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California Stories

New fellowship will help L.A. County fill shortage of HIV-trained doctors

Soumya Karlamangla, Los Angeles Times | 1.20

Since May, Dr. Robert Bolan has been trying to hire a physician who knows how to treat HIV patients. One of the doctors at the Los Angeles LGBT Center, where Bolan is the medical director, moved away last year.

"I just haven't been able to land somebody and put them in a clinic," he said. "There really is a shortage of primary care physicians, and particularly primary care physicians who want to go into HIV care."

Experts say that the first generation of doctors trained in HIV medicine is beginning to retire, and not enough physicians are entering the field to replace them.

To address that problem, L.A. County health officials announced Tuesday that they are launching a fellowship to train doctors in HIV-related medicine. Funded by a \$7.5-million grant from pharmaceutical company ViiV Healthcare, the program will teach physicians how to care for HIV-infected patients at county facilities.

The fellows will be paid a salary during the two-year training and could receive student loan debt repayment assistance.

Dr. Mitchell Katz, the head of the county Department of Health Services, called the lack of physicians who specialize in HIV-related medicine an "alarming reality." L.A. County has more than 60,000 people estimated to be infected with HIV.

Katz trained as a physician at the height of the AIDS crisis, he said. Now, physicians are looking to enter specialties that pay better, he said.

"I didn't set out to be an HIV doctor either, but the emergence of the epidemic is what led us to do what we do," Katz said. "My concern is what does that look like into the future."

Advocates agree that the new initiative is good news for HIV-prevention efforts, but also note that ViiV Healthcare manufactures and sells HIV medications.

"To be clear, this is not charity on the part of ViiV," said AIDS Healthcare Foundation President Michael Weinstein.

Weinstein said he didn't see any problems with the county accepting the money, but that it should be viewed as a way for the company to increase sales.

Katz said ViiV Healthcare will have no influence over the prescribing practices of doctors.

Katz acknowledged that the grant comes at a time when drugmakers are being lambasted for reaping huge profits, "but I don't think we want people's skepticism to prevent pharmaceutical companies from doing the right thing."

According to county documents, ViiV Healthcare officials approached the county last year about the project.

Katz said the money that would help fellows pay off loans was a major part of the appeal in ViiV Healthcare's proposal. If fellows who have completed the program work in underserved areas anywhere in the country, they can get up to \$50,000 a year toward paying off their medical debt.

"If people come out of residency with crushing debt, you can hardly blame them for looking for the most lucrative careers," he said.

The grant is expected to last five years and will be used to train 10 to 18 physicians. Doctors who apply must have completed a clinical residency.

Dr. Andrew Zolopa, the company's global medical director, called the program the first of its kind and said he hopes it becomes a national model for HIV training. It has the potential to benefit the county, doctors, patients and the company, he said.

"In the end it's a win-win-win-win, all the way around," he said.

View the story online: [Click here](#)

Court Rules Catholic Hospital Can Refuse Reproductive Health Care

Jessica Mason Pieklo, RH Reality Check | 1.19

A California state court judge has tentatively rejected a lawsuit brought by a California woman against a Catholic hospital that has refused her request for a tubal ligation.

Rebecca Chamorro and Physicians for Reproductive Health sued Dignity Health and Mercy Medical Center in Redding, California in December 2015. Chamorro, who is eight months pregnant and scheduled to give birth at the end of January, wanted a tubal ligation at that time, according to the complaint. But Dignity Health refused Chamorro's request and told Chamorro's doctor that he could not perform the procedure, citing religious directives written by the United States Conference of Catholic Bishops.

Those directives state that direct sterilization is "inherently evil."

That refusal, according to the complaint, amounts to sex discrimination because the prohibition against sterilization disproportionately impacts women.

Dignity Health is the fifth largest health system in the nation and the largest hospital provider in California. Each year it receives millions in government grants, Medicare and Medicaid reimbursements, and government programs, according to recent tax filings.

Chamorro had asked the court for an order declaring that the hospital chain's refusal violated California civil rights laws, business and professions laws, and the Health and Safety Code, as well as an injunction requiring the hospital allow the procedure.

Superior Court Judge Ernest Goldsmith denied that request in a tentative ruling last week. Chamorro's discrimination claim is likely to fail because Dignity Health's sterilization policy "applies equally to men and women," Goldsmith wrote.

Goldsmith continued: "[p]laintiff can obtain the desired procedure at other hospitals that do not follow defendant's directive."

According to Chamorro's attorneys, their client is still scheduled for a January 28 cesarean section at Mercy Medical, where her doctor will not be allowed to perform the tubal ligation procedure. Despite last week's order tentatively rejecting Chamorro's claims, Elizabeth Gill with the ACLU of Northern California said in a statement the rest of their case would move forward.

"We will continue to litigate the case on behalf of Physicians for Reproductive Health," Gill said. "We believe that the courts will ultimately ensure that government-funded hospitals serving the general public and people of all faiths cannot use religion to discriminate, interfere in the doctor-patient relationship, or deny women basic healthcare."

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County gonorrhea spike outstrips national trend

Lauryn Schroeder, San Diego Union-Tribune | 1.18

The rate of gonorrhea cases in the San Diego metro area has increased significantly since 2010, according to recently released federal data on sexually transmitted diseases.

When the county's health department publicized the new data earlier this month, it portrayed the spike as part of a broader trend.

"Gonorrhea and syphilis cases increased across the nation in 2014, and San Diego was no exception," public health officer Wilma Wooten said in a news release.

But the San Diego area's increase in sexually transmitted diseases has been sharper, and more sustained, than the national average.

Local cases of gonorrhea have increased by nearly 70 percent since 2010, according to the report, while nationwide cases grew by 13 percent.

As a result, San Diego has gone from a rank of No. 34 in metropolitan areas for gonorrhea to No. 16.

Five years ago, there were about 65 gonorrhea cases for every 100,000 residents in the San Diego area, well below the nation's rate of 100 per 100,000. New federal data show local rates now reach about 107 cases per 100,000 residents in 2014, falling just behind the national rate of 111.

"We weren't trying to tone it down," said Dr. M. Winston Tilghman, the sexually transmitted disease controller for San Diego County, who helped the department draft the release. "We were just trying to

get an introduction that would grab people and engage people. The increase in our gonorrhea rates is concerning, and it's primarily affecting men."

The federal data show the rate of gonorrhea in males was more than double the rate in females, with men between the ages of 20 and 29 at the highest rate of infection. Tilghman said the many of the cases for males are occurring in the gay and bisexual communities, where sexual networks are smaller and the risks are higher.

"Basically what that statement is saying is that we're also seeing increases like other parts of the country, with the exception of chlamydia, which has leveled off and actually decreased slightly over the past few years," he said.

A review of the federal data found that the San Diego metro area saw gonorrhea cases jump to 3,420 in 2014 from 2,825 in 2013, a 20 percent increase. Syphilis numbers grew to 986 from 791 over the same time period, a 25 percent increase.

The Centers for Disease Control report, released in November, provides data on a national, statewide and metropolitan level for chlamydia, gonorrhea, syphilis and other sexually transmitted diseases.

On a statewide level, California has the highest number of gonorrhea cases in the country, accounting for nearly 15 percent of all cases nationwide. It had more than the entire northeast and accounted for nearly 60 percent of cases in the west.

Tilghman said a range of factors could be driving the increases, such as limited funding for intervention programs and dating apps that make traditional public-health outreach methods less effective. He also said increases could be the result of more efficient and diligent screening to identify more cases, as well as an increase in the public's access to health facilities.

The county currently operates four STD clinics, all of which offer full screening and treatment services. He said county residents also have access to a strong network of community health networks and family planning clinics, which provide the same, if not similar services.

A spike in local rates of congenital syphilis, which is when the disease is transmitted from an infected mother to her unborn child, is a cause for concern among public health officials as well.

The condition is preventable if women are treated with penicillin before giving birth, but cases left untreated can cause severe health effects. It starts with unexplained sores and rashes and can progress to paralysis, blindness, internal organ damage and death. The disease is also linked with higher rates of premature birth and stillbirth, and untreated children often develop problems in multiple organs.

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San Joaquin County to launch services for HIV prevention

As reported by Lodi News-Sentinel | 1.20

San Joaquin County Public Health Services (PHS) will begin offering HIV pre-exposure prophylaxis (PrEP) in February. PrEP is a way for people who do not have HIV, but who have an increased chance of getting

it, to prevent HIV infection by taking a pill called Truvada every day. Truvada has been shown to be safe and to help HIV-negative people to stay that way. PrEP is used along with other prevention methods, such as condoms. When taken daily, PrEP can reduce the chance of getting HIV by more than 90 percent. If not taken daily, PrEP will not be as protective against HIV infection.

“Approximately 80 people become newly infected with HIV in San Joaquin County each year,” says Julie Vaishampayan, MD, MPH, Assistant Public Health Officer. “We are committed to using every effective method to decrease new HIV infections in San Joaquin County. PrEP is another step forward in our efforts to end this epidemic.”

PHS is now taking appointments for anyone interested in PrEP. Truvada is covered by most health insurance providers. For questions or to schedule an appointment, call 209-468-3830.

View the story online: [Click here](#)

National Stories

HIV Testing Low for Youth, Despite Broad Recommendations

Marcia Frellick, Medscape | 1.20

Approximately 26% of new HIV cases in the United States occur in youths aged 13 to 24 years. However, low testing in this age group means they are more likely than any other age group to be unaware of their status, according to a new study.

The study, published online January 18 in *Pediatrics*, found that just 22% of high school students who had ever had intercourse had been tested for HIV (17% of boys and 27% of girls). For young adults in that category, the testing rate was 33%.

Michelle Van Handel, MPH, from the Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia, and colleagues note it appears that current recommendations to screen all adolescents and young adults for HIV infection, regardless of risk, are not widely known or implemented.

Researchers analyzed National Youth Risk Behavior Survey and Behavioral Risk Factor Surveillance System data to assess HIV testing prevalence among high schoolers and young adults aged 18 to 24 years, respectively.

They found that testing rates have not improved during the last decade. "During 2005–2013, the percentage of sexually experienced high school students who had ever been tested for HIV did not change overall or for any subgroup," the authors write.

Poor access to healthcare and prevention is a major barrier for young people, but provider knowledge of updated recommendations is also a problem, the researchers explain.

In 2006, the Centers for Disease Control and Prevention released the "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings," advocating for screening all people aged 13 to 64 years. But many providers still are not aware of these recommendations.

"Even among those with access to preventive health care, studies have found limited knowledge of HIV testing recommendations for adolescents and young adults among pediatricians and health care providers. In an analysis of adolescents at a large urban pediatric emergency department, 78% of providers were unaware of the revised recommendations," the authors write.

They recommend better provider education, adolescent-friendly testing services, and sexual health education.

The Centers for Disease Control and Prevention estimates that more than 25,000 HIV-positive young people in the United States are undiagnosed. Stagnant levels of HIV testing among young adult males and decreased testing among young adult black females (from 68.9% in 2011 to 59.9% in 2013) are particularly worrisome because these groups make up the majority of new infections in the 13- to 24-year age group, the authors write.

Testing decreased significantly during 2011 to 2013 among young adult females overall (from 42.4% to 39.5%). The rate among adult white females also dropped from 37.2% to 33.9% during that period.

Journal Reference:

Pediatrics. Published online January 18, 2016. [Abstract](#)

View the story online: [Click here](#)

HPV Vaccine Rates Highest in Poor and Hispanic Communities: Study

Researchers say teen girls in mostly black and mostly white neighborhoods have lowest rates

Robert Preidt, HealthDay, as reported by Medline Plus | 1.14

Teen girls in poor or predominately Hispanic communities are more likely to receive at least one dose of the human papillomavirus (HPV) vaccine than those in other communities, a new study finds.

HPV can cause cancers of the cervix, vulva, vagina, anus, penis and throat, and the U.S. Centers for Disease Control and Prevention recommends that all girls and boys aged 11 to 12 receive three doses of the HPV vaccine.

Researchers examined 2011 and 2012 CDC data on provider-verified vaccination records for more than 20,500 girls, aged 13 to 17. In each of those years, 53 percent of the girls received at least one dose of HPV vaccine.

The highest vaccination initiation rate (69 percent) was among girls in predominately Hispanic communities and the lowest rates were among girls in predominately black communities (54 percent) and white communities (50 percent).

Poverty levels also influenced vaccination rates. Regardless of the racial/ethnic composition of a community, girls in communities in which at least 20 percent of the residents lived below the poverty line were 1.2 times more likely to have initiated HPV vaccination than those in the wealthiest communities.

The study was published Jan. 14 in the journal *Cancer Epidemiology, Biomarkers & Prevention*.

"HPV vaccines could dramatically reduce the incidence of HPV-associated cancers, but uptake of these vaccines is far lower than for other routine childhood and teen immunizations," said study author Kevin Henry. He is an assistant professor at Temple University in Philadelphia and a member of Fox Chase Cancer Center's Cancer Prevention and Control program.

"The main goal of our study was to understand if geographic factors -- that is, characteristics about a person's community -- affect vaccination uptake, because this knowledge could inform current efforts to increase vaccination and prevent cancer," he said in a journal news release.

"The higher HPV vaccination rates among girls living in poor communities and majority Hispanic communities, which also tend to have high poverty rates, are encouraging because these communities often have higher cervical cancer rates. But, continued cervical cancer screening of vaccinated and unvaccinated women is needed because the vaccine does not cover all cancer-causing HPV types and sexually active women could have been infected prior to vaccination," Henry said.

"The higher HPV vaccination rates in these groups also provide some evidence supporting successful health care practice and community-based interventions," he added.

"What is not encouraging is that girls living in predominantly high-poverty non-Hispanic black communities have HPV vaccination rates that are lower than rates for Hispanics. Additional research is needed to better understand why these differences exist," Henry concluded.

SOURCE:

Cancer Epidemiology, Biomarkers & Prevention, news release, Jan. 14, 2016

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Tenofovir Alone as PrEP May Fail

As reported by aidsmeds.com | 1.19

Two cases have been documented of gay men taking Viread (tenofovir), one of the two drugs in Truvada (tenofovir/emtricitabine), for hepatitis B virus (HBV) and contracting HIV, *aidsmap* reports. These cases suggest that Viread alone may not be enough to prevent HIV through pre-exposure prophylaxis (PrEP), and that Emtriva (emtricitabine) is also required for such prevention. However, there is a possibility that the presence of hep B may have increased the men's risk of HIV acquisition.

Publishing their analysis in *Infectious Diseases and Therapy*, researchers documented case reports of two gay men who contracted HIV while adhering to a Viread regimen to treat hep B.

In one of the men, the Viread wound up suppressing his new HIV infection to undetectable levels. The

other man had a viral load of about 100,000 shortly after contracting HIV, a moderate level for an acute infection. Tests indicated that HIV had sufficiently integrated into the cells of each man to establish a permanent infection.

To read the aidsmap article, [click here](#).

View the story online: [Click here](#)

Opt-Out Screening Can Improve Acceptance of HIV Testing

Nicola M. Parry, Medscape | 1.21

Compared with active choice testing, opt-out screening can substantially increase HIV testing, and opt-in schemes may reduce testing, a new study has suggested.

"Our study provides evidence that small changes in wording can significantly affect patients' behavior and thus our understanding of their preferences. Specifically, modifying HIV testing defaults led to clinically and statistically significant differences in test acceptance percentages," write Juan Carlos C. Montoy, MD, from the University of California, San Francisco, and colleagues. They published the results of their study online January 19 in the BMJ.

"We found that active choice testing, although previously considered a form of opt-in testing, is a distinct category: compared with a strict opt-in scheme informing patients that they can request a test, simply asking patients if they would like a test increased test acceptance by 13 percentage points," the authors write.

To improve patients' acceptance of HIV testing, the Centers for Disease Control and Prevention revised its HIV screening guidelines in 2006, calling for routine, nontargeted, opt-out testing. Yet, although the centers noted that emergency departments may offer ready access to identify the estimated 20% of HIV-positive people who are undiagnosed, most hospitals have not implemented the opt-out recommendations. In addition, whereas studies of emergency department–based HIV screening have demonstrated that opt-out programs are associated with testing of an increased proportion of patients, they have reported conflicting results, with patients' test acceptance ranging from 29% to 87%.

Dr Montoy and colleagues therefore aimed to evaluate the effect of default test offers on the likelihood of acceptance of an HIV test among patients in an emergency department.

The researchers performed a nonblinded, randomized clinical trial in 4800 patients who visited an emergency department. They included patients aged 13 to 64 years who were able to consent to HIV testing, and excluded those who had previously been diagnosed with HIV or had received an HIV test in the previous 3 months. During the visit, nonclinical staff approached patients on two separate occasions — first to offer them a questionnaire, and again to offer them a rapid screening HIV test — and informed them that the emergency department was offering HIV tests in a nontargeted manner to all patients.

Patients were randomly assigned to opt-in (notifying patients that HIV testing was available but requiring them to ask for it), active choice (directly asking patients whether they would like to be tested), or opt-out (notifying patients that they would be tested unless they declined) HIV test offers.

Patients accepted 51.6% of all offers of HIV tests: 38.0% of those in the opt-in group accepted an HIV test compared with 51.3% in the active choice group (difference, 13.3%; 95% confidence interval [CI], 9.8% - 16.7%; $P < .001$) and 65.9% in the opt-out group (difference, 27.9%; 95% CI, 24.4% - 31.3%; $P < .001$). And compared with active choice testing, opt-out testing resulted in 14.6% (95% CI, 11.1% - 18.1%) more test acceptances.

In all groups, patients were more likely to accept testing if they were at intermediate (difference, 6.4%; 95% CI, 3.4% - 9.3%; $P < .001$) or high (difference, 8.3%; 95% CI, 3.3% - 13.4%; $P = .0013$) risk for HIV infection. The opt-out effect was significantly smaller (interaction term, -15.5%; 95% CI, -27.8% to -3.1%) for patients at high risk for HIV infection; however, the active choice effect did not significantly vary by level of reported HIV risk behavior.

In an accompanying editorial, Jason S. Haukoos, MD, and Sarah E. Rowan, MD, both from the University of Colorado School of Medicine, Aurora, emphasize that, "the study by Montoy and colleagues represents one of the largest trials to evaluate consent for HIV testing among emergency department patients, and the only one to do it in a randomized fashion but with particular focus on the efficacy of the various consent options."

However, they note that the authors' version of "opt-in" consent seems unrealistic because it is unlikely that clinicians would tell patients that they perform HIV testing without asking them whether they want to be tested. "If this occurs in practice, we believe it should be abandoned," they write.

Nevertheless, Dr Haukoos and Dr Rowan acknowledge the importance of using evidence to guide decisions about the best way to conduct HIV screening to maximize test acceptance and improve HIV diagnosis. "We commend the authors for conducting a large, thoughtful, and methodically rigorous clinical trial to help to improve our understanding of how best to offer an HIV test. Their results support the notion that 'the ask' is a critical piece of the equation and is probably as important as 'the test,' " they conclude.

This work was supported by the National Institute on Aging. The authors and editorialists have disclosed no relevant financial relationships.

BMJ. Published online January 19, 2016. [Article full text](#), [Editorial full text](#)

View the story online: [Click here](#)

CVD mortality risk increasing for US adults with HIV

Tracey Romero, Healio | 1.11

Proportionate CVD mortality more than doubled among HIV-infected adults in the United States between 1999 and 2013, according to study findings published in The American Journal of Cardiology.

Matthew J. Feinstein, MD, of Northwestern University Feinberg School of Medicine, and colleagues assessed patterns of CVD mortality for HIV-infected adults in comparison with general and inflammatory

polyarthropathy populations using the CDC WONDER online database. All participants were aged 25 years or older.

According to the findings, although total mortality in the HIV-infected population decreased from 15,739 to 8,660 between 1999 and 2013, proportionate CVD mortality increased from 1.95% to 4.62%, particularly in men ($P < .0001$). During the same period, proportionate CVD mortality decreased for the general and inflammatory polyarthropathy populations. Feinstein and colleagues also reported that for HIV-infected adults, mortality caused by ischemic heart disease tripled from 0.8% in 1999 to 2.5% in 2013. In the general population, however, ischemic heart disease mortality decreased from 22.8% to 14.6% during the same period.

In addition, the researchers observed that hypertensive heart and renal diseases, as well as pulmonary circulatory diseases, also were common causes of CVD-related death in the HIV-infected population.

“The results of this study underscore the emerging need for enhanced CVD risk prediction and prevention in the HIV-infected population. Traditional [CHD] risk prediction models, such as the Framingham risk score, may provide inadequate discrimination and be poorly calibrated in the HIV-infected population in light of the elevated HIV-related MI risks that may differ from traditional risk factors,” Feinstein and colleagues wrote.

Journal Reference:

[Feinstein MJ, et al. *Am J Cardiol.* 2015;doi:10.1016/j.amjcard.2015.10.030.](https://doi.org/10.1016/j.amjcard.2015.10.030)

View the story online: [Click here](#)

Now You Can Get Birth Control Through These Apps

Stephanie M. Lee, BuzzFeed News | 1.11

It’s getting easier and easier to get birth control — and now, a new generation of apps are making it possible to do on your smartphone.

Through startups such as Nurx, Maven, and Lemonaid, patients can get a prescription and order pills to be delivered to their home or a nearby pharmacy. Such services are catching on as access to birth control is expanding in the U.S. in general: New legislation in a few states — Oregon as of this month, and California in March — allows women to get a prescription from a pharmacist without going through a doctor. And under the Affordable Care Act, private insurers are increasingly covering the cost of birth control without co-pays or deductibles.

“For some women, it can be challenging to get away from work or family in order to see your doctor for a prescription or even go to a pharmacist for a refill,” Dr. Jennifer Conti, a clinical instructor of obstetrics and gynecology at Stanford University, told BuzzFeed News. “In general, services like these have the potential to remove an additional barrier to obtaining birth control. In that way, I think they’re a great addition.”

Last month, for example, Nurx launched a website that asks people to choose a medication brand and fill out a series of yes-or-no and multiple-choice questions about their blood pressure, allergies, and other conditions. An independent doctor remotely reviews their answers and places an order, which a

network of pharmacies then fills and mails to the customer, according to Nurx. If the patient has insurance — from carriers including Aetna, Blue Shield, Cigna, and United Healthcare — Nurx bills the insurer and pays for the delivery, and the consumer doesn't pay, as mandated by the Affordable Care Act. If the patient lacks insurance, medications start at about \$15. Most requests are approved within 40 minutes and pills arrive the next day, although the goal is to deliver within two to four hours, according to Nurx. The company is currently shipping pills throughout California only.

Based in San Francisco, Nurx was founded in 2014 by Hans Gangeskar, a former attorney and executive at the microbiome-sequencing startup uBiome, and Edvard Engesaeth, a physician. The two said they were excited about the growing field of telemedicine, and realized that birth control was a consistent medical need for many people. As Gangeskar put it, "We started thinking, how can we pare this service down into something that's as fast as possible, but still give a good and responsible service to users?" Nurx aims to make money by charging pharmacies and insurers to partner with the company in exchange for generating extra business. (It also plans to soon let patients get prescriptions for Truvada, the daily HIV prevention pill.)

On Maven's app, which lets patients video-conference and message with nurse practitioners, birth control pills are, perhaps unsurprisingly, the most requested prescription, CEO Kate Ryder told BuzzFeed News. Providers recommend a medication on the spot and order it to be sent to a pharmacy near the patient. Unlike Nurx, Maven charges for the consultation (\$18 for 10 minutes). Both services let patients follow up with the provider with questions.

Still other health apps offer variations on the theme: Planned Parenthood (which requires a video consultation and mails it to you); Lemonaid (which charges \$15 for a prescription for a three-month supply); Glow (which refills existing prescriptions), and PillPack (which lets you order pills online, but requires you to get a prescription elsewhere).

It's not hard to see why birth-control prescribing is starting to rely less on an in-person doctor visit. Public health agencies clearly lay out the kind of medical information that providers need about patients in order to safely prescribe them birth control. And though some people have conditions, like high blood pressure, that can lead to complications when mixed with birth control, experts say studies show that people can be trusted to accurately self-report their risk factors.

In a 2008 study led by the nonprofit Ibis Reproductive Health, more than 1,200 women in Texas were asked to complete a medical checklist of risk factors; a nurse practitioner then interviewed them, took their blood pressure, and compared their answers. "Women who are likely to seek contraception — especially younger women — are able to identify conditions that might make oral contraceptive use dangerous," the researchers concluded.

In a separate experiment, about 400 female patients from Seattle clinics filled out medical eligibility questionnaires for oral contraception; their answers lined up with their providers' evaluations more than 90 percent of the time.

Perhaps that's why apps like Nurx have drawn little opposition so far.

In fact, one of the few objections raised by clinicians is that birth control should be even easier to get — that is, patients should ultimately be able to get birth control over the counter, without needing to see a medical professional at all.

As Dr. Daniel Grossman, a professor of obstetrics, gynecology and reproductive sciences at UC San Francisco, and an unpaid advisor to Nurx, told BuzzFeed News by e-mail, “That will be the best way to improve access for all women in every state across the country.”

View the story online: [Click here](#)

Scientific Papers/Conference Abstracts

Running Backwards: Consequences of Current HIV Incidence Rates for the Next Generation of Black MSM in the United States

Matthews DD, Herrick AL, Coulter RWS, et al. *AIDS and Behavior* 2016;20(1):7-16

Abstract:

Black men who have sex with men (MSM) in the United States are disproportionately impacted by HIV. To better understand this public health problem, we reviewed the literature to calculate an estimate of HIV incidence among Black MSM. We used this rate to model HIV prevalence over time within a simulated cohort, which we subsequently compared to prevalence from community-based samples. We searched all databases accessible through PubMed, and Conference on Retroviruses and Opportunistic Infections abstracts for HIV incidence estimates among Black MSM. Summary HIV incidence rates and 95 % confidence intervals (CIs) were calculated using random effects models. Using the average incidence rate, we modeled HIV prevalence within a simulated cohort of Black MSM (who were all HIV-negative at the start) from ages 18 through 40. Based on five incidence rates totaling 2898 Black MSM, the weighted mean incidence was 4.16 % per year (95 % CI 2.76–5.56). Using this annual incidence rate, our model predicted that 39.94 % of Black MSM within the simulated cohort would be HIV-positive by age 30, and 60.73 % by 40. Projections were similar to HIV prevalence found in community-based samples of Black MSM. High HIV prevalence will persist across the life-course among Black MSM, unless effective prevention and treatment efforts are increased to substantially reduce HIV transmission among this underserved and marginalized population.

View the paper online: [Abstract](#)

Estimating Incidence of HIV Infection Among Men Who Have Sex with Men, San Francisco, 2004–2014

Raymond HF, Chen Y, McFarland W. *AIDS and Behavior* 2016;20(1):17-21

Abstract:

After 30 years of the HIV epidemic in San Francisco there is hope that the number of new infections among men who have sex with men (MSM) is decreasing and that current novel interventions such as treatment as prevention and pre-exposure prophylaxis will hasten the year that the city sees the last of new HIV infections. In addition, new HIV cases/incidence is the key indicator to measure the trajectory of the HIV epidemic. In this analysis we present an alternate age-cohort approach to estimating HIV incidence and compare our results to other indicators of incidence. Data for the present analysis were collected through National HIV Behavioral Surveillance conducted among MSM in San Francisco using

time location sampling from 2004 to 2014. We estimated HIV incidence using a model where a closed population of 100 was divided into number infected and uninfected according to the HIV prevalence of the 21–25 year group and then estimated what incidence over 30 years would result in the HIV prevalence at age 50+. Incidence estimates were 7 per 1000 person years (PY) (338 cases), 7 per 1000 PY (312), 6 per 1000 PY (285) and 6 per 1000 PY (271) for 2004, 2008, 2011 and 2014, respectively. Conclusion: Our data suggest that recent declines in new HIV diagnoses among MSM in San Francisco maybe due to a reduction in a “back log” of undiagnosed cases and not as large of a decline in new cases or HIV incidence. We hypothesize that the decline in new HIV infections among MSM in San Francisco is much slower than suggested by the decline in new HIV diagnoses.

View the paper online: [Abstract](#)

Alcohol Use Predicts Number of Sexual Partners for Female but not Male STI Clinic Patients

Carey KB, Senn TE, Walsh JL, et al. *AIDS and Behavior* 2016;20(S1):52-59

Abstract:

This study tested the hypothesis that greater alcohol involvement will predict number of sexual partners to a greater extent for women than for men, and that the hypothesized sex-specific, alcohol—sexual partner associations will hold when controlling for alternative sex-linked explanations (i.e., depression and drug use). We recruited 508 patients (46 % female, 67 % African American) from a public sexually transmitted infections (STI) clinic. Participants reported number of sexual partners, drinks per week, maximum drinks per day, frequency of heavy drinking; they also completed the AUDIT-C and a measure of alcohol problems. As expected, men reported more drinking and sexual partners. Also as expected, the association between alcohol use and number of partners was significant for women but not for men, and these associations were not explained by drug use or depression. A comprehensive prevention strategy for women attending STI clinics might include alcohol use reduction.

View the paper online: [Abstract](#)

Do People Know I’m Poz?: Factors Associated with Knowledge of Serostatus Among HIV-Positive African Americans’ Social Network Members

Hoover MA, Green Jr HD, Bogart LM, et al. *AIDS and Behavior* 2016;20(1):137-146

Abstract:

We examined how functional social support, HIV-related discrimination, internalized HIV stigma, and social network structure and composition were cross-sectionally associated with network members’ knowledge of respondents’ serostatus among 244 HIV-positive African Americans in Los Angeles. Results of a generalized hierarchical linear model indicated people in respondents’ networks who were highly trusted, well-known to others (high degree centrality), HIV-positive, or sex partners were more likely to know respondents’ HIV serostatus; African American network members were less likely to know respondents’ serostatus, as were drug-using partners. Greater internalized stigma among respondents living with HIV was associated with less knowledge of their seropositivity within their social network whereas greater respondent-level HIV discrimination was associated with more knowledge of seropositivity within the network. Additional research is needed to understand the causal mechanisms

and mediating processes associated with serostatus disclosure as well as the long-term consequences of disclosure and network members' knowledge of respondents' serostatus.

View the paper online: [Abstract](#)

Resources, Webinars, & Announcements

HIV/AIDS Guidelines App available for iOS and Android Devices

AIDSinfo is releasing a new HIV/AIDS Guidelines app for mobile devices. The AIDSinfo Guidelines app provides mobile access to the [federally approved HIV/AIDS medical practice treatment guidelines](#). The guidelines include recommendations approved by expert panels on the treatment of HIV infection and related opportunistic infections in adults, adolescents, and children and on the management of perinatal HIV infection.

Health care providers surveyed on the AIDSinfo website expect mobile access to up-to-date HIV information at the point of care—even when an Internet connection is unavailable. Designed to meet that expectation, the app automatically refreshes guidelines content when the user is connected to a wireless or cellular data network. When wireless Internet access is not available, app users can view and search the guidelines offline, and the app will check for and download any updates when the user is back online and connected again.

Available for both [iOS](#) and [Android](#) devices, the free AIDSinfo Guidelines app includes several features to personalize the app to meet individual needs. Using these features, app users can:

- View only guideline recommendations or tables
- Receive alert notifications when a new guideline is released or guideline content is updated
- Bookmark sections of a guideline
- Add notes to sections of a guideline
- Share guidelines and notes via social media, email, or text
- Search for information within guidelines
- Use the guideline spell suggest feature for searching when connected to wireless or using cellular data

Visit [AIDSinfo](#) to download the free Guidelines app to your iOS or Android device today.

If you have comments, suggestions or issues with the app, please contact AIDSinfo directly at ContactUs@idsinfo.nih.gov.

STD Tx Guide App now available on Android

The highly anticipated [Android version](#) of the 2015 STD Treatment Guidelines mobile app is now available for download. The Android version has a great new look and an up-to-date design with the latest version of the Android OS. Both the Android and [Apple](#) versions now have the ability to receive Push Notifications that can be used to alert the user to new versions of the app or other updates. Also,

both versions have the ability to share info about the app with colleagues via Facebook, Twitter, email and text. Download the free app today and let us know what you think!

Managing Patients with HIV Virologic Failure: Key US Guideline Updates

The US Department of Health and Human Services has revised its guidelines on the management of virologic failure, and a summary of key updates is provided here. The guidelines now include treatment recommendations for (1) virologic failure in various clinical scenarios involving first-line and second-line antiretroviral regimens and (2) isolated central nervous system (CNS) virologic failure with the onset of new neurologic symptoms.¹ The complete guidelines are available on the AIDSinfo website at <http://www.aidsinfo.nih.gov>.

For more information: [Click here](#)

2016 STD Prevention Conference: Call for Abstracts is Now Open

Dear Partners in Prevention,

Abstracts are being accepted for the 2016 STD Prevention Conference through April 25, 2016. The Conference theme: *Transcending Barriers. Creating Opportunities.*, offers you the perfect opportunity to share your work in the areas of STD prevention research, program, policy, diagnosis, and treatment.

Abstract submissions are peer-reviewed for scientific content, logical presentation, timeliness, and current interest of the topic to the scientific community. Abstracts must be submitted no later than **Monday, April 25, 2016 at 11:59pm PST**. Instructions for submitting an abstract and a new resource to help guide you through the development process are available at the [2016 STD Prevention Conference website](#).

We look forward to seeing you September 20-23 in Atlanta and to exploring how to bring this year's theme – *Transcending Barriers. Creating Opportunities* – into our everyday work, and ultimately, maximizing the health of our communities.

Thank You,
Gail Bolan, M.D.
Director,
Division of STD Prevention National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

WEBINAR: Addressing Myths + Concerns About Contraceptive Method Risk

DATE: Jan. 25

TIME: 12:00 – 1:00 PM PST

Presenter:

Anita Nelson, MD, Medical Director, California Family Health Council Research Center; Chief of Women's Health Care Education Programs, Professor, Department of Obstetrics and Gynecology, UCLA

Overview:

Contraceptive method choice is affected by a variety of factors. Women may have concerns about contraceptive safety that may be fueled by the media, myths that are shared anecdotally or advertisements seeking to recruit plaintiffs in legal cases. This session will explore how to utilize and implement a client-centered approach when discussing contraceptive safety and risk - both real and perceived - during a patient visit. Participants will learn how to differentiate between side effects and health risks that are attributable to contraceptive methods and compare contraceptive risks to those that may occur in daily life.

What Will You Learn?

After attending this training, participants will be able to:

- Describe women's concerns over time about the safety and side effects of different methods of contraception
- Explain why women may believe that there are serious health risks related to contraceptive use
- Discuss how you can approach a patient who only wants to use methods that they view as "natural"
- Quantify the known health risks attributable to contraception compared to risks in daily life
- Describe the nocebo effect

For more information and to register: [Click here](#)

WEBINAR: PrEP4Life Webinar Series on Women and PrEP

DATE: Jan. 26

TIME: 1:00 – 2:30 PM CT

Iris House, in collaboration with The National Women and AIDS Collective (NWAC) and Christie's Place is hosting an educational webinar series on women and PrEP. "PrEP4Life" is a two-part webinar series held on January 26 and February 2 from 1:00 to 2:30 CT.

PrEP means Pre-Exposure Prophylaxis. PrEP is a medication designed to keep HIV-negative people from becoming HIV-positive. This webinar series will provide professionals in the field of HIV and people living with HIV with information on distinguishing the facts from the myths, helping women access PrEP, and linking women to treatment.

- The presenters for Session One (January 26): The Facts from the Myths are Dazon D. Dixon, Executive Director, SisterLove and Ofelia Barrios, Sr. Dir. of Community Health Initiatives, Iris House.
- The presenter for Session Two (February 2): Linking Women to Treatment is Dr. Theresa Mack, MD., Internal Medicine /Infectious Disease Specialists, St. Luke's Medical Group.

Attendees who attend both sessions will receive a Certificate of Attendance.

To learn more and to register, visit the [webinar website](#). If you have any questions about NWAC or the webinar series, please [email NWAC](#).

WEBINAR: HIV Prevention Advocacy in the 2016 Election Year: Priorities and Challenges

DATE: Jan. 25

TIME: 3:00 – 4:30 PM ET

The 2016 elections will shape the work of many HIV prevention policy advocates as we continue to push for broader access to comprehensive services for all priority populations. **With impending changes in Federal and state leadership fast approaching, HIV advocates and activists must be well positioned to continue to push for key policies and actions under current administrations and hold newly elected leaders accountable to their constituents' HIV prevention needs.**

Join Treatment Action Group and the HIV Prevention Justice Alliance for a [webinar on January 25th from 3:00 to 4:30 pm ET](#) as we explore federal, state, and local HIV prevention priorities in 2016. Speakers will focus on two critical policy areas:

1. Federal, state, and local targets to improve coverage of comprehensive HIV prevention services for priority populations, including PrEP and PEP.
2. Potential state and local HIV prevention policy advocacy priorities, including opportunities for young gay and bisexual men of color, and transgender women and men.

Panelists include:

- Amy Killelea, Director of Health Systems Integration, NASTAD
- Cecilia Chung, Senior Strategist, Transgender Law Center
- Kenyon Farrow, US and Global Policy Director, Treatment Action Group

Moderator: Jeremiah Johnson, HIV Research and Policy Coordinator, Treatment Action Group

For more information and to register: [Click here](#)

Job/Internship Postings

Health System Communications Officer – San Mateo County

Organization: County of San Mateo
Location: San Mateo, CA
Salary: \$8,140 - \$10,175 / Month
App. Deadline: February 1, 2016

FINAL DATE FOR FILING: February 01, 2016.

THE POSITION

NOTE: *The recruitment schedule was amended on January 19, 2016 to include the interview date.*

San Mateo County is seeking highly qualified candidates for the position of **Health System Communications Officer**.

The Communications Officer is responsible for developing, directing and implementing a wide range of communication strategies for a large, complex County health department to help residents live longer and better lives and to build trust with and ensure a successful flow of information with key stakeholders.

Working closely with, and under general direction from Health System Division heads, the Communications Officer develops, implements, and evaluates internal and external communication strategies, programs, and media engagement activities that help broaden awareness and visibility of the Health System's priorities, programs, projects and services. The person in this position also works to build the capacity of the organization to communicate effectively with specific target audiences, including the public.

The Communications Officer oversees all media relations for the Health System, serving as the point of contact for press inquiries, managing writing and distributing news releases, talking points, crisis communications, and training employees on media relations. The Communications Officer serves as the Public Information Officer for the Health System and is responsible for developing and maintaining communication response plans for emergencies, crises, and disasters.

The person in this position also leads and manages a team that works closely with Department divisions and vendors to identify, develop, and implement communication efforts through multiple communication channels, including public and internal websites, social media platforms, print materials, and engagement and promotional outreach campaigns. Additional responsibilities include developing and managing the communications budget and vendor contracts.

Performance in this position requires considerable independence, skillful coordination with executive, management and line staff, initiative and discretion. The successful individual will have extensive knowledge and experience in marketing and communications, media relations, and staff supervision.

The ideal candidate will have:

- Extensive experience in marketing, communications, community outreach, and media relations
- Strong knowledge of and experience with public health, healthcare, government or organizations working with diverse or vulnerable audiences/populations
- Strong knowledge of and experience with diverse electronic and print media and communication channels
- Excellent verbal and written communication skills with the ability to condense complex issues into clear, concise and easy to understand language for public consumption
- Ability and experience in building strong internal and external working relationships
- Effective organizational and management abilities that can ensure timely completion of multiple responsibilities and deliverables while responding to quick-changing priorities and issues
- College degree and minimum five years of marketing and communications experience with increasing responsibility in the areas outlined above
- Minimum of three years supervisory or management experience

NOTE: The eligible list generated from this recruitment may be used to fill future extra-help, term, unclassified, and regular classified vacancies.

QUALIFICATIONS

Education and Experience: Any combination of education and experience that would likely provide the required knowledge and skills is qualifying. A typical way of gaining the knowledge and skills is equivalent to a Bachelor's degree from an accredited college or university with major coursework in public relations, communications, journalism, business or public administration, or a related field and five (5) years of management experience in public affairs, media relations, or related area.

Knowledge of: Administrative principles and practices, including goal setting, program development, implementation, and evaluation; public agency contract administration, County-wide administrative practices, and general principles of risk management related to the functions of the assigned area; organizational and management practices as applied to the analysis and evaluation of projects, programs, policies, procedures, and operational needs; principles and practices of public information, media relations, and community outreach project and program development; applicable Federal, State, and local laws, regulatory codes, ordinances, and procedures relevant to assigned area of responsibility; methods and techniques for the development of press releases, talking points, newsletters, presentations, business correspondence, and information distribution; research and reporting methods, techniques, and procedures; record keeping principles and procedures; modern office practices, methods, and computer equipment and applications related to the work; English usage, grammar, spelling, vocabulary, and punctuation; techniques for effectively representing the County in contacts with governmental agencies, community groups, and various business, professional, educational, regulatory, and legislative organizations; and techniques for providing a high level of customer service by effectively dealing with the public, vendors, contractors, and County staff.

Skills/Ability to: Develop and implement goals, objectives, policies, procedures, work standards, and internal controls for assigned department; provide professional leadership and direction in managing department-specific communication strategies, media relations, and campaigns; conceptualize messages and effectively communicate in writing, speech, and other methods of communication; develop and maintain effective working relationships with reporters, editors, and other media representatives; interpret, apply, explain, and ensure compliance with Federal, State, and local policies, procedures, laws, and regulations; effectively represent assigned department in committees and meetings with stakeholders and the community; prepare clear and concise reports, correspondence, policies, procedures, and other written materials; conduct complex research projects, evaluate alternatives, make sound recommendations, and prepare effective technical staff reports; organize and prioritize a variety of projects and multiple tasks in an effective and timely manner; organize own work, set priorities, and meet critical time deadlines; operate modern office equipment including computer equipment and specialized software applications programs; use English effectively to communicate in person, over the telephone, and in writing; use tact, initiative, prudence, and independent judgment within general policy, procedural, and legal guidelines; and establish, maintain, and foster positive and effective working relationships with those contacted in the course of work.

Physical Demands: Must possess mobility to work in a standard office setting and use standard office equipment, including a computer, to operate a motor vehicle, and to visit various County and meeting sites; vision to read printed materials and a computer screen; and hearing and speech to communicate in person, before groups, and over the telephone. This is primarily a sedentary office classification although standing in work areas and walking between work areas may be required. Finger dexterity is needed to access, enter, and retrieve data using a computer keyboard or calculator and to operate standard office equipment. Positions in this classification occasionally bend, stoop, kneel, reach, push, and pull drawers open and closed to retrieve and file information. Employees must possess the ability

to lift, carry, push, and pull materials and objects weighing up to 25 pounds.

Environmental Elements: Employees work in an office environment with moderate noise levels, controlled temperature conditions, and no direct exposure to hazardous physical substances. Employees may interact with upset staff and/or public and private representatives in interpreting and enforcing departmental policies and procedures.

APPLICATION/EXAMINATION

Anyone may apply. Current San Mateo County and San Mateo County Superior Court employees with at least six months (1040 hours) of continuous service in a classified regular, probationary, SEIU or AFSCME represented extra-help, or temporary position prior to the final filing date will receive five points added to their final passing score on this examination.

The examination process will consist of an application screening (weight: pass/fail) based on the candidates' applications and responses to the supplemental questionnaire. Candidates who pass the application screening will be invited to a panel interview (weight: 100%). Depending on the number of applicants, an application appraisal of education and experience may be used in place of other examinations, or further evaluation of work experience may be conducted to group applicants by level of qualification. All applicants who meet the minimum qualifications are not guaranteed advancement through any subsequent phase of the examination. All examinations will be given in San Mateo County, California, and applicants must participate at their own expense.

IMPORTANT: Applications for this position will only be accepted online. If you are currently on the County's website, you may click the 'Apply Online' button above or below. If you are not on the County's website, please go to <http://jobs.smcgov.org> to apply. Online applications must be received by the Human Resources Department before midnight on the final filing date.

~ TENTATIVE RECRUITMENT SCHEDULE ~

Final Filing Date: FEBRUARY 1, 2016

SME Application Screening: FEBRUARY 4, 2016

Civil Service Panel/Department Interviews: FEBRUARY 16, 2016

(Anticipated start mid March 2016)

The County of San Mateo does not require job applicants to disclose conviction history information until after the applicant successfully completes all examination phases for the recruitment. All passing applicants will receive instructions by email only from Human Resources staff to complete and submit a conviction history questionnaire online within a specified deadline of two business days. Failure to do so within the time frame will disqualify you from the rest of the process. Please visit this link at <http://hr.smcgov.org/conviction-information-applicants-faq> to find out more information about the conviction history questionnaire so that you can prepare accordingly.

Note: Positions in criminal justice agencies currently required by law to pass background checks are exempted from this bill, and applicants may be required to submit conviction information at the time of application.

For more information: [Click here](#)

Deputy Public Health Officer – Santa Clara County

Organization: Santa Clara County
Location: Santa Clara, CA
Salary: \$181,929.28 – \$233,421.76 Annually
App. Deadline: Continuous

NOTE: The position is posted here: <https://www.sccgov.org/sites/esa/employment/Pages/oco.aspx>
Under “Search Criteria”, check the box “public health”, press “go” and the Deputy Public Health Officer will be among a handful of positions posted. Click on the title for job description and instructions for applying.

Description:

Under general direction of the Health Officer/Public Health Director, acts as the Infectious Disease and Response Branch Director, responsible for the overall administrative and programmatic responsibility for the Infectious Disease and Response Branch, which includes Communicable Disease Control and Prevention (including the Immunization Program), Tuberculosis Control and Prevention, STD/HIV Control and Prevention, Surveillance and Epidemiology, Public Health Disaster Preparedness and Response, Public Health Laboratory, and Public Health Pharmacy.

APPLICATION FILING PROCEDURE

This recruitment requires the submission of an online application. No paper applications will be accepted. Applicants must apply online at <http://www.sccjobs.org/>. Computers are available at the County Government Center, 70 West Hedding Street, 8th Floor, East Wing, San Jose, CA 95110, during normal business hours, for applicants to apply online.

DEADLINE: This is a continuous recruitment which may close as early as 10 days after initial posting. Please apply as early as possible.

Questions regarding this Executive recruitment may be directed to Patricia Carrillo, Executive Services at (408) 299-5897.

Completion of the Supplemental Questionnaire and a CV is required. Applications submitted without the Supplemental Questions and CV will be rejected.

Typical Tasks:

- Provide a vision for Infectious Disease and Response Branch priorities, direction, and strategic initiatives;
- Provide administrative and clinical leadership to ensure effective and efficient programs and functions;
- Oversee budget development and expense monitoring for the Branch;
- Prepare and present formal communications and reports to the County Board of Supervisors;
- Direct and oversee organizational and programmatic improvements, including integration and consolidation strategies across the Branch;
- Ensure evidence-based practices are implemented and outcomes are monitored and documented throughout the Branch;

- Hire, supervise, mentor, and coach direct reports, including, but not limited to, the CD Controller, the TB Controller, the STD/HIV Manager, Public Health Preparedness Manager, the Public Health Lab Director, and the Public Health Pharmacy Director;
- Facilitate the development and promotion of a culture of learning and quality improvement throughout the Branch;
- Provide leadership for incorporating a health equity lens within the Branch;
- Participate as a member of the Public Health Department Executive Team and supervise the Assistant Health Officers and other subordinate staff as assigned;
- Serve as Santa Clara County's representative on local, state, and national committees and taskforces;
- Fill in for the Health Officer as requested on all Health Officer-related matters;
- Provide expert consultation to the medical community in Santa Clara County in the area of infectious disease and disaster/emergency preparedness and response;
- Act as the medical/physician liaison with the Department of Environmental Health and the County Office of Emergency Services;
- Establish strong community relationships to facilitate best practices related to infectious disease and response in Santa Clara County;
- Provide medical/physician leadership on the Department's disaster and emergency preparedness and response plans and climate change initiative;
- Ensure the implementation of cutting edge surveillance and epidemiology practices to monitor, prevent and control infectious diseases, including information sharing and data technology strategies;
- Consult with department heads, city, state, and federal health department officials and others in addressing infectious disease control and prevention issues in the community;
- Ensure that appropriate measures are being taken to prevent the spread of TB, STD/HIV, and communicable diseases;
- In coordination with the Public Health Department's Health Information Officer, act as spokesperson for the Infectious Disease and Response Branch to the media;
- Support departmental response to disaster events and assume duties as assigned by the Health Officer or Incident Commander;
- Shares 24/7 after-hours night and weekend call with the other public health physicians for all public health related issues; and
- Perform other related duties as assigned.

Employment Standards:

Must be a physician licensed in California and Board Certified in an appropriate medical specialty (e.g. Internal Medicine, Pediatrics, or Family Medicine) and have significant training and experience to perform the above tasks.

Note: A successful candidate will possess at least seven (7) years of post-residency experience in disease control or public health, at least three (3) of which involved significant administrative and managerial responsibilities. A Master in Public Health or completion of the CDC's Epidemic Intelligence Service, and/or Board Certification in Infectious Disease is highly desirable.

Knowledge of:

- Laws, codes, and/or ordinances related to areas of responsibility including, but not limited to, California Health and Safety Code including reportable disease, Public Health Administrative Standards/Practices, and Abuse Reporting Laws;
- Clinical medicine, public health and health care (e.g., epidemiology, biostatistics, environmental health, maternal and child health), management and administration;
- Federal, state, and local laws governing public health programs;
- Principles and procedures of program development, implementation, and evaluation in a multi-service agency;
- Principles of governmental organization, public financing, and budgeting; and
- Current developments in local public health programs.

Ability to:

- Effectively plan, direct, and evaluate work of subordinate staff;
- Prepare, implement, and evaluate program budgets;
- Serve as the Public Health link to the local medical community and county medical association;
- Understand, interpret, and apply provisions of federal, state, and local legislation, rules, and regulations pertinent to the administration of appropriate programs;
- Evaluate health risks and hazards and communicate information effectively and proactively;
- Facilitate interaction of complex mix of public agencies and community-based organizations that impact public health and public policy;
- Effectively communicate and work collaboratively with a diverse staff and community; and
- Speak before professionals, community groups and the media as the public health media spokesperson.

Aaron Kavanaugh

Office of Policy, Planning, and Communications
 STD Control Branch, California Department of Public Health
 850 Marina Bay Parkway, Building P, 2nd Floor
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