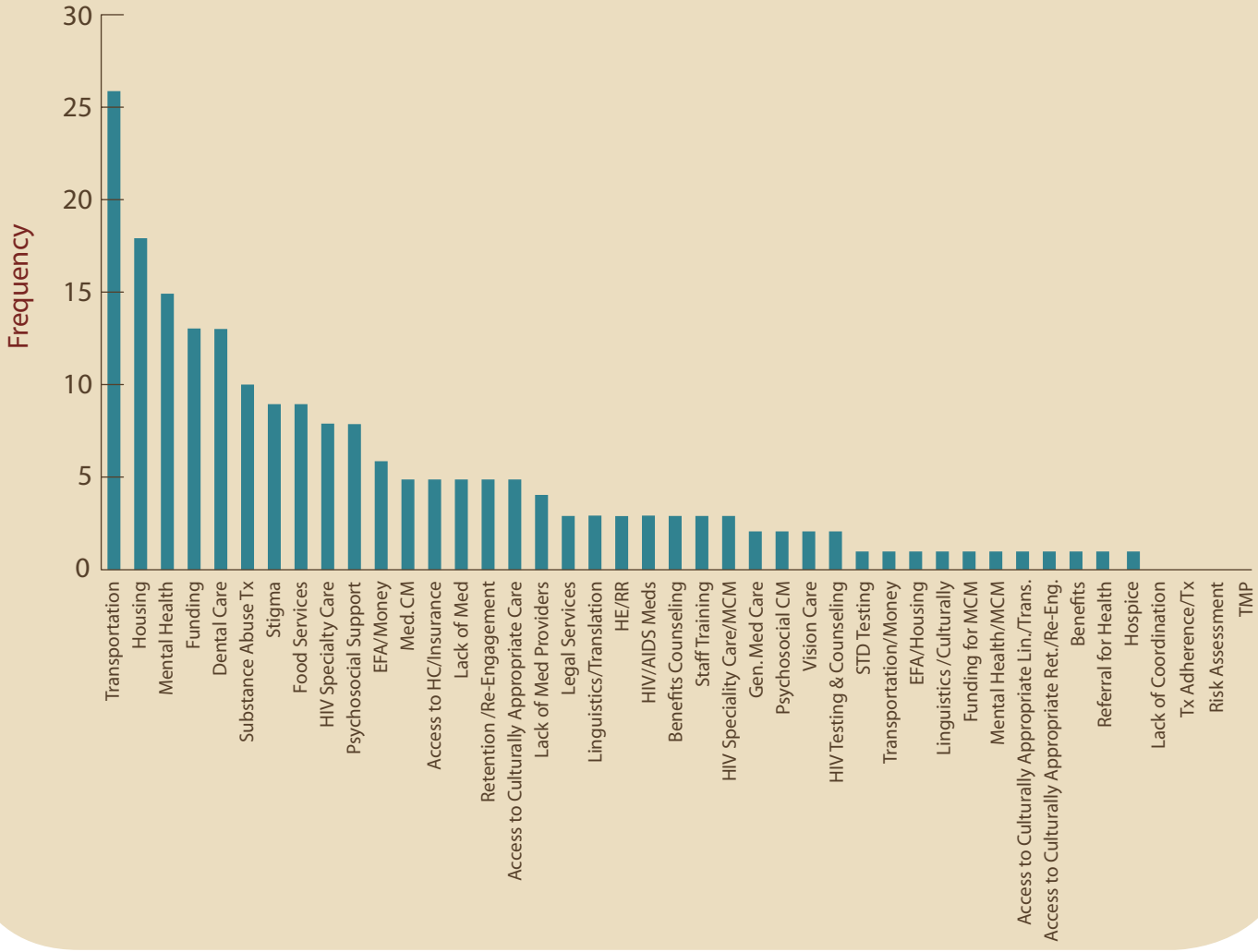
The following two charts (Charts 11 and 12 from the survey) represent providers' responses to HIV Care service needs, service gaps and/or barriers to service. Respondents were asked to indicate the top five service needs of People Living with HIV (PLWH), both in care and not in care in their community. Respondents were also asked to indicate the top five service gaps and/or barriers to service that exist within their community. Service gaps were defined a priori for participants as *"service needs not currently being met for all PLWH except for the need for primary health care for individuals who know their status but are not in care."* Service gaps include additional need for primary health care for those already receiving primary medical care ("in care"). Barriers to services were also defined in the survey as *"anything standing in the way of obtaining services or providing services."*

Chart 11: HIV Care Service Needs



- A wide range of service needs were identified. Although 50% of respondents currently provide oral health care and housing assistance, 25% also prioritized these two services as the greatest needs among their clients. Other frequently reported service needs include medical care, mental health and transportation services.

Chart 12: HIV Care Service Gaps and/or Barriers to Service



- Respondents prioritized HIV/AIDS service gaps and/or barriers similar to service needs with transportation rated as the most frequently reported service gap/barrier to service, followed by housing, mental health and oral health care.

<u>Prevention Clients and Services Provided</u>

- The vast majority of providers target injection drug users and MSM, followed by HIV positive individuals, sex partners of at-risk groups, youth and homeless persons. Latinos are targeted by 58% of providers surveyed, while African Americans are targeted by 40%. Over one-third of respondents target transgender individuals, sex workers and migrant workers.

- Population groups actually served are similar to those targeted. Other responses indicated that providers offer free condoms and provide basic public health services, including court mandated drug treatment and sexual assault services.

- The vast majority of providers offer HIV counseling, testing referral and partner services. Outreach, health education, individual, group and community level interventions are also provided. Thirty percent provide syringe exchange services or have enrolled pharmacies in the sale of non-prescription syringes.

- A majority of HIV Prevention service providers served between 1,001 and 5,000 clients in a 12 month period.

Prevention Service Needs, Barriers, and Gaps

The following two charts (Charts 17 and 18 from the survey) represent providers' responses to HIV prevention service needs, service gaps and/or barriers to service. Respondents were asked to indicate the top five service needs of their identified target populations as well as other populations they serve. Respondents were also asked to indicate the top five service gaps and/or barriers to service that exist within their community. In the survey service gaps was defined for participants as *"all prevention service needs not currently being met for identified target populations as well as other populations served."* Barriers to services were defined in the survey as *"anything standing in the way of obtaining services or providing services."*

- The most frequently reported prevention service need (25%) is outreach to high risk populations, which is a prevention service that no longer receives targeted funding. HIV testing in health care settings is also considered a major prevention need among respondents.

Chart 17: HIV Prevention Service Needs

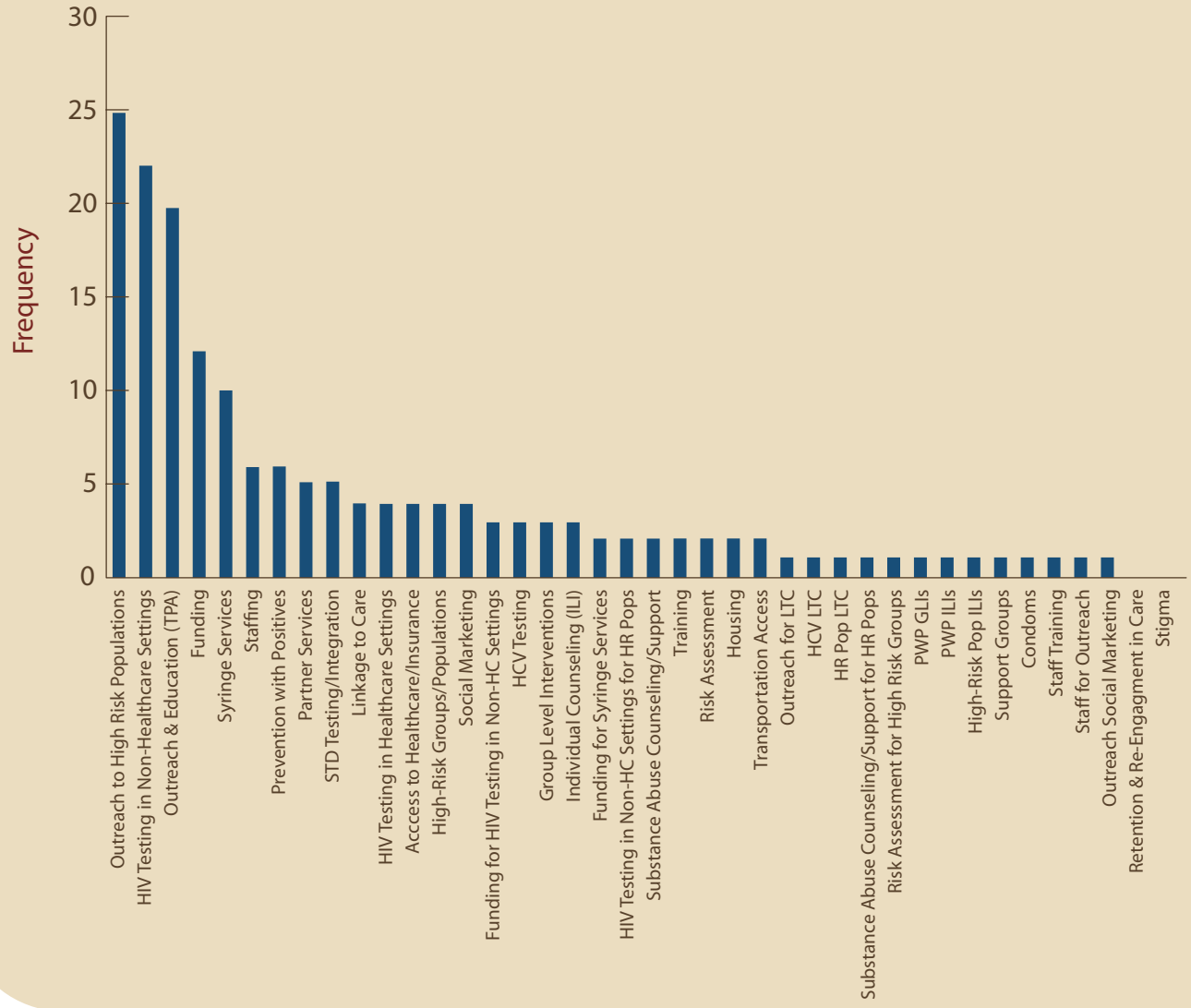
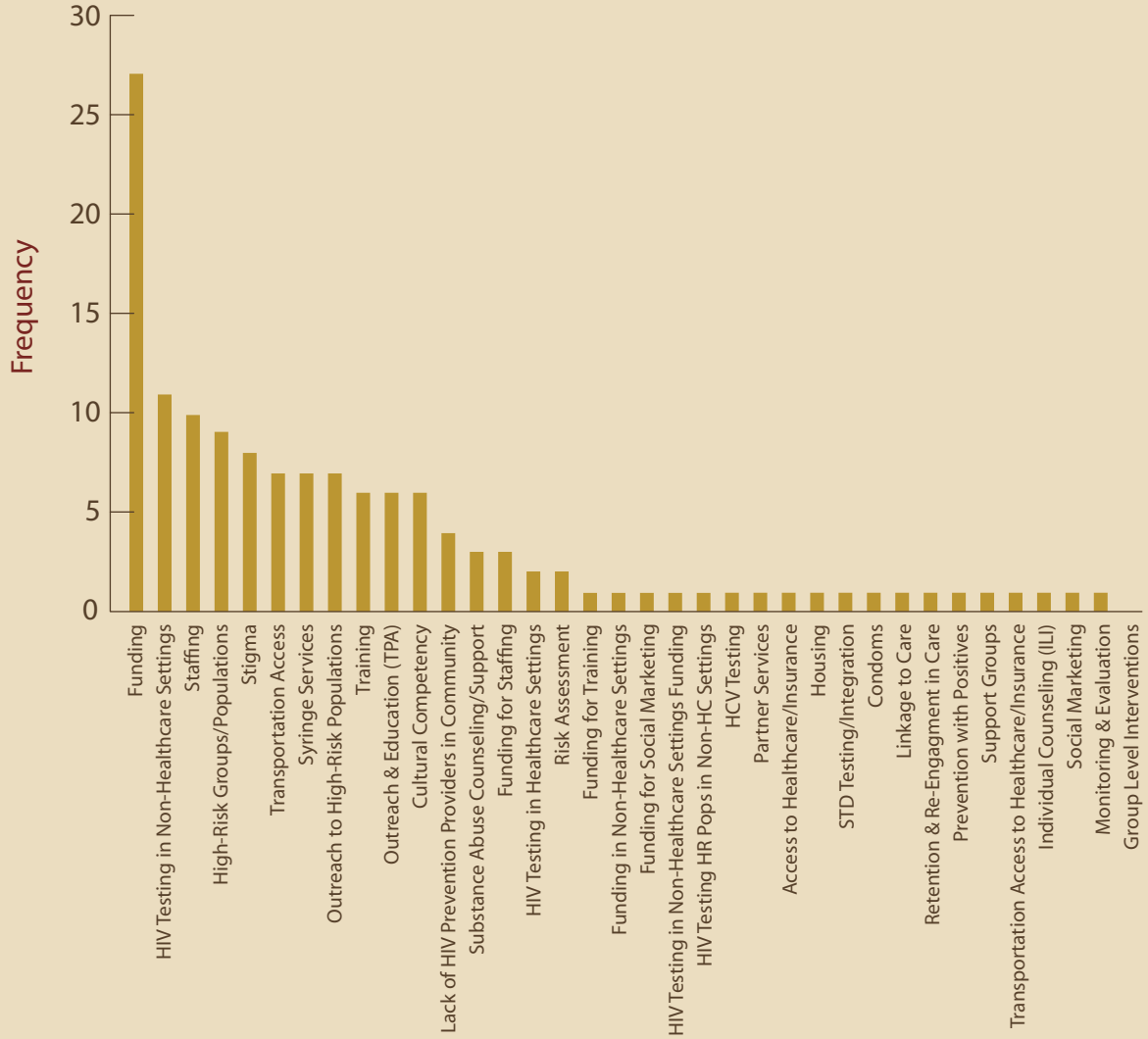


Chart 18: HIV Prevention Service Gaps and/or Barriers to Service



- Respondents ranked "funding" as the most frequent gap or barrier to prevention services. A majority of other gaps and barriers are associated with limited public health infrastructure and structural interventions.

Health Care Reform

Respondents were asked *"What is the most pressing need within your LHJ/community to prepare for HCR implementation?"* Space was given for a narrative response where the respondent could provide any information which they felt was relevant to the topic of HCR readiness. A total of 55 respondents chose to answer the question, and the responses clustered within the following primary domains:

Patient Navigation Concerns and Understanding New Systems of Care

Twenty four percent of responses expressed concerns related to assisting patients to navigate the new systems of care and educating patients about changes related to HCR. Of concern were clients falling out of care due to complicated forms, clients falling through the cracks as they shift between systems of care, and eligibility requirements. One respondent stated that they need "Case Management to assist clients to understand and access confusing systems."

Another needed a "clear understanding of client eligibility guidelines and training all providers to assist clients with enrollment".

Collaboration/Integration with Other Systems of Care

Twenty four percent of respondents talked about concerns related to uncertainty about collaboration with new care providers such as FQHCs and non-Ryan White medical providers. Themes of continuity of care again came up in these responses, as well as questions about how to integrate Ryan White funding with the Low Income Health Plans. Three respondents specifically identified concerns regarding the integration of HIV specialty care.

Funding

Twelve respondents (22%) identified concerns related to funding changes, and the impact on Ryan White funding in particular. Additionally, respondents described already dealing with being short of funds for needed services such as dental care, case management, outreach, and dealing with multiply-diagnosed clients. Several responses talked about staffing shortages and more general difficulties due to budget shortfalls.

Education/Technical Assistance

Twenty percent of respondents identified needs related to education and/or technical assistance, both for themselves and for their client and provider communities. Themes included better understanding of what the provider landscape will look like, what they need to do to prepare for Health Care Reform, and general comments of needing guidance from the State and Federal offices. One respondent specifically identified needing assistance with electronic health record implementation.

Other needs and/or areas identified included a concern that their area has insufficient numbers of medical providers, or that additional providers will be needed with the expansion of HCR (4 responses), uncertainty about the impact of HCR on funding for prevention activities (5 responses), and general outreach concerns (3 responses). Four respondents indicated that they did not know what their needs would be to prepare for HCR in their community.

Additional Information

Respondents were asked to share any additional information about care or prevention needs which may be of interest or consideration in preparing the Integrated Plan or the SCSN. As this was an open-ended question there was quite a variety of responses among the 29 respondents who answered the question. A few themes emerged, however:

- Prevention & Testing
  Forty five percent of responses (13) used this space to discuss needs for enhanced prevention and testing activities, including routine testing and integrated HIV & STD testing. One respondent highlighted the need to "map the epidemic" on a statewide basis.

- Funding
  Ten of the responses (34%) referred to funding issues, with three of them specifically calling attention to the fact that case numbers in their counties are underreported due to their county not being where the case was originally identified.

- Geography
  Three respondents highlighted challenges delivering care and prevention services in rural counties. Travel distance was reported as a barrier, and a reminder was offered that care and prevention models designed for urban populations may not be appropriate for rural communities.

  In addition to the above, two respondents identified needs specific to youth and young adult populations, and two indicated that funding cuts to their surveillance programs were resulting in fewer cases being identified and thus an additional loss of funds. Finally,

one respondent detailed challenges in their county related to linkage and retention of HIV positives in care.

The CPG/OA Community Assessment Survey is an important source of current information regarding prevention and care needs across the state, and represents a significant opportunity to begin to assess the challenges faced by HIV prevention and care providers in the era following the funding cuts imposed during the 2009 recession. An equally important component in needs assessment within the overall scope of jurisdictional planning is an assessment of California's unmet need for HIV primary medical care.

The legislative requirements for the Ryan White HIV/AIDS Program Part A and Part B are to "determine the size and demographics of the population of individuals with HIV disease," and to "determine the needs of such populations, with particular attention to both individuals with HIV disease who know their HIV status and are not receiving HIV-related services" and "disparities in access and services among affected subpopulations and historically underserved communities". This is the first step towards ensuring that they obtain primary medical care and supportive services, through Ryan White HIV/AIDS Program-funded activities or other sources.

Each year OA develops the ***statewide estimate of unmet need***, working in conjunction with California's eight Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs): Los Angeles, Oakland (including Alameda and Contra Costa counties), Orange, Sacramento (including El Dorado, Placer and Alpine counties), San Bernardino/Riverside, San Diego, San Francisco (including San Mateo and Marin counties), and Santa Clara. This collaboration assists the Part A grantees in developing their local estimate of unmet need, and enables OA to refine its statewide estimate through access to local care data provided by the eight Part A grantees.

The goal of this ongoing assessment is to estimate California's unmet need for HIV primary medical care. An individual with AIDS or HIV (non-AIDS/aware of status) is considered to have unmet need for HIV primary medical care when there is no evidence of any of these three components of HIV primary medical care in a 12-month period: viral load testing, CD4 count, or anti-retroviral therapy. Twenty three percent of PLWA and 40% of PLWH/non-AIDS-aware, for a total of 30% of all HIV-positive/aware individuals, were calculated as having an unmet need for HIV primary medical care in the most recent estimate of unmet need.

Needs of Individuals Who are Unaware of Their HIV-Positive Status

With Ryan White passage in 2009, a new requirement was added to determine not only the number and demographics of HIV-positive individuals, but also to account for those individuals who are unaware of their HIV-positive status. Individuals in this category include HIV-positive persons who have not been tested for HIV, and HIV-positive persons who have tested for HIV but did not receive their test results. The CDC estimates that 21% of all PLWHA in the U.S. are unaware of their HIV status, and uses this estimate as the basis for their *Estimated Back Calculation (EBC) methodology*, which is a tool that may be used in order to develop an estimate of the size of HIV positive unaware populations. The EBC provides a baseline raw-number estimate of total HIV-positive persons who are unaware of their HIV positive status, but does not provide demographic or other important characteristics.

The internal estimates used by OA for this population are based on the national estimate coupled with recent case accumulation patterns in statewide surveillance data. As of the end of 2011, it is estimated that between 29,523 and 31,948 HIV-positive and unaware individuals reside in California.

This estimation likely represents less than the true number for two primary reasons. First,

names-based HIV reporting took effect in California on April 16, 2006, and it is unlikely that the HIV (non-AIDS) component of the total living count is complete. Secondly, as widespread, free anonymous HIV testing is available in California, there is estimated to be a significant population of HIV-positive individuals who have anonymously tested (and know their status) but have yet to initiate care. Until these individuals initiate care, they will not be reported into the surveillance system but cannot be classified as "undiagnosed".

In an effort to identify and address the needs of HIV-positive and unaware individuals, RW funding is aligned with the NHAS strategy through EIIHA. EIIHA is defined as "Identifying, counseling, testing, informing, and referring of diagnosed and undiagnosed individuals to appropriate services, as well as linking newly diagnosed HIV positive individuals into care".

EIIHA has been established as a priority by HRSA and requires grantees to describe the strategy, plan, and data reporting associated with ensuring that individuals who are unaware of their HIV-positive status are identified, informed of their status, referred into care, and linked to care. Consistent with the NHAS and EIIHA, California requires that funded LHJs provide an EIIHA plan that defines local target populations for focused EIIHA efforts.

Unmet Need and EIIHA Goals, Strategies, and Activities

California's overall goal regarding the EIIHA priority of identifying and testing those unaware of their HIV status has been to develop a statewide strategy that encompasses the broad array of needs and populations represented across funded jurisdictions statewide. While maintaining focus on the goal of addressing the needs of individuals unaware of their HIV status, an effective statewide approach must take into account California's size and diversity when identifying priority populations and interventions. In order to initiate this statewide approach, OA requested that each Local Health Jurisdiction (LHJ) and Community Based Organization (CBO) contractor funded through Ryan White Part B submit an EIIHA program plan. The plan includes EIIHA activities that focus on program priority populations and provides justification for each service category selected to illustrate that proposed services are aligned with the findings of the jurisdiction's most recent needs assessment.

EIIHA Goals

The *Office of AIDS Goals and Strategies Framework* identifies the state's primary goals and the key strategies that will be utilized in the coming months and years in order to accomplish these goals. The state's primary goals are:

- To minimize the number of new HIV infections
- To maximize the number of people with HIV infection who access appropriate care, treatment, support, and prevention services and,
- To reduce HIV/AIDS-related health disparities

These key goals are clearly aligned with the purpose of the EIIHA initiative "to increase the number of individuals who are aware of their HIV status, as well as increase the number of HIV positive individuals who are in care."

California identified the following high-risk priority populations for EIIHA: (1) Latino and African American men who have sex with men (MSM), (2) Injection Drug Users who are MSM (IDU-MSM), (3) African American women and Latinas, (4) Undocumented Latino/as or Latino/as born outside of the US; and (5) Transgender youth. Because of California's geographic and demographic diversity, OA recognizes that there may also be distinct epidemiological or demographic factors in a given LHJ that support inclusion of additional target groups.

California developed two initial goals for EIIHA implementation: First, to develop and provide unified guidance to funded LHJs regarding EIIHA expectations, and secondly to establish coordinated EIIHA program plans in each funded LHJ that address priority populations with the highest risk of never engaging in care.

California's EIIHA program plan development steps include the following:

- Each jurisdiction is to determine which local populations are the most impacted by HIV/AIDS.
- Once the LHJ's priority populations are identified, they are prioritized based on local HIV/AIDS epidemiological data.
- Each LHJ will outline the service categories and activities used for EIIHA to identify, refer and link clients to medical services.
- Each LHJ will provide a description of how they plan to collaborate and integrate other Ryan White funded Parts into their EIIHA plan as well as related OA-funded services and activities.

Some California jurisdictions are emphasizing the implementation of strategies to assist in identifying subgroups of individuals unaware of their HIV status. These include activities such as expansion of HIV testing venues, social marketing message campaigns, media campaigns, use of peer advisory groups, use of community planning groups, and expansion of HIV testing of positive partners.

Other jurisdictions are expanding their strategies to provide outreach and testing services targeting high risk populations by utilizing specialized outreach workers, mobile outreach vans, and better identification of venues where higher-risk individuals may be located, including homeless encampments, shelters, methadone treatment programs, food banks/free meal programs, and Rancherias.

The majority of the EIIHA plans address EIIHA activities through coordinating with Ryan White funded programs, HIV Prevention programs, and other community efforts in identifying, informing, referring and linking high risk HIV populations to care and treatment services.

OA is encouraging jurisdictions to develop strategies that are based on local epidemiology and that address local needs within the following framework of statewide goals and objectives for EIIHA:

EIIHA Goal 1: Reduced new infections

Objective 1: By December 31, 2015, OA's unmet need data will indicate a 10% reduction of the percentage of individuals in California who are unaware of their HIV status.

Activities: 2012-2015

- increase emphasis on diagnosis, linkage, retention, and engagement in care
- adopt community-level approaches to HIV-related stigma and discrimination
- increased emphasis on the use of partner services

Objective 2: By December 31, 2015, OA will have increased the proportion of HIV-positive persons with an undetectable viral load in California.

Activities: 2012-2015

- increase access to care
- increase access to HIV medication
- operationalize use of surveillance data by LHJs to identify those who have fallen out of care and link them back into care
- provide adherence support in HIV primary care settings

EIIHA Goal 2: Increased access to care and optimized health outcomes

Objective 1: By December 31, 2015, 100% of HIV-positive individuals receiving RW care services will have appropriate and continuous medical care and support services.

Activities: 2013-2015

- increase the proportion of HIV+ persons who remain in continuous care
- establish/strengthen service and care systems to re-engage HIV-positive persons who have fallen out of care
- develop and support strategies to maintain high levels of adherence to antiretroviral treatment

- increase screening of RW clients for eligibility for other third-party payers and need for continual RW wrap-around services

Objective 2: By December 31, 2015, 100% of OA-funded HIV testing sites will provide seamless, on-site linkage to care services.

Activities: 2013-2015

- establish/strengthen service and care systems to engage and link HIV-positive persons who have never been in care

Objective 3: By December 31, 2015, OA will increase the percentage of newly diagnosed HIV+ persons linked to clinical care within three months of HIV diagnosis.

Activities: 2012-2015

- continue to improve the capacity of OA data reporting systems to measure linkage to care

EIIHA Goal 3: Reduced HIV-related health disparities

Objective 1: Decrease the number of new infections in gay and bisexual men, African Americans, and Latinos by 25%.

Activities: 2012-2015

- use available data to identify populations experiencing HIV-related health disparities
- develop strategies to reduce HIV-related stigma and discrimination in communities disproportionately impacted by HIV

Objective 2: Address social determinants of health and cofactors that lead to disease progression among HIV-positive individuals.

Activities: 2013-2015

- increase the number of Ryan White clients with permanent housing

Objective 3: Increase the proportion of HIV-diagnosed gay and bisexual men, African-Americans, and Latinos with undetectable viral load by 20%.

Activities: 2012-2015

- increase the proportion of HIV-diagnosed gay and bisexual men, African Americans, and Latinos who meet Group 1 HAB indicators

Planning and Priorities Based on Unmet Need and Subpopulation Analysis

OA utilizes these statewide data to help guide funding allocations and the development of policies and standards for Care services. OA continues to prioritize the HRSA service category of Outpatient/Ambulatory Medical Care services, as the first service priority (Tier I) Services for all RW Part B (non-MAI) funding. LHJs are required to ensure that outpatient medical services are met for PLWH/A in their jurisdiction regardless of funding sources before allocating other funds for support services or Tier II service categories.

LHJs are required to complete local assessments of unmet need through the development of service delivery plans (SDPs) and needs assessment. These local data are used to inform gender and race/ethnic-specific outreach and care adherence/retention programming. OA requires that LHJs identify target populations and particular activities based on a comprehensive assessment of unmet need within the jurisdiction.

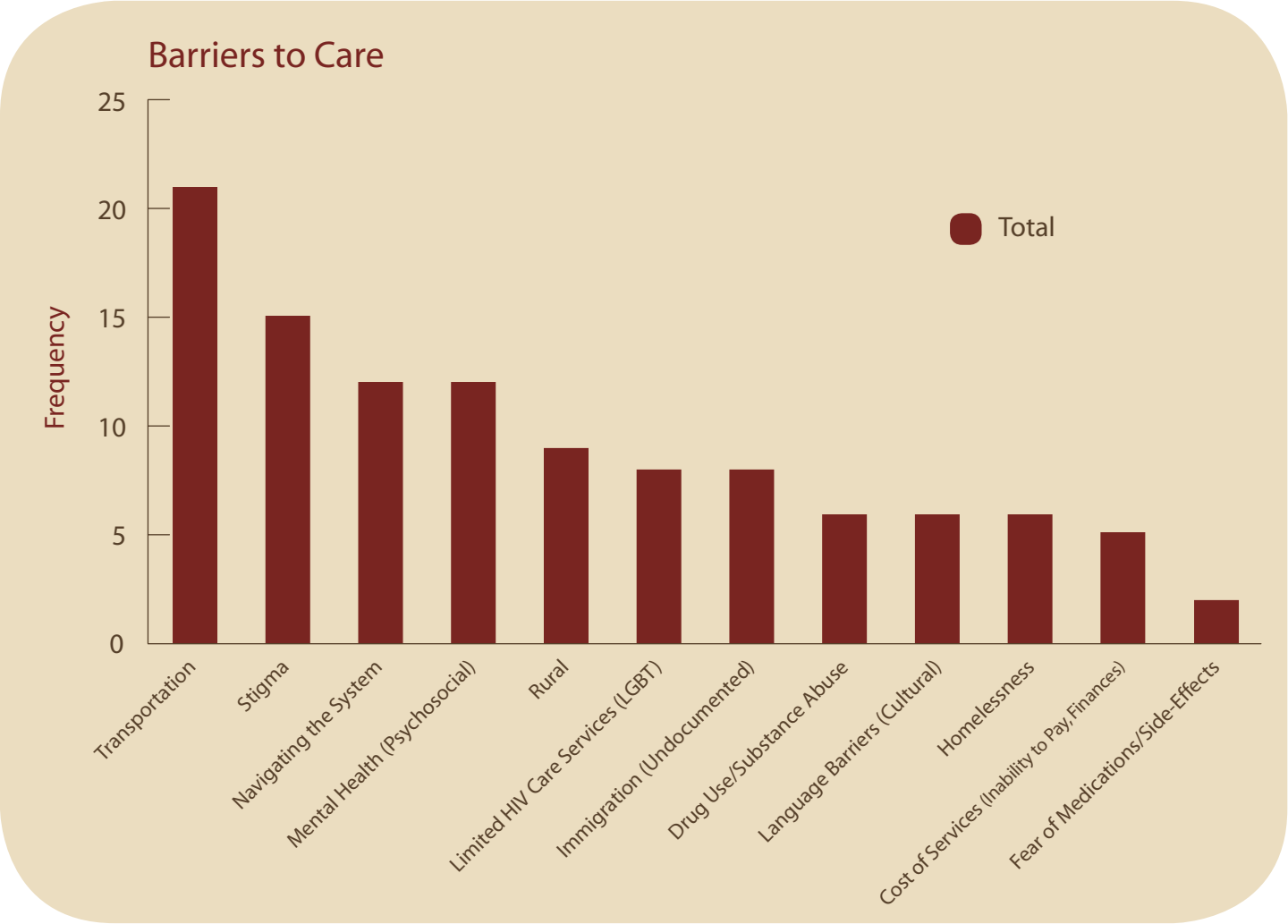
Client-Reported Barriers to Care

The data compiled from the SDPs was consistent with the CPG/OA statewide community needs assessment survey findings for Gaps and Barriers to Care. The SDP data results identified the lack of available transportation as the most frequently reported barrier followed by stigma,

navigating the system, mental health concerns, and the challenges of living in rural regions. Other barriers mentioned were: limited LGBT HIV care predominantly in non- EMA/TGAs, cost of services, and fear of medications and/or medication side effects.

Clients in some jurisdictions have reported being discouraged by waiting up to seven hours to be seen by a doctor, and up to a month to see a case manager for financial screening, which discourages them from further engagement with the care system. Other barriers to care included drug and alcohol addiction, money issues, and those who reported that because they felt better (had no symptoms), they believed they didn't need health care.

Clients who had dropped out of care and subsequently re-entered care reported the following factors influenced their decision to re-engage with care: health reasons included becoming ill, developing new symptoms, needing to access treatment for substance abuse, and seeking support for coping with mental health issues including depression. Psychosocial reasons included being encouraged to enter care by family and friends and feeling psychologically ready to deal with their HIV status. Finally, structural factors also enabled clients to decide to re-engage with care, including being provided with access to stable housing and receiving information about the availability of free medical care and treatment.



Data results from SPDs sent to OA. Clients identified barriers in care when answering an open ended question in the SDP: ***What are the barriers for clients accessing and remaining in care?***

Persons Who are Aware of Their HIV-Positive Status But are Not in Care

Despite the importance of initiating timely HIV treatment and care, as many as 20-40% of HIV-positive persons in the United States do not initiate care within the first 6 months after their diagnosis. Many others present to care beyond the clinical period recommended by current guidelines, resulting in compromised health outcomes and increased transmission risk (85). Factors associated with delayed care entry include receiving HIV test results at anonymous or community-based sites not closely linked with health care providers, fears of side effects from HIV medication, and concerns around stigma.

Among communities of color, Latino/as living with HIV are among the most likely to delay HIV testing and treatment, often receiving an AIDS diagnosis within just one year after an HIV diagnosis. Factors associated with delayed testing and care among Latino/as include older age, being foreign-born, having less than a high school education, and preferring to communicate in Spanish (86). Young African American men are more likely than other ethnic/racial groups to be diagnosed with HIV only after being diagnosed with an opportunistic infection and to delay care for several months after receiving an HIV diagnosis (87).

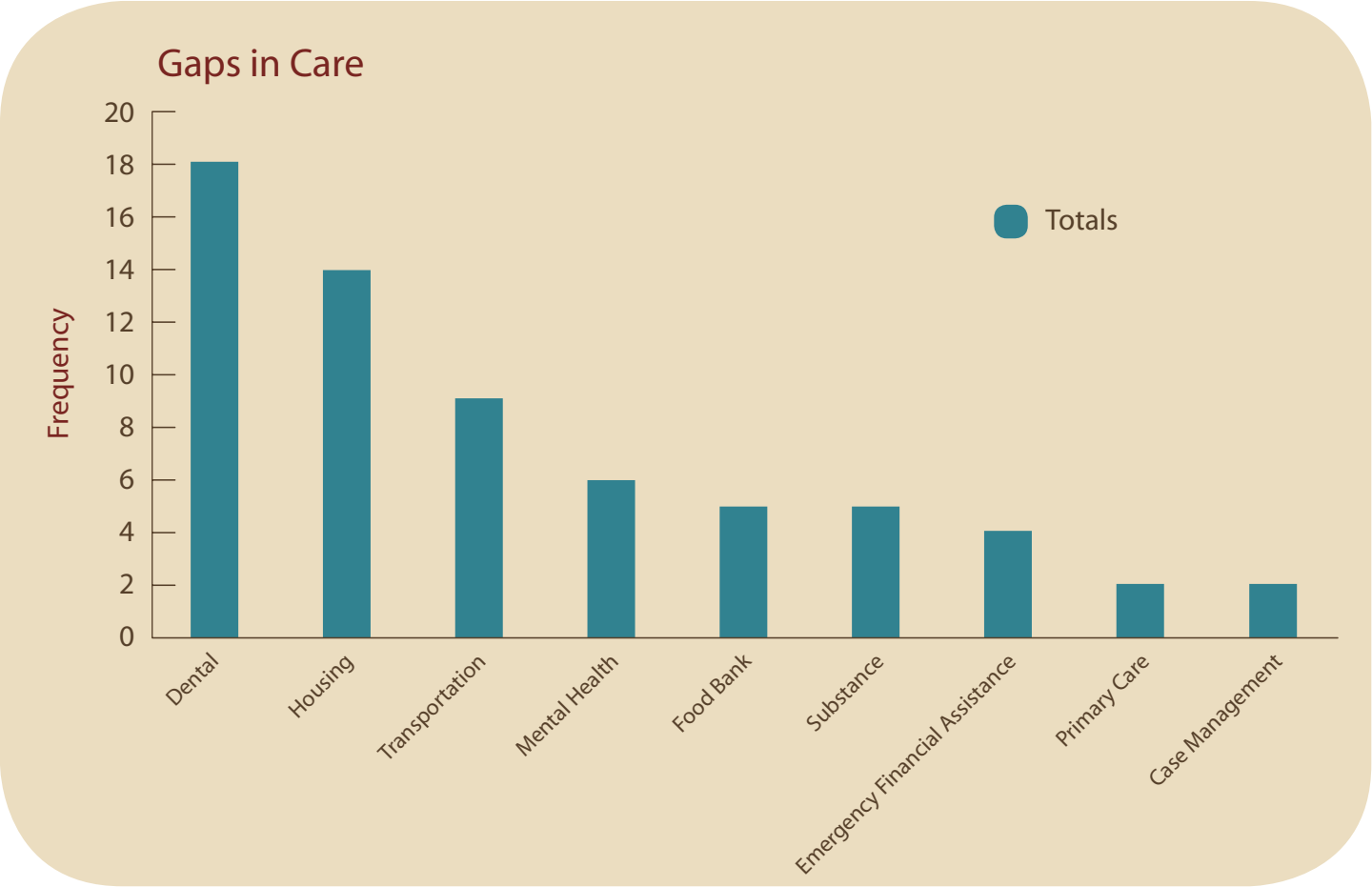
One California study was conducted with outreach workers at OA-funded care sites to identify factors independently associated with never receiving care among an ethnically/racially diverse (59% Latino/a; 20% African American) population (88). Reported barriers to HIV care included fears around disclosure, feeling too ashamed to access care, not wanting to think about HIV, and not feeling sick. The health belief systems among participants who had never accessed care were focused on concerns related to HIV medications. Those never in care were more likely to think that they did not need HIV medications until they got very sick, that the government had not adequately tested HIV medications, that medications would do more harm than good, that doctors want to start people on HIV medication even if not needed, and that it is safer to use natural remedies.

COMPARED TO PERSONS IN CARE, PARTICIPANTS WHO HAD NEVER RECEIVED CARE WERE SIGNIFICANTLY LESS LIKELY TO REPORT BEING OFFERED ASSISTANCE IN SETTING UP A MEDICAL APPOINTMENT.

Compared to persons in care, participants who had never received care were significantly less likely to report being offered assistance in setting up a medical appointment. They were also less likely to report that someone at the testing facility spent enough time with them after informing them of their positive diagnosis, or answered all their questions regarding their HIV diagnosis. A majority of participants said that someone at the testing facility talked to them about the importance of getting HIV care at the time of receiving their positive test result, but only half said that someone at the facility helped them set up an appointment for HIV care. Those who did not get appointment assistance were significantly more likely to have never received care.

Gaps in Care

Gaps in HIV services refer to missing or inadequate services for those who are not in primary medical care for their HIV, those who are not accessing services, and those living with HIV who are getting most but not all of their needs met. The results of recent needs assessments of LHJs and the review of current RW Part B Service Delivery Plans from LHJs show broad gaps in HIV care. It is important to note that not all these issues affect care to the same degree, and not all apply to every region of California. Many of these needs overlap and are interrelated, further exacerbating access to care for PLWH/A.



Data results from SPDs sent to OA. Clients identified gaps in care when answering an open ended question in the SPD: ***What services do clients say they need that is <u>not</u> currently funded?*** *Dental was rated as the highest client-identified gap, followed by housing, transportation and mental health.*

Data compiled from the SDPs identified dental/oral health as the most frequently reported client-identified gap in care followed by housing, transportation, mental health services, food bank/home delivery of meals, primary care, substance abuse treatment, and emergency financial assistance.

Gaps in Dental/Oral Health

Persons living with HIV/AIDS report high rates of unmet oral health care needs and low utilization of oral health services. While regular dental care can help ensure that PLWH/A are better able to maintain their health, the lack of oral health care services continues to be a significant gap in HIV services in California, with nearly 25 percent of all respondents reporting that they do not receive dental/oral health care.

Preventive dental care is extremely important and plays a vital role in the health of PLWH/A, who face a number of oral opportunistic infections that are often first diagnosed by dentists, yet it is unavailable to many HIV-infected populations who rely on publicly funded care.

Dental services are not mandated under the federal Medicaid program and California, with a program called Denti-Cal, was one of the few states to cover non-emergency services for adults. But with the state budget crisis in 2009, non-mandatory dental services were eliminated. This represented a critical source for dental services in California for low-income consumers. An analysis conducted by the California Healthcare Foundation looked at the impacts of the cuts in the year following their implementation. They found a $6 million increase

in the use of hospitals and emergency rooms for dental issues that could have been dealt with on an outpatient basis (89). Private dental insurance policies that finance dental services under a reimbursement model in which patients must pay for dental services and then wait for reimbursement by an insurance company may also limit access to services for many.

Some dentists are still unwilling to treat people with HIV. Other issues affecting access to these services include the lack of publicly funded dental benefits and the low reimbursement rates dentists receive as payment for those individuals who do have benefits. OA Care-based needs assessments show client-identified challenges in finding local providers with HIV expertise, limited availability of appointments, and problems related to caps on individual benefits. Difficulties accessing transportation to and from appointments were also identified as an issue.

Gaps in Transportation Services

Ensuring access to transportation services is a central need for many PLWH/A, yet transportation challenges continue to be a significant gap in the ability to access both medical and supportive HIV services.

California's extensive geography, the high cost of gasoline, insufficient public transportation infrastructure, and the low income of the much of the client population, makes travelling to medical appointments and support services difficult and sometimes impossible.

In a 2011 study of HIV-positive rural women in northern California, 37.5% reported missing an HIV medical appointment in the previous 12-month period, primarily due to their physical health and transportation limitations (32), but transportation challenges are not limited to rural regions. In urban areas, simply getting to the nearest public rail or bus stops can be difficult, and public transportation waiting areas are unsafe in some communities. OA Care needs assessments showed that the majority of jurisdictions reported a lack of time-efficient and affordable transportation options, compounded by the problem of insufficient funds to buy taxi vouchers, and long travel distances to and between providers which made taxi vouchers cost-prohibitive.

Research to be presented at the 2012 meeting of the American Public Health Association finds that participants who rely on public transportation to get to HIV-related services faced more challenges than those with their own car. They were more likely to report that delays in transportation caused them to be late or miss their appointments, and there were services they were unable to access due to insufficient transportation. In addition, transportation problems compromised adherence to HIV-related treatment plans, including difficulty filling prescriptions and maintaining a stable connection with medical providers (90).

Gaps in Housing

Based on the large body of evidence showing that housing interventions are an essential and cost-effective component of HIV prevention and health care, housing availability is an important component of addressing structural-based HIV health disparities.

For many HIV-positive persons in California, safe and stable housing is simply out of reach. The "Paycheck to Paycheck 2011" report by the Center for Housing Policy shows that ten of twenty least affordable rental markets in the United States are in California. One in two renters in California pay in excess of 30% of their income, while one in four pay more than half of their income toward rent (91).

Among persons at highest risk for HIV, housing status is increasingly identified as a determinant of health outcomes. The only long-term study assessing the impact of housing on HIV-related health demonstrates that over a 12-year period, receipt of housing assistance was one of the strongest predictors of accessing HIV primary care, maintaining continuous care, receiving care that meets clinical practice standards, and entry

into HIV care among those outside of or marginal to, the health care system (92).

Homeless/unstably housed PLWHA are less likely to receive appropriate health care, and experience higher rates of opportunistic infections, Hepatitis C Virus (HCV), and other co-morbidities than those in stable housing situations. The death rate due to HIV disease among homeless PLWHA is seven to nine times the death rate due to HIV in the general population (93). Among HIV-infected persons, unstable housing is associated with fewer ambulatory care visits, greater reliance on emergency departments, frequent or longer hospitalizations, and decreased use of/ adherence to antiretroviral therapy (94). Despite available evidence demonstrating that stable housing has positive effects on health outcomes for HIV-positive persons, housing remains one of the most significant unmet service needs. The National AIDS Housing Coalition's report on the 2012 budget request for HOPWA indicated that that as of 2011 there were 140,000 households needing housing assistance in the U.S., but due to funding limitations HOPWA was able to serve only 56,600 households nationwide (95).

Gaps in Mental Health Services

Throughout the state, many county mental health services are under-funded and difficult to access, and the shortage of long-term counseling and therapeutic services and psychiatric care for PLWH/A remains. Over the past several years, multiple OA-funded care providers report an increase in clients with mental health and substance abuse problems that amplify and complicate their HIV/AIDS issues, making it difficult for them to follow through with accessing care, treatment adherence, and retention in care. This issue is exacerbated by in-patient mental health services that are difficult to access and the lack of local in-patient drug treatment services. Several jurisdictions reported challenges associated with no longer having clinical mental health and substance abuse services readily available to clients, due to the elimination of the State Early Intervention Program in the 2009 budget cuts.

Data compiled from the Ryan White Service Delivery Plans indicate that people with mental health disorders often have difficulty accessing ongoing medical care at county or community-based medical clinics due to their mental disorder and lack of insurance. These difficulties are compounded by the general lack of resources many providers are facing, making it more difficult to obtain relevant education or to develop the skillset required to provide adequate and sensitive medical care to dually-diagnosed HIV-positive persons. Clients may face structural barriers as well, in that some medical providers maintain policies that restrict service provision to persons with mental disorders unless they are stabilized and taking psychotropic medications.

Gaps in Substance Abuse Services

While the concept of "treatment on demand" for HIV-positive persons has been acknowledged as an important policy and structural intervention since the 1990s, funding cuts at the federal, state, and local level mean that entry into drug treatment programs has steadily become more difficult. Accessibility issues are especially persistent in programs that care for indigent clients and in methadone maintenance programs (96).

Not all substance abuse treatment programs are equipped to support HIV-positive persons in areas such as managing recovery and treatment adherence or providing adequate monitoring of HIV medication levels in light of physiological changes related to recovery. Based on OA provider surveys, multiple jurisdictions report that clients who are ready to enter treatment programs report problems with program availability. Clients often struggle with the decision to enter substance abuse treatment and when they are finally motivated to seek help, the experience of being turned away due to lack of available space creates a formidable barrier.

Since the beginning of the epidemic, multiple studies have consistently demonstrated the effectiveness, safety, and cost-effectiveness of syringe exchange programs (SEPs) in reducing injection-related risk behavior and transmission of HIV (97). While there are now decades' worth of knowledge regarding effective, evidence-based prevention programs for IDU, in many settings the primary response to IDU is focused on criminalization and enforcement of drug laws. This contributes to marginalization of IDU, creating a "hidden population" that is difficult to reach with prevention and treatment services (98).

Provider-centered barriers can rise through reluctance to prescribe HAART to IDUs based on the belief that they will not adhere to treatment, that they will increase risk behaviors if treated, or that they will develop and transmit antiretroviral-resistant HIV. The first two concerns can be largely addressed through use of individual and socio-structural interventions (99), while the third is not supported by evidence (ibid).

Systematic reviews of the literature demonstrate that opioid substitution therapy is strongly associated with improved treatment adherence among IDU and that it reduces injection-related risk behavior (100). However, coverage of medication-assisted substance abuse treatment, including methadone and buprenorphine for opioid dependence, is limited.

Gaps in Emergency Financial Assistance

This is a critically important life line for very low-income HIV-positive individuals in economically impacted areas of California. Emergency financial assistance helps HIV/AIDS clients to pay for emergency needs such as rent, utilities, medications, food, transportation, and other essential needs and is critical to providing access to core medical services.

Gaps in Food Bank/Home-Delivered Meals

Low-income people living with HIV/AIDS have access to food bank services which are offered throughout the state. Home-delivered meals are available in some jurisdictions to HIV-positive clients who are disabled and/or unable to independently prepare meals. As a result of the 2009 recession and California's budget crisis, many jurisdictions reported increases of over 50 percent in food bank usage (101). Recent reports from the Food Research and Action Center show that 20.5 percent of California residents (7.5 million) are struggling with food hardships as the recession lingers (102).

Gaps in Home Health Professional Care

Home health professional care services provide homebound persons living with HIV/AIDS access to personal care, and are critical in preventing the need for costly long term residential care. Based on RW Part B expenditures, Home and Community Based Health Services have increased nearly 12% over the past 2 years, indicating a shift to fill the gap for these needed services.

Priority Populations

When determining which populations are of greatest importance in allocating resources and implementing the interventions and strategies supported by California's surveillance, prevention, and care funding, it is essential to implement a data driven process that accurately reflects the state's HIV epidemic. Based on trends in the epidemic and assessment of service needs, OA, with review and approval by the CPG, has established the following priority populations: HIV-positive persons at high risk of transmitting HIV; their partners; injection drug users (IDUs); MSM (especially African American and Latino MSM); and African American and Latina women.

Within these larger groups, however, there are statewide and regional sub-populations representing significant levels of risk for HIV acquisition or transmission, or which experience known HIV-related health disparities. In order to effectively direct resources to the populations

OA, with review and approval by the CPG, has established the following priority populations: HIV-positive persons at high risk of transmitting HIV, their partners, injection drug users (IDUs), MSM (especially African American and Latino MSM), and African American and Latina women.

and communities most affected by the HIV epidemic, more depth of analysis for the broader Latino/a, African American, MSM, and IDU populations is required. While the populations themselves are the framework upon which this analysis will be based, other elements must be taken into account as well, such as behavioral risk, identity, geography, and factors related to HIV prevention and care access. Finally, the process must also be informed by contributors to increased vulnerability for HIV transmission or acquisition.

In response to this need, OA, with input and review from CPG, is developing Population Profiles for populations which are found to be at greatest risk for acquiring or transmitting HIV. Upon completion, each Population Profile will be integrated within the annual California HIV/AIDS Epidemiologic Profile. Based on the profile information, OA, in collaboration with CPG and other key stakeholders, will then develop population action plans that are meant to inform both program and policy decisions. It is hoped that the Population Profiles will allow identification and quantitative description of potential health disparities for these populations in order to better inform resource allocation and planning for reducing HIV/AIDS health disparities in California.

California priority populations have been selected for focus in OA Population Profiles as determined by HIV prevalence, new/recent diagnoses, and known disparities with consideration of measurability. Also included are measures of HIV/AIDS epidemiology and service utilization. Finally, geospatial mapping will be utilized to provide an overlay of drivers of the epidemic, such as poverty, that are important in providing as accurate a portrayal of these populations as is feasible.

Population Profiles will be initially developed for African American women, IDUs (including MSM IDU), Youth (13-19 and 20-24), and Male to Female (MTF) transgender persons. This first set of Population Profiles will pilot OA's analytic approach and provide a basis for working out complications such as data limitations. Additional Population Profiles will be developed for African American youth, MSM, African American MSM (including African American youth), African American men, Latinos, Latinas, and Elders (50-59, 60-69, and 70+).

Strategy to Address the Needs of HRSA-Designated Special Populations

In the guidance for comprehensive jurisdictional HIV services planning for 2012, HRSA noted that there are groups which may not consistently show the greatest burden of disease in every locale, but which have been demonstrated to face circumstances placing them at high risk for HIV infection or failure to access care. HRSA designated four groups within this "special populations" category – adolescents, injection drug users, the homeless, and transgender persons - and called on jurisdictions to develop strategies, plans, and activities to address their needs, with the ultimate goal of improving the continuum of care for these populations.

The four HRSA-identified special populations overlap among and within OA's priority populations, and our EIIHA target populations. In addition, many individuals will meet more than one special population definition. Members of the OA priority population groups and the HRSA special population groups share common experiences and barriers in regard to HIV, including stigma and bias, barriers to health care, insufficient population-specific services, and gaps in data collection.

The *Integrated Plan* is meant to improve the continuum of HIV care for HRSA's special populations through identifying the specific disparities and social determinants influencing HIV-related health outcomes for each group, and utilizing this information to inform the goals, objectives, and activities meant to alleviate these disparities. Properly implemented, the goals, objectives, and activities of the *Integrated Plan* will address needs and gaps occurring both within and across identified population categories.

The 2009 Comprehensive Plan: Evaluation and Meeting Identified Challenges

In the first months of 2009, goals and objectives for achieving California's vision for care and treatment were developed for the Comprehensive Plan. In addition, a Clinical Quality Management (CQM) Committee was developed as required by HRSA, as well as a plan for ongoing monitoring and evaluation based on data collected through the ARIES and ADAP data reporting systems, qualitative data sources, and local data sources.

Soon after submitting the 2009 Comprehensive Plan to HRSA, OA faced severe budget cuts as a result of the national and statewide fiscal crisis. These cuts eliminated or restructured all OA Care-supported programs that formed the basis for evaluation of the Comprehensive Plan. With only the CQM remaining in place, it was impossible to implement the original evaluation plan.

This document incorporates the 2012-2015 Comprehensive Plan and includes goals, objectives and strategies that are measurable and will be evaluated periodically through the plan effective period.

Because program cuts made it impossible to proceed with the original evaluation plan for the 2009 Comprehensive Plan, OA focused instead on assisting funded jurisdictions in meeting the challenge of delivering HIV care services after statewide elimination of most previous OA-funded care programs. As the remaining providers were struggling to function with much smaller budgets and staffing ratios, OA responded by implementing a flexible single allocation Care program model that places first priority on Outpatient/Ambulatory medical care, with secondary priority on services that support access to and retention in Tier One care. In addition, OA initiated work on a comprehensive Goals and Strategies Framework: http://www.cdph.ca.gov/programs/aids/Documents/OAGoalsStrategies122409.pdf

Completed in 2010, the Framework is in alignment with the NHAS and is intended to serve as a tool to guide OA's response to ongoing and new care and prevention needs.

Monitoring the Progress of the Integrated Plan in Achieving the Goals of the NHAS

As established in the CDC's *2012 HIV Planning Guidance*,[20] the primary task of CPG is to partner with OA to address how the state can accomplish the development and implementation of the Integrated Plan, the successful execution of programs and activities based on the CDC's 'High Impact Prevention' strategy, and the achievement of the goals of the NHAS.

The CDC's new HIV planning guidance continues to support significant community involvement, and maintains the emphasis on ensuring a scientific basis for program decisions and targeting resources to have the greatest effect on HIV transmission and acquisition. Notable shifts from previous versions of the guidance include the fact that it is structured throughout to provide more flexibility. Because some previous monitoring requirements were determined to be too labor-intensive, there is also a strong emphasis on reducing the amount of required reporting documentation, a more streamlined approach to monitoring and evaluation, more focus on engaging a broader group of stakeholders, and an overall desire

[20] http://www.ricpg.org/2012-03-26_HPG_Pre-Decisional.pdf

to facilitate communication, coordination, and implementation of needed services.

The CPG/OA plan for monitoring and evaluation of California's Integrated Plan is based on the monitoring model put forward by the CDC, which is meant to facilitate community and stakeholder involvement. The monitoring plan includes two primary areas of focus: monitoring the progress of the plan's implementation in achieving the goals of the NHAS for reducing HIV incidence and addressing HIV-related health disparities, and monitoring the jurisdictional planning process itself. Monitoring questions designed to address each goal for the Integrated Plan are below. The entire set of goals, objectives, and activities for the Integrated Plan may be referenced on pages 7-10 of this document.

Goal 1: Reducing New HIV Infections

Principle:
Target HIV prevention efforts in the communities and venues where HIV is most heavily concentrated, with primary effort directed toward HIV-positive persons.

Monitoring Questions:
To what extent was success achieved in selected health care settings in promoting routine, opt-out HIV testing and integrating HIV screening into work flow?

Did non-clinical HIV testing services effectively target communities with the greatest disease prevalence?

Did non-clinical HIV testing services effectively target populations with the greatest disease burden?

To what extent was success achieved in ensuring that every individual who received a positive test result was offered Partner Services?

Goal 2: Increase Access to Care and Optimize Health Outcomes

Principles:
Ensure that every person in California who is HIV-positive has access to appropriate, coordinated HIV care and treatment.

Systems must be established that immediately link people to comprehensive, coordinated care when they are diagnosed with HIV.

Monitoring Questions:
In health care settings conducting routine, opt-out HIV testing, to what extent was success achieved in establishing linkage to care (LTC) networks across prevention, care, and social service systems?

In settings offering targeted non-medical HIV testing services, to what extent was success achieved in establishing LTC networks across prevention, care, and social service systems?

To what extent did funded jurisdictions receive appropriate support in developing capacity for implementing HIV treatment adherence strategies?

Was there effective monitoring and use of surveillance data for identifying clients with unsuppressed viral load and/or insufficient engagement in HIV medical care?

To what extent were systems established across prevention and care systems for engaging HIV+ persons who have never been in care?

To what extent were systems established across prevention and care systems for re-engaging HIV+ persons who have fallen out of care?

Goal 3: Reduce HIV-Related Health Disparities

Principles:
All HIV+ persons should have access to equitable, appropriate, and effective HIV care that is free from stigma or discrimination.

No HIV+ person should experience gaps in health care based on age, gender, race, socio-economic status, sexual orientation, or gender identity.

Monitoring Questions:
To what extent were available data and existing research utilized to assist in identifying California populations experiencing HIV-related health disparities?

To what extent were jurisdictions assisted in identifying, developing, and implementing strategies to reduce HIV-related stigma and discrimination?

To what extent were community-level approaches identified and implemented for reducing HIV infection in high-risk communities?

Goal 4: Achieve a Coordinated Response to the HIV Epidemic in California

Principles:
In order for California to successfully fulfill the vision of the NHAS, emphasis must be placed on coordination of activities within and between state agencies and across all levels of government.

The development of a coordinated response to HIV must include improved and streamlined mechanisms for monitoring and reporting on progress toward achieving goals.

Monitoring Questions:
To what extent were data collection requirements streamlined among providers, including creating shared, standardized data collection forms where possible?

To what extent was collaboration strengthened between internal OA branches, STD and other communicable disease programs and other relevant CDPH divisions in developing coordinated strategies for HIV care and prevention?

To what extent were LHJs provided TA and support in establishing active collaborations between HIV prevention and care providers?

To what extent were LHJs provided TA and support in establishing active collaborations between HIV providers and hospitals, clinics, pharmacies, CBOs, alcohol and other drug programs, and housing and other support services?

To what extent were potential HIV-related issues associated with full implementation of ACA identified and planned for?

Goal 5: Maximizing Resources Through Efficacy of Planning and Allocation, Flexibility, and Effective Program Fiscal Management

Principles:
In order to achieve broad coverage for HIV prevention and care programs, the OA will allocate existing funding in accordance with established priorities and apply for all available and applicable funding resources.

Resource allocation should include broad stakeholder input including community planning as a guide to inform the support of programs and services for identified priority populations, strategies, and interventions.

OA will engage in ongoing fiscal monitoring to ensure efficient and effective use of HIV funds among its grantees.

Monitoring Questions:
To what extent did OA allocate funding based on established principles and informed by the objectives of the Integrated Plan?

To what extent were new resources identified and allocated with community planning and other stakeholder input?

To what extent, and using which methods, was OA able to determine effective program fiscal management?

Goal 6: Monitoring the HIV Epidemic by Using OA HIV and AIDS Surveillance Data to Support and Direct Program and Policy Decisions

Principles:
The OA will encourage and provide technical assistance when needed to all providers of HIV prevention and care services to enhance reporting of HIV infection, viral load, and other data essential for program implementation and monitoring.

Using surveillance data on an ongoing basis will assist the OA in identifying emerging trends in HIV infection.

Program and policy decisions will be based upon surveillance data, program experience, and evidence based practices.

Monitoring Questions:
To what extent were LHJs provided TA and support relating to enhanced reporting and use of surveillance and epidemiological data to improve program planning and policy decisions?

To what extent were HIV prevention efforts concentrated in geographic areas and populations consistent with the epidemic, i.e., in the highest risk and emerging target populations?

Monitoring the Jurisdictional Planning Process

Monitoring the jurisdictional planning process is informed by the overall goal of maintaining a working partnership between OA, the community, and key stakeholders in order to enhance access to HIV prevention, care, and treatment services for the highest risk populations.

CPG's stakeholder and membership profile, OA Advisory Network participant list, surveillance data, and service indicators, combined with use of four monitoring questions that are based on CDC recommendations, represent the framework for monitoring and evaluation of California's jurisdictional plan.

Monitoring of California's jurisdictional planning process will be conducted as recommended based on the documentation, tools, monitoring indicators and monitoring questions put forward on page 41 of the *2012 HIV Planning Guidance*.

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