# *California Needs Assessment for HIV*

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

*September 2016*


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# California Needs Assessment for HIV

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## Acknowledgements:

The Office of AIDS would like to thank the following for their contributions to this document: Denise Absher, Irina Banar, Jessica Brown, Valorie Eckert, Anna Flynn, Sunitha Gurusinghe, Karl Halfman, Liz Hall, Jessica Heskin, Sara Johnson, Marjorie Katz, Christine Kibui, Scott Masten, Peter Oh, Kolbi Parrish, Chris Paular, Cynthia Reed-Aguayo, Shelley Vinson, Dave Webb, Sherry Williams, Lin Alma Zhang, and the Pacific AIDS and Education Center.

The Riverside/San Bernardino Transitional Grant Area would like to thank the following for their contributions to this document: Angelia Fox, Bonnie Flippin, Inland Empire HIV Planning Council, Desert AIDS Project, Foothill AIDS Project, San Bernardino County Department of Public Health, and Riverside University Health Systems.

The Sacramento Transitional Grant Area would like to thank the following for their contributions to this document: Adrienne Rogers, Paula Gammell, and Staci Syas.

The San Jose Transitional Grant Area would like to thank the following for their contributions to this document: Jim McPherson, Sarah C. Lewis, Supriya Rao, Wen Lin, Raj Gill, Mike Torres, and Phuong-Thao (Phoebe) Nguyen.

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# 1.0 Executive Summary

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

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

### Epidemiologic Overview

OA estimates that in 2014 there were approximately 139,000 people living with HIV (PLWH) in California, of whom 91 percent had been diagnosed. The vast majority (87 percent) of people living and diagnosed with HIV in California in 2014 were male. Seventy-three percent of infections were among gay, bisexual, or other men who have sex with men (MSM) and 14 percent were among people who inject drugs (PWID). More Whites (42.0 percent) were living with diagnosed HIV infection than any other racial/ethnic group, followed by Hispanics/Latinos (33.7 percent) and Blacks/African Americans (18.2 percent). However, the highest prevalence rate (1,031.1 per 100,000) was among Blacks/African Americans, followed by Whites (354.4 per 100,000) and Hispanics/Latinos (284.7 per 100,000). A higher proportion of PLWH in the Sacramento and San Bernardino/Riverside TGAs were White (55 percent and 53 percent, respectively) than statewide (42 percent); the San Jose TGA percentage (41 percent) was lower than the statewide percentage. All three jurisdictions also had a smaller proportion of PLWH who were MSM (54 percent, 67 percent, and 64 percent, respectively).

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

Among the 126,241 persons living and diagnosed with HIV statewide in 2014, 71 percent were in HIV care and 57 percent were virally suppressed. The percentage of PLWH who were in care ranged from 69-74 percent and the percentage of PLWH who

were virally suppressed ranged from 49-54 percent among the three TGAs. Among persons newly diagnosed with HIV at the state level, 74 percent were linked to care within 1 month of diagnosis, and 61 percent were virally suppressed within 12 months of diagnosis. In the TGAs, linkage to care ranged from 69 percent to 80 percent within 1 month of diagnosis; viral suppression was 61-63 percent within 12 months of diagnosis.

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

### Human and Financial Resource Inventory

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

While it is not possible to fully enumerate the number of health care providers who routinely provide care to PLWH, Ryan White clinics serve approximately 45 percent of PLWH in California and the distribution of Ryan White clinics generally correlates well with the distribution of PLWH throughout the state. However, many communities–especially small to medium-sized cities and rural areas–report challenges maintaining sufficient numbers of HIV providers in their area. This is particularly true for dental and mental health providers who are comfortable and familiar with treating PLWH.

## Needs, Gaps, and Barriers

### Routine Opt-out HIV Testing

Performing routine HIV testing in health care settings can decrease the proportion of people unaware of being infected with HIV, and improve linkage and re-engagement in care. Routine opt-out HIV testing is a U.S. Preventive Services Task Force (USPSTF)

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

### Pre-exposure Prophylaxis (PrEP)

PrEP is the process of taking an anti-HIV medication daily to prevent HIV infection. Using national Centers for Disease Control and Prevention estimates applied to California, OA estimates that there are 220,000 to 240,000 Californians with an indication for PrEP, including 104,000-121,000 MSM. Data from multiple sources, including Medi-Cal, the Los Angeles County Comprehensive HIV Plan (2017-2021), and multiple sources in San Francisco, suggest that a minimum of 9,000 people are currently taking PrEP in California. This number has increased dramatically since 2014. Common barriers to PrEP include: insufficient number of providers who are comfortable prescribing PrEP and costs for patients. Currently, there are at least 200 clinical sites offering PrEP in California.

## 2.0 Background and Overview

The California Needs Assessment for HIV — 2016 outlines the needs of persons at risk for HIV infection and the needs of persons living with HIV, identifies current resources available to meet those needs, and determines what gaps in prevention, care, and treatment services currently exist throughout California.[1] The California Needs Assessment for HIV was developed by the California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) and partners to support data-driven decision making for the development and implementation of California's Integrated HIV Surveillance, Prevention, and Care Plan, as well as to meet the Health Resources Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC) requirements for the grant-mandated Statewide Coordinated Statement of Need/Needs Assessment.

This document presents information on the following:

1) An overview of the current epidemiology of HIV in California, including Continuums of HIV Care;
2) A detailed analysis of high priority HIV-related services and activities to determine the scope of the need, current state of the services and activities, available resources, and gaps in services; and
3) A human and financial resources inventory of programs working on HIV/AIDS in California.

OA intends to review and update California Needs Assessment for HIV periodically to identify ongoing and evolving needs of program planning and development, and to assess additional HIV services and activities based on input from stakeholders. At a minimum, an updated and revised version of the California Needs Assessment for HIV will be released in 2021 to form the foundation for the next Integrated Plan.
The following HRSA Ryan White Part A entities served as co-authors of this document:

- California Department of Public Health, Office of AIDS (Lead author);
- San Bernardino/Riverside Transitional Grant Area (TGA): includes San Bernardino and Riverside County health departments and HIV planning council;
- Sacramento TGA: includes Sacramento, El Dorado, and Placer County health departments and HIV planning council; and
- San Jose TGA: includes Santa Clara County health department and HIV planning council.

All Ryan White Part A and CDC Prevention grant recipients in California were invited to participate in the California Needs Assessment for HIV and Integrated HIV Surveillance, Prevention and Care Plan. The remaining Part A grant recipients in California (including

the Counties of Alameda, Contra Costa, Los Angeles, Orange, San Francisco, and San Diego) elected to develop their own local needs assessments and integrated plans, but also provided input into the statewide Needs Assessment and Plan.

## References


1. Centers for Disease Control and Prevention National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention Division of HIV/AIDS Prevention, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB). *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017- 2021.* June 2015.

# 3.0 Methods

## Guidance Document (CDC/HRSA)

The Integrated HIV Prevention and Care Plan Guidance, CY 2017- 2021, was used to identify required steps and components for completing the California Needs Assessment.[1] Since this needs assessment document is organized somewhat differently than from what the Guidance suggests, a cross-walk table correlating the different components can be found in Appendix B (Table 31).

## Key Components

Broadly speaking, the California Needs Assessment is comprised of three key components:

- an epidemiologic overview (an overview of the current epidemiology of HIV in California, including Continuums of HIV Care, based on HIV surveillance data);
- a resources inventory (a tabular summary of the financial resources spent on HIV-related programs and services in California and a description of state and local workforce capacities); and
- an assessment of service needs (a detailed analysis of high priority HIV-related services and activities to determine the scope of the need, current state of the services and activities, available resources, and gaps in services).

## Selecting High Priority Areas for Assessment

Due to the size and diversity of California, as well as the limited time available for completing California's Needs Assessment for HIV, OA and the Part A co-authors elected to limit the scope of the assessment to the highest priority HIV-related services and activities. Identification of high priority areas sought engagement and discussion with multiple, external stakeholders; a description of that process follows.

- OA and the California Planning Group[a] (CPG) conducted separate brainstorming sessions to generate a list of all HIV-related services and activities provided to or needed by people living with HIV (PLWH) and persons at high risk of becoming infected with HIV.
- After development of what OA and CPG felt was a comprehensive list of services and activities, CPG members were asked to assign a total of ten votes to the services/activities that they felt were the most important to assess. This activity was repeated with OA staff and management, and through an online survey that

[a] CPG is a statewide planning and advisory group that works in collaboration with CDPH/OA to reduce new HIV infections, increase access to care and improve health outcomes for persons living with HIV, reduce HIV-related health disparities, and achieve a statewide coordinated response to the HIV epidemic in California. The group members are representative of the HIV epidemic in California and include consumers and others involved in HIV prevention, care, and treatment services/programs.

was widely disseminated to stakeholders. Through these processes we obtained input from 240 consumers, local planning council members, providers, local health departments, Ryan White grant recipients, and advocates; 23 percent of respondents self-identified as consumers, 18 percent as persons of color, 2 percent as transgender, and 35 percent as gay, lesbian, bisexual, transgender, or questioning.

- Based on input from these sources, the OA California Needs Assessment Workgroup selected twelve priority service and activity areas to assess. This list was shared broadly and stakeholders were provided with an opportunity to comment. OA also identified multiple medium priority services/activities that can be addressed in future, statewide needs assessments.
- The list of priority areas selected for inclusion in the California Needs Assessment for HIV—2016 follows.
    1. Routine opt-out HIV testing in healthcare settings
    2. Pre-Exposure Prophylaxis (PrEP)
    3. Linkage to care for persons newly diagnosed with HIV
    4. Partner services to support PLWH informing sex and needle sharing partners of potential exposure to HIV
    5. Case management (including medical case management, non-medical case management, benefits counseling, patient navigation, and other similar patient support activities)
    6. Housing
    7. Mental health care and treatment
    8. Substance abuse care and treatment
    9. Quality of HIV medical care including attaining viral suppression, use of appropriate anti-retroviral therapy, and implementation of recommended sexually transmitted infection (STI) testing practices.
    10. Retention in care
    11. Re-engagement in care
    12. Additional Local Needs, Gaps, and Barriers
- For Priority Area 12, Part A co-authors provided additional information regarding local needs, gaps, and barriers.
- Priority areas 1, 2, and 12 (i.e., routine opt-out HIV testing, PrEP, and additional local needs, gaps, and barriers) are presented within this document. Priority areas 3 through 11 are separate, supplemental documents that will be released as completed.

Concurrent with the above process and using the same methods, stakeholders were asked to prioritize sub-populations on which the California Needs Assessment for HIV—2016 should focus. This process was to identify sub-populations for analysis, in addition to the routine analyses by gender, race/ethnicity, and risk behavior. The following

priority sub-populations were selected for inclusion in the California Needs Assessment for HIV—2016:

1. Transgender persons
2. Gay, bisexual, and other men who have sex with men (MSM) of color
3. Young MSM (defined as <25 years old)
4. Persons who are incarcerated or have been recently released from correctional facilities

## Geography

The primary scope of this document is the entire state of California; therefore, the most detailed information is provided at the state level. Additional local information is also provided for the three participating Ryan White Part A Transitional Grant Areas. When possible, data are also presented for other California jurisdictions; data for counties with very small populations are combined into multi-county regions.

## Data Sources

OA prioritized the use of existing data sources that had a high degree of representativeness for the relevant populations and/or were collected in a scientifically robust manner. As part of this process, the California Needs Assessment Workgroup also searched the peer-reviewed literature for relevant publications that could be used to support the assessment process. The data sources that were most frequently used in needs assessment analyses are:

- California HIV surveillance data: Medical providers and clinical laboratories are legally required to provide demographic, clinical, laboratory, and risk factor information on all PLWH in California to local health jurisdictions (LHJs) and OA. These data are regularly collected as part of routine public health work under the authority of the Local Health Officer and CDPH, and are maintained by the OA HIV Surveillance Section. HIV surveillance data collected by OA are available for analysis 12 months after the calendar year ends to ensure completeness of data collection. HIV surveillance data presented in this report include all cases diagnosed through December 31, 2014, using data submitted to OA by December 31, 2015. Information about the characteristics of HIV cases reported to surveillance can be found in the Epidemiologic Overview section.
- California Ryan White program and other health program data: The Ryan White program is funded by HRSA to provide care and treatment services to low-income PLWH. HRSA funds OA (Ryan White Part B), highly-impacted metropolitan areas (Ryan White Part A), and individual clinics (Ryan White Parts C and D) to provide these services. In California, data for Ryan White-funded health care and support services are primarily collected through the secure, online AIDS Regional Information and Evaluation System (ARIES). During 2015, all Ryan White Part A and B providers in California entered or imported data into

ARIES except for Part A providers in Sacramento and Los Angeles Counties. The AIDS Medi-Cal Waiver Program, which provides in-home care to PLWH who require a nursing-home level of care and are Medi-Cal clients, and HOPWA (Housing Opportunities for Persons with AIDS), a housing-support program for low-income PLWH, also submit data to ARIES. As a result, ARIES contains comprehensive data on low-income PLWH in California who are receiving public services. ARIES data were used throughout this document to assess the needs and barriers for this population.

- OA HIV Prevention Program data: The OA HIV Prevention Program is funded by CDC and the State General Fund. CDC-funded targeted testing, expanded testing, partner services, and risk-reduction activities are conducted in 18 high-burden local health jurisdictions (LHJs) in California: Alameda, Contra Costa, Fresno, Kern, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura. Data collection corresponding to these activities is mainly reported through the Local Evaluation Online (LEO), a secure online system.[b] San Francisco and Los Angeles receive funding for these prevention activities directly from CDC; these data are not reported in LEO. LEO data presented here include all data collected from OA-funded sites with years of observation specific to the priority areas (e.g., routine opt-out HIV testing used calendar year 2014).
- Medical Monitoring Project (MMP): MMP is a CDC-funded national survey of a representative sample of PLWH, which includes the administration of an in-depth interview and medical record abstraction for sampled participants in selected jurisdictions. There are three MMP jurisdictions in California: the City and County of San Francisco, Los Angeles County, and the rest of California (i.e., California Project Area). During 2008-2014, sampled MMP participants included only PLWH in care. Starting in 2015, all PLWH identified through HIV surveillance were potential participants, including persons out of care. The needs assessment uses MMP data from the 2014 cycle as 2015 data were not available when this report was written. National data or data from the California Project Area were utilized. Data were analyzed using CDC-supplied sample weights.
- National HIV Behavioral Surveillance (NHBS): NHBS is a CDC-funded behavioral surveillance system of persons at high risk for HIV infection. NHBS is conducted in rotating, annual cycles in three different populations: gay, bisexual and other men who have sex with men (MSM cycle); persons who inject drugs (IDU cycle); heterosexuals at increased risk for HIV infection (HET cycle). NHBS is performed

[b] Exceptions to data reported via LEO include: expanded testing records for which the client's HIV status is non-negative (e.g., positive, preliminary positive, discordant, etc.) are reported in XML format via secure file transfer site; and partner services records for which co-infection is reported are reported via CalREDIE.

in 22 project areas, including three in California: Los Angeles, San Diego, and San Francisco. NHBS data presented here are either national data or from the San Diego project and include the 2014 MSM cycle, the 2013 HET cycle, or the 2012 IDU cycle. Data from the 2015 IDU cycle are not yet available for analysis. Data are unweighted.

- California Health Interview Survey (CHIS): CHIS is a random-dial telephone survey that asks Californians questions on a wide range of health topics. It provides representative data on all 58 counties in California. CHIS data for this report were obtained from publically-available CHIS datasets.

Many other data sources were used in development of this report. Specific references are cited in the relevant sections.

### Analysis Methods for Assessment of Service Needs

For each priority area, key questions were developed with input from OA subject matter experts, CPG, and Part A co-authors. The questions focused on delineating the scope or size of the need for the priority areas, and understanding the current state of the particular service or activity including a summary of the current human and financial resources invested in the service/activity. Questions were then prioritized based on the availability of data, the importance of addressing the question to understand the scope of the need, and the complexity of the analysis. Questions that were tangential, specifically related to implementation or program evaluation, or deemed to be research were excluded.

Potential data sources were identified and the California Needs Assessment Workgroup collaborated with subject matter experts and analytic staff to develop appropriate tables, further refine questions, and summarize the data for the final document.

### Stakeholder Engagement

All Ryan White Part A Grantees were invited to a teleconference in June 2015 to discuss the California Needs Assessments for HIV and Integrated HIV Surveillance, Prevention, and Care Plan (i.e., Integrated Plan), and the options outlined in the Integrated HIV Prevention and Care Plan Guidance regarding collaboration between state and local agencies. Following the teleconference, OA sent a formal invitation to each Grantee asking them to indicate whether they wanted to co-author the Integrated Plan with OA or develop a distinct plan. Alameda, Los Angeles, Orange, San Diego and San Francisco Emerging Metropolitan Areas/Transitional Grant Areas (EMA/TGA) chose to write distinct local plans. The Riverside/San Bernardino TGA (San Bernardino and Riverside Counties), Sacramento TGA (including El Dorado and Placer Counties), and San Jose TGA (Santa Clara County) chose to co-author the California Needs Assessment for HIV and Integrated Plan with OA.

Throughout the development of the California Needs Assessment for HIV and Integrated Plan, OA provided updates to all local planning groups and the CPG through

monthly progress reports. Additionally, OA hosted several teleconferences for all Part A Grantees to provide updates on progress and activities related to their respective independent needs assessments and integrated plans.

Preliminary drafts of the California Needs Assessment for HIV were shared with the CPG and co-authoring Part A Planning Councils in summer 2016 to obtain initial input, and a final draft was shared in September 2016.

### Other Ryan White Parts

In August 2015, OA hosted a teleconference with the Ryan White Grantees from all the Parts to discuss the California Needs Assessment for HIV and Integrated Plan. An overview of the project, activities completed to date, description of additional planned activities, and opportunities for engagement were discussed. Participants were invited to provide input or comments on the call or through e-mail.

### Town Halls

Three virtual town halls were convened by OA and Part A co-authors during June 2016 to obtain input on preliminary findings from the California's Needs Assessment for HIV from all Ryan White Parts, consumers, HIV care providers, local health jurisdictions, partner agencies, and federally-recognized Indian tribes. Input received during these sessions was integrated into the final document.

## References

1. Centers for Disease Control and Prevention National Center for HIV/AIDS Viral Hepatitis STD and TB Prevention Division of HIV/AIDS Prevention, Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB). *Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2017- 2021.* June 2015.

# 4.0 Epidemiologic Overview and Continuum of HIV Care

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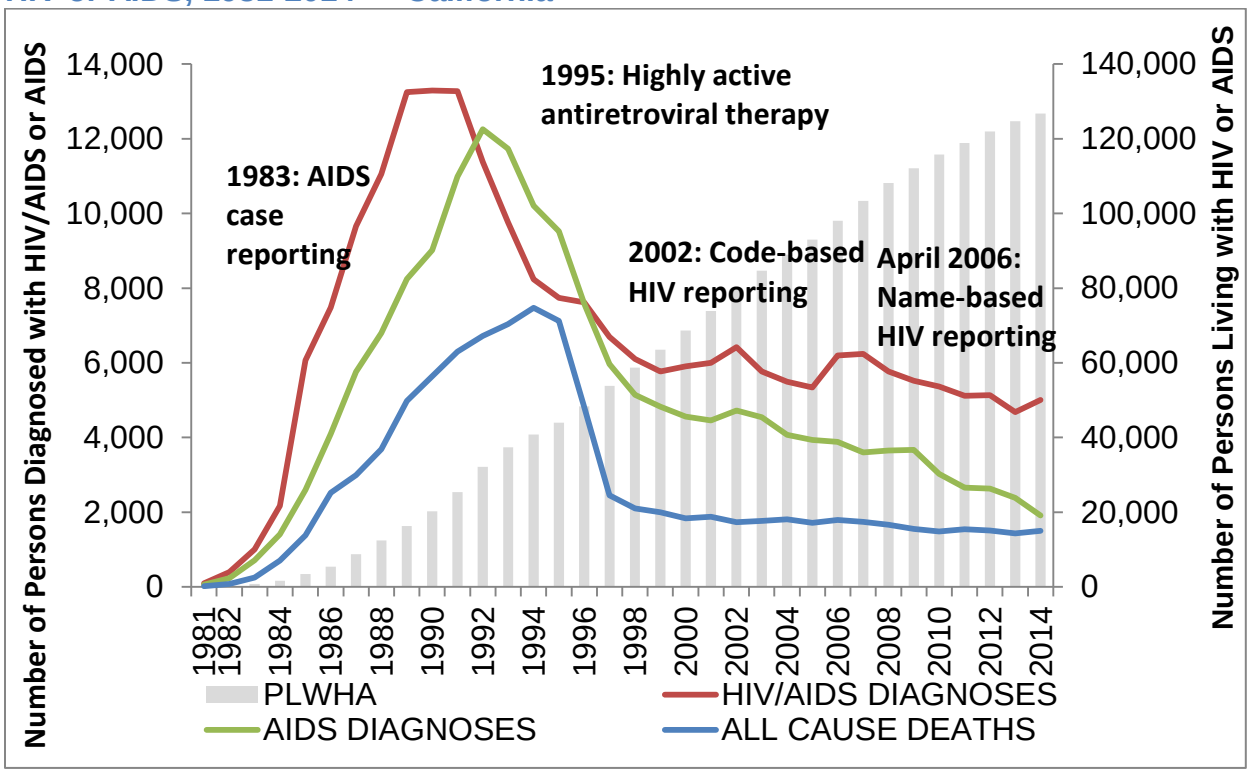
California, where what would come to be known as AIDS was first described, was one of the early epicenters of the HIV epidemic and continues to have one of the largest epidemics in the country.[1] According to the CDC, during 2014 California had the second highest number of persons newly diagnosed with HIV in the U.S., after Florida, and the second highest number of people living with HIV, after New York.[2]

The HIV epidemic in California peaked in the early 1990s, when the development of highly-active antiretroviral therapy led to a rapid decline in the number of new diagnoses and deaths (Figure 1). Since that time, there has been a gradual decrease in the number of persons newly diagnosed with HIV and the number of AIDS diagnoses, with slight increases in 2002 and 2006 due to changes in how HIV surveillance data were collected.

**Figure 1. HIV/AIDS Diagnoses, AIDS Diagnoses, Deaths, and Persons Living with HIV or AIDS, 1981-2014 — California**




Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay.

California is the most populous state in the U.S., with over 38 million residents in 2014, and the third largest state by geography. There are 61 local health jurisdictions, including 58 counties and three cities. There is substantial diversity in these jurisdictions as they range in size from 9.8 million people (Los Angeles) to 1,175 persons (Alpine County).

## People Living with HIV in California

HIV infection is not always diagnosed promptly, and individuals can live for years without being aware of their infection. Persons who are infected, but not diagnosed with HIV, contribute to approximately 30 percent of new HIV infections in the U.S.[3] OA estimates that in 2014 there were approximately 139,000 people living with HIV in California, of whom 91 percent had been diagnosed (
Table 1). The estimated number of persons living with HIV infection are California-specific estimates calculated using the Centers for Disease Control and Prevention's (CDC) 'Back Calculation Method,' which estimates the prevalence of diagnosed and undiagnosed HIV-infected persons, and are adjusted for reporting delays, missing or incorrect data, and under-reporting.[4] Due to the sample sizes required for the method, the estimated percentage of persons diagnosed with HIV is only available for selected

populations. These estimates require a minimum of 18 months reporting delay to calculate; therefore the most recent available estimate is from 2013.

### Table 1. Percentage of People Living with HIV in California Who Have Diagnosed Infection — 2013

| Population | Percentage of People Living with HIV Who Have Diagnosed Infection | |
|---|---|---|
| | % | 95% Confidence Interval |
| **Total** | **91** | **(89.8 - 92.3)** |
| | | |
| **By sex at birth** | | |
| Female | 91.8 | (89.0 -- 94.7) |
| Male | 90.9 | (89.3 -- 92.3) |
| | | |
| **By race/ethnicity** | | |
| Black/African American | 90.8 | (88.5 -- 94.3) |
| Hispanic/Latino | 87 | (84.9 -- 90.8) |
| Other race/ethnicity | 85.1 | (84.9 -- 90.8) |
| White | 94.3 | (92.0 -- 96.1) |
| | | |
| **By transmission category** | | |
| High-risk heterosexual contact | 88.2 | (84.9 -- 91.2) |
| Injection drug use (IDU) | 93.2 | (89.3 -- 96.7) |
| Male-to-male sexual contact (MSM) | 90.5 | (88.7 -- 92.2) |
| | | |

Source: Estimates calculated using CDC Back Calculation Method (Hall et al., 2016) applied to data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 18 months reporting delay. High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). Other risk groups (i.e., MSM/IDU, cases with risk factors not reported or not identified (e.g., non-high-risk heterosexual cases), and cases with hemophilia, or blood/tissue/organ transplantation/transmission, or perinatal exposures) were not reported due to statistical instability.

## People Living and Diagnosed with HIV in California

As of December 31, 2014, there were 126,241 persons living and diagnosed with HIV (PLWH) in California (Table 2). Persons aged 45–54 years made up the largest percentage of persons living with diagnosed HIV (35.2 percent). The age group with the highest rate of diagnosed HIV (888.4 per 100,000 population) was 50–54 years. The largest percentage of persons living with diagnosed HIV infection was represented by Whites (42.0 percent), followed by Hispanics/Latinos (33.7 percent) and Blacks/African Americans (18.2 percent). However, by far the highest prevalence rate (1,031.1 per

100,000) was among Blacks/African Americans, followed by Whites (354.4 per 100,000) and Hispanics/Latinos (284.7 per 100,000). The vast majority (87 percent) of PLWH in California in 2014 was male, and the estimated prevalence rates were 572.5 per 100,000 for men, and 77.3 per 100,000 for women. Among a total of 111,139 adult/adolescent men, 75.1 percent of infections were attributed to male-to-male sexual contact, 4.9 percent to injection drug use, 7.1 percent to heterosexual contact, and 8.3 percent to both male-to-male sexual contact and injection drug use (Table 3).

Additional information on people living and diagnosed with HIV during prior years can be found in the California HIV Surveillance report at: http://www.cdph.ca.gov/programs/aids/Pages/TOASurv.aspx.

### People Newly Diagnosed with HIV

There were 5,002 persons newly diagnosed with HIV during 2014 (Table 4). The 25–29 years age group accounted for the largest number (N=929) and highest rate (33.8 per 100,000) of new diagnoses. The largest percentage of persons newly diagnosed with HIV infection was represented by Hispanics/Latinos (44.1 percent), followed by Whites (29.4 percent) and Blacks/African Americans (17.1 percent). However, by far the highest rate of new diagnoses (38.5 per 100,000) was among Blacks/African Americans, followed by Hispanics/Latinos (14.8 per 100,000) compared to Whites (9.8 per 100,000) (Table 4). Similar to prevalent cases, 87 percent of persons newly diagnosed with HIV were male. Among adult and adolescent men, 73.5 percent of infections were attributable to male-to-male sexual contact, 3.2 percent to injection drug use, 3.6 percent to both male-to-male sexual contact and injection drug use, and 9.8 percent to heterosexual contact (Table 5).

Persons newly diagnosed with HIV could have been infected recently, or years prior. While there is no definitive way of differentiating between these groups, it is reasonable to use the percentage of persons who progress to Stage 3 (AIDS) within 12 months of diagnosis (late diagnosis) as a way of identifying persons who have been infected for multiple years. Overall, approximately 23 percent of persons newly diagnosed with HIV in 2014 were also diagnosed with AIDS within 12 months of HIV diagnoses. Disparities in late diagnosis were particularly notable among persons aged 65 years and older, people who inject drugs, and people likely infected through heterosexual sex (Table 6).

## Table 2. Persons Living with Diagnosed HIV Infection by Age, Race/Ethnicity, and Gender, 2014 — California

| Population | No. | % | Rate |
|---|---|---|---|
| **Age at year end (years)** | | | |
| < 13 | 161 | 0.1% | 2.5 |
| 13-14 | 47 | 0.04% | 4.6 |
| 15-19 | 363 | 0.3% | 13.7 |
| 20-24 | 2,914 | 2.3% | 100.4 |
| 25-29 | 6,943 | 5.5% | 252.9 |
| 30-34 | 9,579 | 7.6% | 346.6 |
| 35-39 | 10,974 | 8.7% | 429.4 |
| 40-44 | 14,577 | 11.5% | 559.9 |
| 45-49 | 20,854 | 16.5% | 810.1 |
| 50-54 | 23,597 | 18.7% | 888.4 |
| 55-59 | 16,687 | 13.2% | 676.8 |
| 60-64 | 10,380 | 8.2% | 499.0 |
| ≥ 65 | 9,165 | 7.3% | 183.6 |
| | | | |
| **Race/ethnicity** | | | |
| Hispanic/Latino | 42,523 | 33.7% | 284.7 |
| American Indian/Alaska Native | 443 | 0.4% | 258.1 |
| Asian | 4,762 | 3.8% | 93.7 |
| Black/African American | 22,953 | 18.2% | 1,031.1 |
| Native Hawaiian/Pacific Islander | 298 | 0.2% | 211.9 |
| White | 53,076 | 42.0% | 354.4 |
| Multiple races | 2,175 | 1.7% | 213.9 |
| Unknown | 11 | 0.01% | — |
| | | | |
| **Gender** | | | |
| Male | 109,792 | 87.0% | 572.5 |
| Female | 14,982 | 11.9% | 77.3 |
| Transgender: Male-to-Female | 1,431 | 1.1% | — |
| Transgender: Female-to-Male | 36 | 0.03% | — |
| Total | **126,241** | | **327.5** |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: Rates are per 100,000 population. Dash (—) indicates rates not calculated due to unknown population denominators. Until 2003, Asian/Native Hawaiian/Pacific Islander was classified as a single category; therefore persons with race/ethnicity data only available prior to 2003 are classified as Asian because they cannot be disaggregated.

## Table 3. Persons Living with Diagnosed HIV Infection by Transmission Category, 2014 — California

| Population | No. | % |
|---|---|---|
| **Transmission category, Male adult or adolescent** (≥13 years old at diagnosis) | | |
| Male-to-male sexual contact (MSM) | 83,441 | 75.1% |
| Injection drug use (IDU) | 5,436 | 4.9% |
| MSM and IDU | 9,250 | 8.3% |
| High-risk heterosexual contact* | 3,615 | 3.3% |
| Heterosexual contact (non-high-risk)** | 4,246 | 3.8% |
| Perinatal | 269 | 0.2% |
| Unknown risk | 4,604 | 4.1% |
| Other*** | 278 | 0.3% |
| Subtotal | 111,139 | 88.0% |
| **Transmission category, Female adult or adolescent** (≥13 years old at diagnosis) | | |
| Injection drug use | 2,881 | 19.3% |
| High-risk heterosexual contact* | 7,736 | 51.8% |
| Heterosexual contact (non-high-risk)** | 2,945 | 19.7% |
| Perinatal | 302 | 2.0% |
| Unknown risk | 927 | 6.2% |
| Other*** | 150 | 1.0% |
| Subtotal | 14,941 | 11.8% |
| **Transmission category, Child** (<13 years old at diagnosis) | | |
| Perinatal | 136 | 84.5% |
| Unknown risk | 24 | 14.9% |
| Other*** | 1 | 0.6% |
| Subtotal | 161 | 0.1% |
| **Total** | **126,241** | |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: Rates are per 100,000 population. Dash ( — ) indicates rates not calculated due to unknown population denominators. * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Table 4. Persons Newly Diagnosed with HIV Infection by Age, Race/Ethnicity, and Gender, 2014 — California

| Population | No. | % | Rate |
|---|---|---|---|
| **Age at diagnosis (years)** | | | |
| < 13 | 16 | 0.3% | 0.2 |
| 13-14 | 5 | 0.1% | 0.5 |
| 15-19 | 136 | 2.7% | 5.1 |
| 20-24 | 813 | 16.3% | 28.0 |
| 25-29 | 927 | 18.5% | 33.8 |
| 30-34 | 769 | 15.4% | 27.8 |
| 35-39 | 574 | 11.5% | 22.5 |
| 40-44 | 524 | 10.5% | 20.1 |
| 45-49 | 457 | 9.1% | 17.8 |
| 50-54 | 360 | 7.2% | 13.6 |
| 55-59 | 232 | 4.6% | 9.4 |
| 60-64 | 111 | 2.2% | 5.3 |
| ≥ 65 | 78 | 1.6% | 1.6 |
| | | | |
| **Race/ethnicity** | | | |
| Hispanic/Latino | 2,207 | 44.1% | 14.8 |
| American Indian/Alaska Native | 14 | 0.3% | 8.2 |
| Asian | 351 | 7.0% | 6.9 |
| Black/African American | 857 | 17.1% | 38.5 |
| Native Hawaiian/Other Pacific Islander | 4 | 0.1% | 2.8 |
| White | 1,471 | 29.4% | 9.8 |
| Multiple races | 98 | 2.0% | 9.6 |
| | | | |
| **Gender** | | | |
| Male | 4,354 | 87.0% | 22.7 |
| Female | 588 | 11.8% | 3.0 |
| Transgender: Male-to-Female | 59 | 1.2% | — |
| Transgender: Female-to-Male | 1 | 0.02% | — |
| **Total** | **5,002** | | **13.0** |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: Rates are per 100,000 population. Dash ( — ) indicates rates not calculated due to unknown population denominators.

## Table 5. Persons Newly Diagnosed with HIV Infection by Transmission Category, 2014 — California

| Population | | No. | % |
|---|---|---|---|
| **Transmission category, Male adult or adolescent (≥13 years old at diagnosis)** | | | |
| Male-to-male sexual contact (MSM) | | 3,236 | 73.5% |
| Injection drug use (IDU) | | 139 | 3.2% |
| MSM and IDU | | 158 | 3.6% |
| High-risk heterosexual contact* | | 141 | 3.2% |
| Heterosexual contact (non-high-risk)** | | 289 | 6.6% |
| Perinatal | | 1 | 0.02% |
| Unknown risk | | 439 | 10.0% |
| | Subtotal | 4,403 | 88.0% |
| **Transmission category, Female adult or adolescent (≥13 years old at diagnosis)** | | | |
| Injection drug use | | 57 | 9.8% |
| High-risk heterosexual contact* | | 214 | 36.7% |
| Heterosexual contact (non-high-risk)** | | 241 | 41.3% |
| Perinatal | | 0 | — |
| Unknown risk | | 71 | 12.2% |
| | Subtotal | 583 | 11.7% |
| **Transmission category, Child (<13 years old at diagnosis)** | | | |
| Perinatal | | 12 | 75.0% |
| Unknown risk | | 3 | 18.8% |
| Other*** | | 1 | 6.3% |
| | Subtotal | 16 | 0.3% |
| | **Total** | **5,002** | |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Table 6. People Newly Diagnosed with HIV Who Were Diagnosed with Stage 3 HIV Infection (AIDS) Within 12 Months of HIV Diagnosis, 2014 — California

| Population | No. newly diagnosed | Diagnosed with AIDS within 12 months of HIV diagnosis | |
|---|---|---|---|
| | | No. | Percent |
| **Total** | **5,002** | **1,135** | **23%** |
| | | | |
| **Age at year end (years)** | | | |
| < 13 | 16 | 4 | 25% |
| 13-24 | 954 | 83 | 9% |
| 25-44 | 2,794 | 605 | 22% |
| 45-64 | 1,160 | 405 | 35% |
| ≥ 65 | 78 | 38 | 49% |
| | | | |
| **Race/ethnicity** | | | |
| Hispanic/Latino | 2,207 | 527 | 24% |
| American Indian/Alaska Native | 14 | 4 | 29% |
| Asian | 351 | 83 | 24% |
| Black/African American | 857 | 174 | 20% |
| Native Hawaiian/Pacific Islander | 4 | 0 | 0% |
| White | 1,471 | 320 | 22% |
| Multiple races | 98 | 27 | 28% |
| | | | |
| **Gender** | | | |
| Male | 4,354 | 985 | 23% |
| Female | 588 | 140 | 24% |
| Transgender: Male-to-Female | 59 | 10 | 17% |
| Transgender: Female-to-Male | 1 | 0 | 0% |
| | | | |
| **Transmission category** | | | |
| Male-to-male sexual contact (MSM) | 3,236 | 652 | 20% |
| Injection drug use (IDU) | 196 | 77 | 39% |
| MSM and IDU | 158 | 35 | 22% |
| High-risk heterosexual contact* | 355 | 113 | 32% |
| Heterosexual contact (non-high-risk)** | 530 | 158 | 30% |
| Perinatal | 13 | 3 | 23% |
| Unknown | 513 | 97 | 19% |

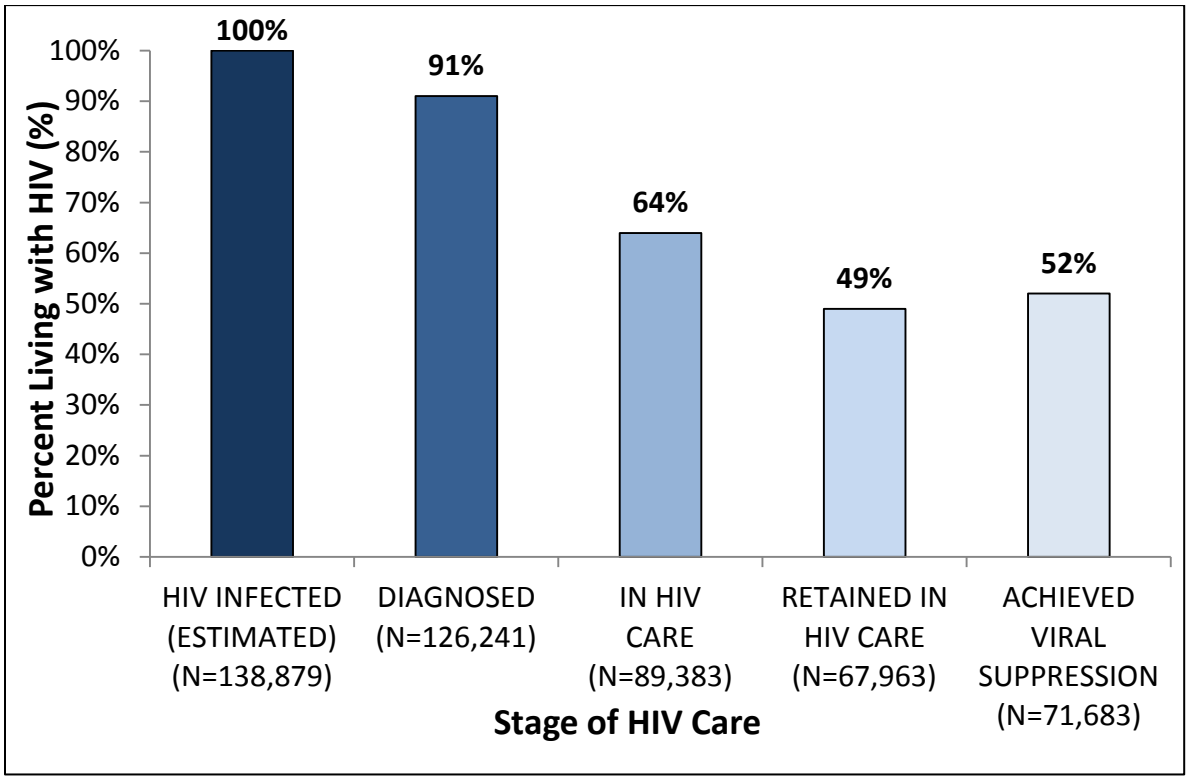
Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Continuum of HIV Care

The Continuum of HIV Care is a model that shows the proportion of people living with HIV at each of the stages of HIV medical care, from initial diagnosis to viral suppression. Among the estimated 138,879 persons living with HIV in California during 2014, approximately 52 percent achieved viral suppression; this includes persons who are not aware of their HIV infection (Figure 2).

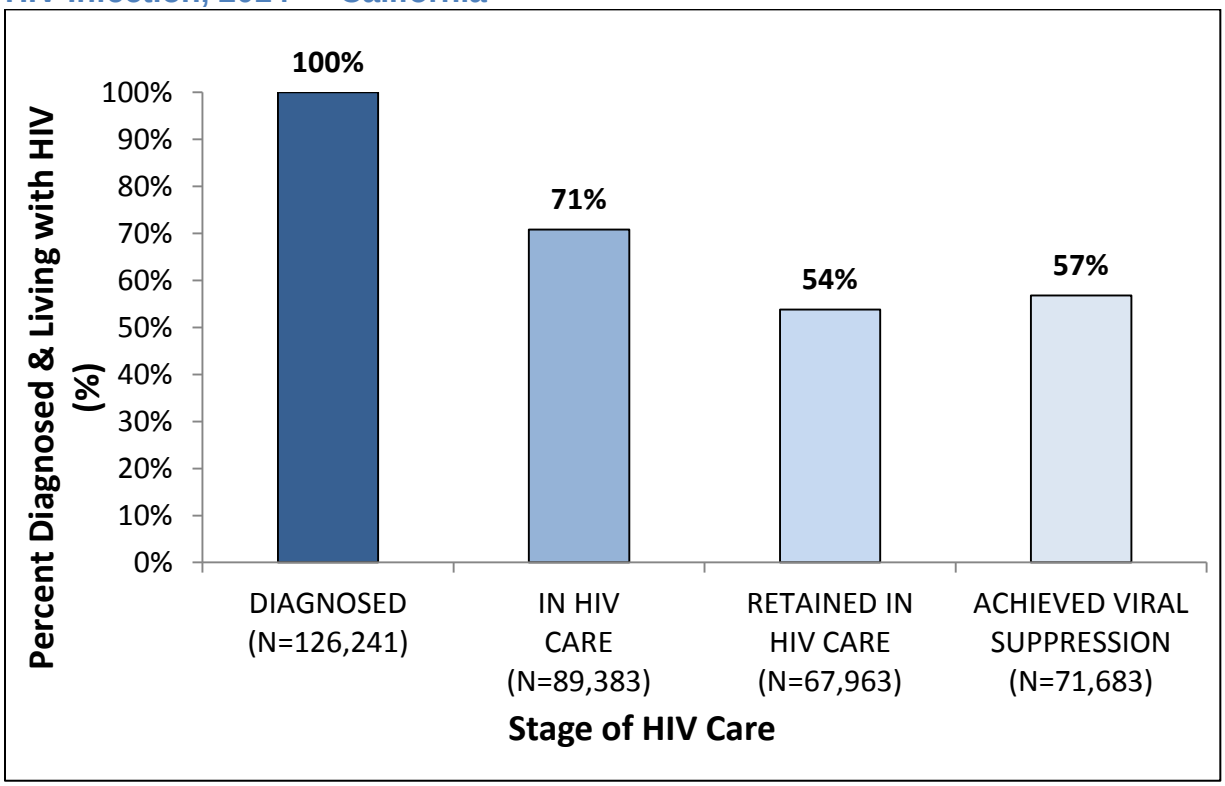
Among the 126,241 persons diagnosed and living with HIV in California during 2014, 71 percent were in HIV care, with at least one visit during the calendar year, and 57 percent were virally suppressed (Figure 3). The percentage of PLWH who were virally suppressed is higher than the percentage who were retained in care due to the fact that some providers only see PLWH with well controlled HIV annually, therefore, these PLWH were not counted in the retained in care measure. Additional details about the HIV continuum in California can be found on the *Continuum of HIV Care — California, 2014* fact sheet at: http://www.cdph.ca.gov/programs/aids/Documents/HIVCareContinuum-2014.pdf. Notable disparities were seen in viral suppression among persons aged 13-24 years, women, transgender persons, Blacks/African Americans, Hispanics/Latinos, American Indians/Alaska Natives, non-high risk heterosexuals, and people who inject drugs (Table 7, Table 8).

### Figure 2. The Continuum of HIV Care for All Persons Living with HIV Infection, 2014 — California




Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay

**Figure 3. The Continuum of HIV Care for All Persons Living and Diagnosed with HIV Infection, 2014 — California**




Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay

## Table 7. Stages of HIV Care by Age, Race/Ethnicity, and Gender, California — 2014

| Population | No. | Percent in HIV care | Percent retained in HIV care | Percent virally suppressed |
|---|---|---|---|---|
| **Total** | **126,241** | **71%** | **54%** | **57%** |
| | | | | |
| **Age at year end (years)** | | | | |
| < 13 | 161 | 83% | 66% | 61% |
| 13-24 | 3,324 | 73% | 47% | 45% |
| 25-44 | 42,073 | 69% | 50% | 51% |
| 45-64 | 71,518 | 72% | 56% | 60% |
| ≥ 65 | 9,165 | 71% | 60% | 63% |
| | | | | |
| **Race/ethnicity** | | | | |
| Hispanic/Latino | 42,523 | 69% | 54% | 54% |
| American Indian/Alaska Native | 443 | 65% | 45% | 48% |
| Asian | 4,762 | 74% | 57% | 63% |
| Black/African American | 22,953 | 67% | 51% | 49% |
| Native Hawaiian/Pacific Islander | 298 | 69% | 52% | 57% |
| White | 53,076 | 73% | 54% | 62% |
| Multiple races | 2,175 | 82% | 62% | 61% |
| | | | | |
| **Gender** | | | | |
| Male | 109,792 | 71% | 54% | 57% |
| Female | 14,982 | 69% | 52% | 53% |
| Transgender: Male-to-Female | 1,431 | 75% | 61% | 51% |
| Transgender: Female-to-Male | 36 | 78% | 72% | 47% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: Until 2003, Asian/Native Hawaiian/Pacific Islander was classified as a single category; therefore persons with race/ethnicity data only available prior to 2003 are classified as Asian because they cannot be disaggregated.

## Table 8. Stages of HIV Care by Transmission Category, California — 2014

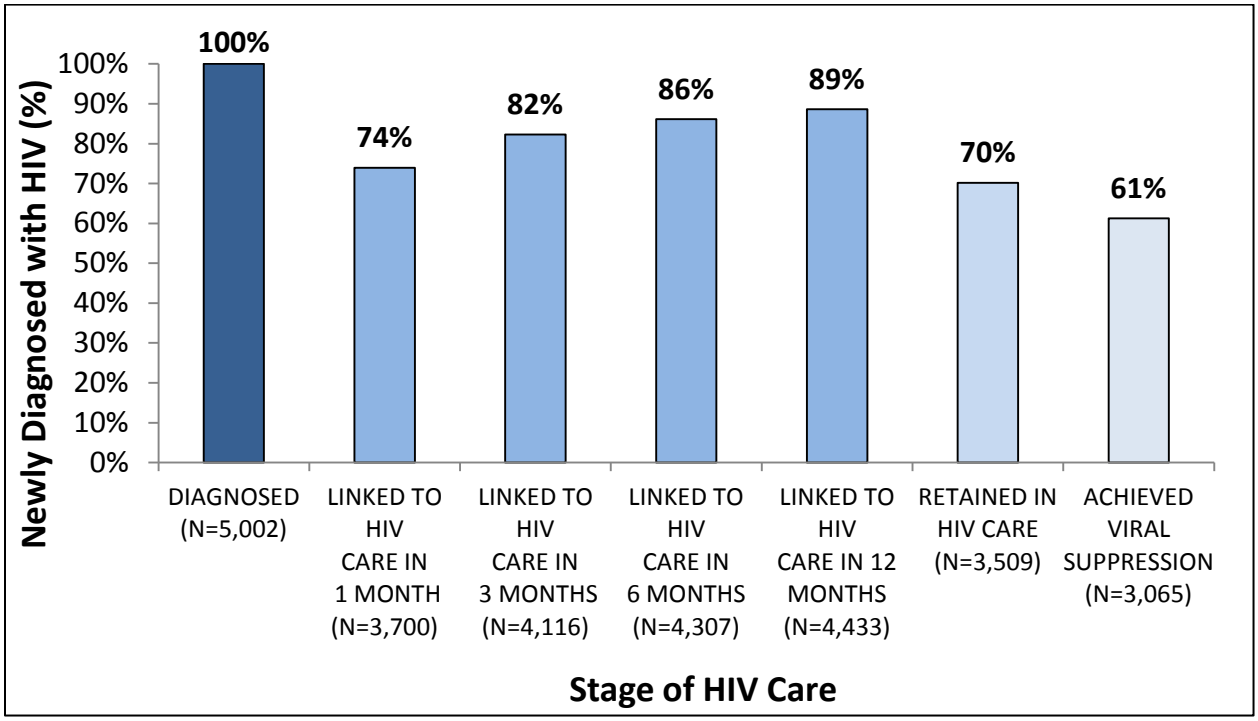
| Population | No. | Percent in HIV care | Percent retained in HIV care | Percent virally suppressed |
|---|---|---|---|---|
| **Total** | **126,241** | **71%** | **54%** | **57%** |
| | | | | |
| **Transmission category** | | | | |
| Male-to-male sexual contact (MSM) | 83,441 | 73% | 56% | 60% |
| Injection drug use (IDU) | 8,317 | 62% | 47% | 45% |
| MSM and IDU | 9,250 | 74% | 56% | 54% |
| High-risk heterosexual contact* | 11,351 | 71% | 53% | 55% |
| Heterosexual contact (non-high-risk)** | 7,191 | 63% | 49% | 50% |
| Perinatal | 707 | 78% | 62% | 52% |
| Unknown | 5,555 | 51% | 39% | 41% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV.

### Continuum of HIV Care for Newly Diagnosed

Among the 5,002 persons newly diagnosed with HIV in 2014, 74 percent were linked to HIV care within one month of diagnosis, and 61 percent were virally suppressed within 12 months of diagnosis (Figure 4). Disparities around linkage to care and viral suppression among newly diagnosed persons were particular notable among persons 13-24 years old, Black/African American persons, multi-racial persons, transgender women, people who inject drugs, and individuals likely infected through heterosexual contact (Table 9 and Table 10).

**Figure 4. The Continuum of HIV Care: Persons Newly Diagnosed with HIV — California 2014**




Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay

## Risk Behaviors and Program Data

Data on risk behaviors from the National HIV Behavioral Surveillance project (NHBS), the Medical Monitoring Project (MMP), the Youth Risk Behavioral Surveillance System (YRBSS), and the Behavioral Risk Factor Surveillance System (BRFSS), and data from the HIV Prevention Program, AIDS Drug Assistance Program, and Ryan White HIV/AIDS programs are presented in the relevant sections assessing needs, gaps and barriers for specific services and activities (Section 6.0, page 66).

## Table 9. Linkage to HIV Care for Persons Newly Diagnosed with HIV by Age, Race/Ethnicity, Gender, and Transmission Category, California — 2014

| Population | No. | Linked to care in 1 month | Linked to care in 6 months | Linked to care in 12 months |
|---|---|---|---|---|
| **Total** | **5,002** | **74%** | **86%** | **89%** |
| | | | | |
| **Age at year end (years)** | | | | |
| < 13 | 16 | 88% | 94% | 100% |
| 13-24 | 954 | 70% | 83% | 87% |
| 25-44 | 2,794 | 74% | 86% | 88% |
| 45-64 | 1,160 | 77% | 89% | 91% |
| ≥ 65 | 78 | 85% | 91% | 92% |
| | | | | |
| **Race/ethnicity** | | | | |
| Hispanic/Latino | 2,207 | 73% | 84% | 86% |
| American Indian/Alaska Native | 14 | 79% | 100% | 100% |
| Asian | 351 | 76% | 89% | 93% |
| Black/African American | 857 | 66% | 83% | 85% |
| Native Hawaiian/Pacific Islander | 4 | 75% | 75% | 75% |
| White | 1,471 | 79% | 90% | 92% |
| Multiple races | 98 | 79% | 91% | 93% |
| | | | | |
| **Gender** | | | | |
| Male | 4,354 | 75% | 87% | 89% |
| Female | 588 | 68% | 83% | 85% |
| Transgender: Male-to-Female | 59 | 73% | 85% | 86% |
| Transgender: Female-to-Male | 1 | 100% | 100% | 100% |
| | | | | |
| **Transmission category** | | | | |
| Male-to-male sexual contact (MSM) | 3,236 | 78% | 90% | 92% |
| Injection drug use (IDU) | 196 | 76% | 90% | 93% |
| MSM and IDU | 158 | 79% | 93% | 95% |
| High-risk heterosexual contact* | 355 | 75% | 88% | 90% |
| Heterosexual contact (non-high-risk)** | 530 | 63% | 78% | 79% |
| Perinatal | 13 | 85% | 92% | 100% |
| Other*** | 1 | 100% | 100% | 100% |
| Unknown | 513 | 54% | 69% | 71% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay.
Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Table 10. Viral Suppression for Persons Newly Diagnosed with HIV by Age, Race/Ethnicity, Gender, and Transmission Category, California — 2014

| Population | No. | Viral suppression in 6 months | Virally suppressed in 12 months |
|---|---|---|---|
| **Total** | **5,002** | **48%** | **61%** |
| | | | |
| **Age at year end (years)** | | | |
| < 13 | 16 | 56% | 63% |
| 13-24 | 954 | 40% | 56% |
| 25-44 | 2,794 | 49% | 62% |
| 45-64 | 1,160 | 52% | 65% |
| ≥ 65 | 78 | 55% | 60% |
| | | | |
| **Race/ethnicity** | | | |
| Hispanic/Latino | 2,207 | 47% | 60% |
| American Indian/Alaska Native | 14 | 36% | 57% |
| Asian | 351 | 61% | 76% |
| Black/African American | 857 | 40% | 52% |
| Native Hawaiian/Pacific Islander | 4 | 50% | 50% |
| White | 1,471 | 53% | 65% |
| Multiple races | 98 | 44% | 53% |
| | | | |
| **Gender** | | | |
| Male | 4,354 | 49% | 62% |
| Female | 588 | 44% | 58% |
| Transgender: Male-to-Female | 59 | 42% | 53% |
| Transgender: Female-to-Male | 1 | 0% | 0% |
| | | | |
| **Transmission category** | | | |
| Male-to-male sexual contact (MSM) | 3,236 | 52% | 65% |
| Injection drug use (IDU) | 196 | 39% | 53% |
| MSM and IDU | 158 | 42% | 53% |
| High-risk heterosexual contact* | 355 | 45% | 60% |
| Heterosexual contact (non-high-risk)** | 530 | 46% | 59% |
| Perinatal | 13 | 54% | 62% |
| Unknown | 513 | 36% | 46% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay.
Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Disparities in the Continuum of HIV Care

Disparities exist at all stages along the Continuum of HIV Care, including in rates of infection and diagnosis; however, the specific disparities vary based on the stage. Using HIV surveillance data, specifically HIV infection rates, estimates of undiagnosed persons, frequency of late diagnosis, linkage to care, engagement in care, and viral suppression, we identified the most notable disparities at each stage (Figure 5). Black/African American individuals were the only group to have substantial disparities along all stages of the continuum.

The disparities present in the Continuum of HIV Care were used to develop health equity focused objectives for the California Integrated Plan.

### Figure 5. Summary of Disparities in the Continuum of HIV Care — California

| Demographic category | Stages of the Continuum of HIV Care | | | | |
|---|---|---|---|---|---|
| | **Infection*** | **Time to diagnosis** | **Linkage to care*** ** | **Engagement in care**** ** | **Viral suppression**** ** |
| Sex/Gender | Male gender<br><br>Transgender | | Female gender | | Female gender<br><br>Transgender |
| Race/ Ethnicity | Black/African American<br><br>Hispanic/ Latino | Black/African American<br><br>Hispanic/ Latino<br><br>Other people of color | Blacks/African Americans | American Indian/Alaska Native<br><br>Black/African American | American Indian/Alaska Native<br><br>Black/African American<br><br>Hispanic/Latino |
| Aged | 25-29 years | 45-64 years<br><br>65 years and older | 13-24 years | | 13-24 years |
| Transmission category/ Risk factor | Male-male sexual activity<br><br>Injection drug use | Heterosexual sex<br><br>Injection drug use | Heterosexual sex | Injection drug use<br><br>Heterosexual sex | Injection drug use<br><br>Heterosexual sex<br><br>Perinatal transmission |

* Based on overall rate of HIV infection in each group
** Based on estimates of undiagnosed HIV and frequency of late HIV diagnosis (progression to Stage 3 (AIDS) within one year of diagnosis)
*** Based on initial linkage to care in the 12 months after diagnosis
**** Based on all diagnosed PLWH

## Local Health Jurisdictions

### Epidemiologic Overview

There is substantial variation among the 61 local health jurisdictions in California with regards to the HIV epidemic. Forty percent of PLWH live in Los Angeles County, and more than 95 percent of people living and diagnosed with HIV reside in only 18 counties (Table 11). San Francisco remains the jurisdiction with the highest rate of new diagnoses (39.9 per 100,000 population) and people diagnosed and living with HIV (1,618.3 per 100,000) in the state, although there have been substantial decreases in recent years in the number of new diagnoses, from 450 in 2010 to 335 in 2014.

### Table 11. All Persons Living and Diagnosed with HIV (PLWH) in 2014 and Persons Newly Diagnosed During 2014 by California Local Health Jurisdiction

| Jurisdiction | Newly diagnosed PLWH | | | All PLWH | | |
|---|---|---|---|---|---|---|
| | No. | % | Rate | No. | % | Rate |
| Alameda | 202 | 4.0% | 12.8 | 6,125 | 4.9% | 387.1 |
| Alpine | 0 | 0.0% | 0.0 | 0 | 0.0% | 0.0 |
| Amador | 0 | 0.0% | 0.0 | 50 | 0.0% | 135.1 |
| Butte | 8 | 0.2% | 3.6 | 240 | 0.2% | 106.9 |
| Calaveras | * | * | * | 35 | 0.0% | 76.9 |
| Colusa | 0 | 0.0% | 0.0 | 5 | 0.0% | 22.5 |
| Contra Costa | 107 | 2.1% | 9.8 | 2,311 | 1.8% | 211.0 |
| Del Norte | 0 | 0.0% | 0.0 | 18 | 0.0% | 63.2 |
| El Dorado | * | * | * | 165 | 0.1% | 89.5 |
| Fresno | 109 | 2.2% | 11.2 | 1,792 | 1.4% | 184.9 |
| Glenn | 0 | 0.0% | 0.0 | 12 | 0.0% | 41.6 |
| Humboldt | 7 | 0.1% | 5.1 | 180 | 0.1% | 131.6 |
| Imperial | 18 | 0.4% | 9.8 | 250 | 0.2% | 136.5 |
| Inyo | * | * | * | 19 | 0.0% | 98.7 |
| Kern | 111 | 2.2% | 12.6 | 1,615 | 1.3% | 183.9 |
| Kings | 8 | 0.2% | 5.2 | 250 | 0.2% | 162.8 |
| Lake | * | * | * | 127 | 0.1% | 194.0 |
| Lassen | 0 | 0.0% | 0.0 | 22 | 0.0% | 62.8 |
| Los Angeles | 2,035 | 40.7% | 20.2 | 50,298 | 39.8% | 498.9 |
| Madera | 11 | 0.2% | 7.1 | 176 | 0.1% | 113.7 |
| Marin | 25 | 0.5% | 9.7 | 900 | 0.7% | 349.1 |
| Mariposa | 0 | 0.0% | 0.0 | 19 | 0.0% | 105.0 |
| Mendocino | 5 | 0.1% | 5.6 | 183 | 0.1% | 206.1 |
| Merced | 15 | 0.3% | 5.6 | 203 | 0.2% | 76.2 |
| Modoc | 0 | 0.0% | 0.0 | * | * | * |
| Mono | 0 | 0.0% | 0.0 | * | * | * |
| Monterey | 26 | 0.5% | 6.1 | 683 | 0.5% | 160.1 |
| Napa | 10 | 0.2% | 7.1 | 246 | 0.2% | 174.3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Nevada | * | * | * | 87 | 0.1% | 88.4 |
| Orange | 282 | 5.6% | 9.0 | 7,187 | 5.7% | 229.9 |
| Placer | 5 | 0.1% | 1.4 | 217 | 0.2% | 58.7 |
| Plumas | 0 | 0.0% | 0.0 | 8 | 0.0% | 41.2 |
| Riverside | 262 | 5.2% | 11.4 | 6,072 | 4.8% | 264.7 |
| Sacramento | 162 | 3.2% | 11.1 | 3,863 | 3.1% | 264.4 |
| San Benito | * | * | * | 40 | 0.0% | 68.7 |
| San Bernardino | 205 | 4.1% | 9.8 | 3,369 | 2.7% | 160.7 |
| San Diego | 480 | 9.6% | 14.9 | 12,862 | 10.2% | 400.2 |
| San Francisco | 335 | 6.7% | 39.9 | 13,600 | 10.8% | 1618.3 |
| San Joaquin | 73 | 1.5% | 10.2 | 1,330 | 1.1% | 186.3 |
| San Luis Obispo | 12 | 0.2% | 4.4 | 622 | 0.5% | 227.9 |
| San Mateo | 63 | 1.3% | 8.4 | 1,602 | 1.3% | 214.4 |
| Santa Barbara | 25 | 0.5% | 5.7 | 601 | 0.5% | 137.8 |
| Santa Clara | 161 | 3.2% | 8.6 | 3,368 | 2.7% | 180.0 |
| Santa Cruz | 20 | 0.4% | 7.3 | 434 | 0.3% | 159.4 |
| Shasta | 8 | 0.2% | 4.5 | 216 | 0.2% | 120.5 |
| Sierra | 0 | 0.0% | 0.0 | * | * | * |
| Siskiyou | * | * | * | 33 | 0.0% | 72.9 |
| Solano | 53 | 1.1% | 12.4 | 1,187 | 0.9% | 276.9 |
| Sonoma | 30 | 0.6% | 6.0 | 1,313 | 1.0% | 264.0 |
| Stanislaus | 18 | 0.4% | 3.4 | 545 | 0.4% | 102.4 |
| Sutter | * | * | * | 77 | 0.1% | 79.2 |
| Tehama | 0 | 0.0% | 0.0 | 42 | 0.0% | 64.8 |
| Trinity | 0 | 0.0% | 0.0 | 13 | 0.0% | 94.3 |
| Tulare | 35 | 0.7% | 7.6 | 333 | 0.3% | 72.1 |
| Tuolumne | 0 | 0.0% | 0.0 | 41 | 0.0% | 75.1 |
| Ventura | 52 | 1.0% | 6.2 | 982 | 0.8% | 116.2 |
| Yolo | 6 | 0.1% | 2.9 | 215 | 0.2% | 103.3 |
| Yuba | * | * | * | 52 | 0.0% | 70.0 |
| **Total** | **5,002** | | **13.0** | **126,241** | | **327.5** |
| | | | | | | |
| **City of residence at diagnosis** | | | | | | |
| Berkeley | 19 | 0.4% | 16.0 | 487 | 0.4% | 409.5 |
| Long Beach | 125 | 2.5% | 25.9 | 4,700 | 3.7% | 975.5 |
| Pasadena | 23 | 0.5% | 16.5 | 591 | 0.5% | 422.8 |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay
Note: Newly diagnosed persons are assigned to the jurisdiction of residence at diagnosis. PLWH are assigned to jurisdiction of the most recent residential address available. Rates are per 100,000 population. Numbers for the city health jurisdictions of Berkeley, Long Beach and Pasadena are subsets of the numbers for the counties in which they are located (Alameda, Los Angeles, and Los Angeles, respectively). *Data suppressed due to small cell counts.

## Table 12. People Living and Diagnosed with HIV in Sacramento, San Bernardino/ Riverside, and San Jose Transitional Grant Areas, California — 2014

| Population | Sacramento | | San Bernardino/ Riverside | | San Jose | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| **Total** | **4,245** | **100%** | **9,441** | **100%** | **3, 368** | **100%** |
| | | | | | | |
| **Age at year end (years)** | | | | | | |
| <13 | 16 | <1% | 18 | <1% | 5 | <1% |
| 13-24 | 133 | 3% | 306 | 3% | 71 | 2% |
| 25-44 | 1,312 | 31% | 2,558 | 27% | 1,130 | 34% |
| 45-64 | 2,471 | 58% | 5,579 | 59% | 1,920 | 57% |
| ≥65 | 313 | 7% | 980 | 10% | 242 | 7% |
| | | | | | | |
| **Race/ethnicity** | | | | | | |
| American Indian/Alaska Native | 27 | 1% | 33 | <1% | 12 | <1% |
| Asian | 139 | 3% | 170 | 2% | 324 | 10% |
| Black/African American | 987 | 23% | 1,381 | 15% | 384 | 11% |
| Hispanic/Latino | 697 | 16% | 2,747 | 29% | 1,230 | 37% |
| Native Hawaiian/Pacific Islander | 25 | 1% | 10 | 0% | 9 | <1% |
| White | 2,315 | 55% | 4,991 | 53% | 1,385 | 41% |
| Multiple races | 55 | 1% | 109 | 1% | 24 | 1% |
| | | | | | | |
| **Gender** | | | | | | |
| Male | 3,531 | 83% | 8,201 | 87% | 2,908 | 86% |
| Female | 698 | 16% | 1,215 | 13% | 433 | 13% |
| Transgender: Male-to-Female | 15 | <1% | 24 | <1% | 27 | 1% |
| Transgender: Female-to-Male | **** | **** | *** | *** | 0 | 0% |
| | | | | | | |
| **Transmission category** | | | | | | |
| Male-to-male sexual contact (MSM) | 2,289 | 54% | 6,317 | 67% | 2,144 | 64% |
| Injection drug use (IDU) | 427 | 10% | 681 | 7% | 210 | 6% |
| MSM and IDU | 378 | 9% | 541 | 6% | 200 | 6% |
| High-risk heterosexual contact* | 832 | 20% | 1,038 | 11% | 376 | 11% |
| Heterosexual contact (non-high-risk)** | 128 | 3% | 507 | 5% | 328 | 10% |
| Perinatal | 42 | 1% | 53 | 1% | 17 | 1% |
| Other*** | 23 | 1% | 32 | <1% | 21 | 1% |
| Unknown | 126 | 3% | 272 | 3% | 72 | 2% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay. Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Table 13. People Newly Diagnosed with HIV in Sacramento, San Bernardino/ Riverside, and San Jose Transitional Grant Areas, California — 2014

| Population | Sacramento | | San Bernardino/ Riverside | | San Jose | |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % |
| **Total** | **170** | **100%** | **467** | **100%** | **161** | **100%** |
| **Age at year end (years)** | | | | | | |
| 0-12 | **** | | **** | | **** | |
| 13-24 | 30 | 13% | 103 | 22% | 23 | 14% |
| 25-44 | 92 | 45% | 230 | 49% | 102 | 63% |
| 45-64 | 46 | 25% | 117 | 25% | 32 | 20% |
| ≥65 | **** | | **** | | **** | |
| **Race/ethnicity** | | | | | | |
| American Indian/Alaska Native | **** | | **** | | **** | |
| Asian | 9 | 5% | 17 | 4% | 27 | 17% |
| Black/African American | 42 | 18% | 62 | 13% | 9 | 6% |
| Hispanic/Latino | 37 | 18% | 202 | 43% | 79 | 49% |
| Native Hawaiian/Pacific Islander | **** | | 0 | 0% | 0 | 0% |
| White | 76 | 39% | 170 | 36% | 43 | 27% |
| Multiple races | 5 | 2% | 12 | 3% | **** | |
| **Gender** | | | | | | |
| Male | 134 | 65% | 404 | 87% | 147 | 91% |
| Female | 35 | 18% | 59 | 13% | 12 | 7% |
| Transgender: Male-to-Female | **** | | **** | | **** | |
| Transgender: Female-to-Male | **** | | **** | | **** | |
| **Transmission category** | | | | | | |
| Male-to-male sexual contact (MSM) | 80 | 39% | 302 | 65% | 101 | 63% |
| Injection drug use (IDU) | 10 | 6% | 21 | 4% | 10 | 6% |
| MSM and IDU | **** | | 12 | 2% | 7 | 4% |
| High-risk heterosexual contact* | 47 | 23% | 36 | 8% | | **** |
| Heterosexual contact (non-high-risk)** | 13 | 6% | 52 | 11% | 31 | 19% |
| Perinatal | **** | 1% | **** | <1% | 0 | 0% |
| Other*** | 0 | 0% | **** | | | **** |
| Unknown | 15 | 6% | 42 | 9% | 7 | 4% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay.
Note: * High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.

## Continuum of HIV Care

HIV surveillance data were also used to develop continuums of HIV care for the local jurisdictions co-authoring this report (Table 14). It was not possible to determine undiagnosed estimates at the local level; however data on all other stages of the continuum were available. Engagement in HIV care, retention in care, and viral suppression were similar to the statewide continuums.

### Table 14. Continuum of HIV Care in Sacramento, San Bernardino/Riverside, and San Jose Transitional Grant Areas, 2014

| HRSA Transitional Grant Area | Diagnosed | | In care | | Retained in care | | Virally suppressed | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| **Sacramento** | 4,245 | 100% | 3,030 | 71% | 2,117 | 50% | 2,272 | 54% |
| **San Bernardino/Riverside** | 9,441 | 100% | 6,559 | 69% | 4,818 | 51% | 5,172 | 55% |
| **San Jose** | 3,368 | 100% | 2,483 | 74% | 1,831 | 54% | 1,635 | 49% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay

There was variation in linkage to care, retention in care, and viral suppression among persons who were newly diagnosed with HIV in 2014. Between 69 and 80 percent of newly diagnosed persons were linked to care within one month of diagnosis; however, within 12 months, 89 to 92 percent of newly diagnosed persons were linked to care, which met or exceeded statewide linkage to care levels.

### Table 15. Continuum of HIV Care in for Persons Newly Diagnosed with HIV, 2014 — Sacramento, San Bernardino/Riverside, and San Jose Transitional Grant Areas

| HRSA Transitional Grant Area | Newly diagnosed | Linked to care in 1 month | | Linked to care in 6 months | | Linked to care in 12 months | | Viral suppression at 12 months | |
|---|---|---|---|---|---|---|---|---|---|
| | No. | No. | % | No. | % | No. | % | No. | % |
| **Sacramento** | 170 | 131 | 77% | 145 | 85% | 151 | 89% | 106 | 62% |
| **San Bernardino /Riverside** | 467 | 323 | 69% | 405 | 87% | 427 | 91% | 283 | 61% |
| **San Jose** | 161 | 129 | 80% | 146 | 91% | 148 | 92% | 102 | 63% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay

## Table 16. Linkage to care for Persons Newly Diagnosed with HIV, 2014 - Sacramento, San Bernardino/Riverside, and San Jose Transitional Grant Areas

| Population | Sacramento TGA | | | San Bernardino/ Riverside TGA | | | San Jose TGA | | |
|---|---|---|---|---|---|---|---|---|---|
| | No. | Linked to care in 1 month | Linked to care in 12 months | No. | Linked to care in 1 month | Linked to care in 12 months | No. | Linked to care in 1 month | Linked to care in 12 months |
| **Total** | **170** | **77%** | **89%** | **467** | **69%** | **91%** | **161** | **80%** | **92%** |
| **Age at year end (years)** | | | | | | | | | |
| 0-12 | ** | ** | ** | ** | ** | ** | ** | ** | ** |
| 13-24 | 30 | 67% | 87% | 103 | 59% | 85% | 23 | 74% | 100% |
| 25-44 | 92 | 76% | 88% | 230 | 70% | 92% | 102 | 76% | 88% |
| 45-64 | 46 | 85% | 91% | 117 | 74% | 95% | 32 | 97% | 100% |
| ≥65 | 0 | - | - | 14 | 79% | 100% | ** | ** | ** |
| **Race/ethnicity** | | | | | | | | | |
| American Indian/Alaska Native | 0 | - | - | ** | ** | ** | ** | ** | ** |
| Asian | 9 | 78% | 100% | 17 | 65% | 94% | 27 | 78% | 96% |
| Black/African American | 42 | 69% | 83% | 62 | 58% | 84% | 9 | 89% | 89% |
| Hispanic/Latino | 37 | 78% | 84% | 202 | 71% | 93% | 79 | 78% | 92% |
| Native Hawaiian/Pacific Islander | | | | 0 | - | - | 0 | - | - |
| White | 76 | 82% | 93% | 170 | 71% | 92% | 43 | 84% | 91% |
| Multiple races | 5 | 60% | 80% | 12 | 75% | 92% | ** | ** | ** |
| **Gender** | | | | | | | | | |
| Male | 134 | 75% | 88% | 283 | 70% | 91% | 147 | 80% | 92% |
| Female | 35 | 86% | 91% | 38 | 64% | 92% | 12 | 83% | 92% |
| Transgender: Male-to-Female | ** | ** | ** | ** | ** | ** | ** | ** | ** |
| Transgender: Female-to-Male | 0 | - | - | 0 | - | - | 0 | - | - |
| **Transmission category** | | | | | | | | | |
| Male-to-male sexual contact (MSM) | 80 | 79% | 90% | 302 | 71% | 92% | 101 | 79% | 93% |
| Injection drug use (IDU) | 10 | 90% | 100% | 21 | 86% | 100% | 10 | 80% | 80% |
| MSM and IDU | | | ** | ** | ** | 92% | 7 | 86% | 100% |
| High-risk heterosexual contact* | 47 | 79% | 89% | 36 | 72% | 97% | ** | ** | ** |
| Heterosexual contact (non-high-risk)** | 13 | 77% | 77% | 52 | 72% | 97% | 31 | 87% | 97% |
| Perinatal | ** | ** | ** | ** | ** | ** | 0 | - | - |
| Other*** | 0 | - | - | 0 | - | - | ** | ** | ** |
| Unknown | 15 | 53% | 80% | 42 | 55% | 83% | 7 | 71% | 71% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay.
* High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks.
**Data were suppressed due to small cell counts.

## Table 17. Viral suppression for Persons Newly Diagnosed with HIV, 2014 - Sacramento, San Bernardino/Riverside, and San Jose Transitional Grant Areas

| Population | Sacramento TGA | | | San Bernardino/ Riverside TGA | | | San Jose TGA | | |
|---|---|---|---|---|---|---|---|---|---|
| | No. | Viral suppression in 6 months | Viral suppression in 12 months | No. | Viral suppression in 6 months | Viral suppression in 12 months | No. | Viral suppression in 6 months | Viral suppression in 12 months |
| **Total** | **170** | **41%** | **62%** | **467** | **47%** | **61%** | **161** | **43%** | **63%** |
| **Age at year end (years)** | | | | | | | | | |
| 0-12 | ** | 50% | 100% | ** | 33% | 33% | ** | 100% | 100% |
| 13-24 | 30 | 30% | 53% | 103 | 41% | 55% | 23 | 13% | 48% |
| 25-44 | 92 | 38% | 61% | 230 | 44% | 62% | 102 | 49% | 66% |
| 45-64 | 46 | 52% | 70% | 117 | 48% | 66% | 32 | 43% | 69% |
| ≥65 | 0 | - | - | 14 | 43% | 43% | ** | 0% | 0% |
| **Race/ethnicity** | | | | | | | | | |
| American Indian/Alaska Native | 0 | | - | ** | 25% | 50% | ** | 100% | 100% |
| Asian | 9 | 67% | 89% | 17 | 41% | 53% | 27 | 52% | 70% |
| Black/African American | 42 | 31% | 45% | 62 | 36% | 48% | 9 | 44% | 78% |
| Hispanic/Latino | 37 | 41% | 68% | 202 | 48% | 62% | 79 | 35% | 61% |
| Native Hawaiian/Pacific Islander | ** | 100% | 100% | 0 | - | - | 0 | - | - |
| White | 76 | 42% | 67% | 170 | 51% | 65% | 43 | 49% | 60% |
| Multiple races | 5 | 40% | 40% | 12 | 33% | 50% | ** | 50% | 50% |
| **Gender** | | | | | | | | | |
| Male | 134 | 39% | 62% | 404 | 47% | 61% | 147 | 43% | 63% |
| Female | 35 | 48% | 63% | 59 | 44% | 59% | 12 | 50% | 58% |
| Transgender: Male-to-Female | ** | 100% | 100% | ** | 50% | 50% | ** | 0% | 100% |
| Transgender: Female-to-Male | 0 | - | - | 0 | - | - | 0 | - | - |
| **Transmission category** | | | | | | | | | |
| Male-to-male sexual contact (MSM) | 80 | 36% | 64% | 302 | 52% | 65% | 101 | 40% | 63% |
| Injection drug use (IDU) | 10 | 60% | 70% | 21 | 33% | 48% | 10 | 30% | 40% |
| MSM and IDU | ** | 33% | 67% | 12 | 42% | 50% | 7 | 57% | 57% |
| High-risk heterosexual contact* | 47 | 43% | 60% | 36 | 44% | 61% | ** | 50% | 50% |
| Heterosexual contact (non-high-risk)** | 13 | 39% | 54% | 52 | 44% | 62% | 31 | 48% | 74% |
| Perinatal | ** | 50% | 100% | ** | 50% | 50% | 0 | - | - |
| Other*** | 0 | - | - | 0 | - | - | ** | 100% | 100% |
| Unknown | 15 | 53% | 60% | 42 | | 40% | 7 | 57% | 57% |

Source: Data reported to the California Department of Public Health Office of AIDS HIV Surveillance through December 31, 2015, allowing a minimum of 12 months reporting delay.

* High-risk heterosexual contact includes heterosexual intercourse with a person of the opposite sex-at-birth who was HIV-positive or has a high risk for HIV infection (i.e., MSM, IDU). **Heterosexual contact (non-high-risk): heterosexual intercourse with a person of the opposite sex-at-birth who does not have a high risk for HIV. ***Other includes exposure to blood transfusion or blood products, receiving a transplant, occupational exposure, and other unspecified risks. **Data were suppressed due to small cell counts.

## Data Sources/References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4. Hall HI, An Q, Tang T, et al. Prevalence of Diagnosed and Undiagnosed HIV Infection--United States, 2008-2012. *MMWR Morbidity and mortality weekly report.* 2015;64(24):657-662.

# 5.0 California Financial and Human Resources Inventory

## Contents



The Financial and Human Resources Inventory consists of three components: 1) a table summarizing the financial resources for HIV surveillance, prevention, care, and treatment in California; 2) a narrative description of the HIV workforce capacity in California; and 3) a narrative description of how the funding sources interact. Details on the financial and human resources available for specific services or activities (e.g., PrEP), and a summary of gaps can be found in the individual activity/service briefs.

## Financial Resource Summary

The California financial resource summary can be found in Table 18. The information presented in this section includes resource information from California's 58 county and three city local health jurisdictions (LHJ). Financial data are presented from the most recent 12-month budget cycle available for each specific funding source. As a result, the timeframe covered may vary between funding sources.

Following the California statewide table are a table for each of the three transitional grant area co-authors: the San Bernardino/Riverside TGA (San Bernardino and Riverside Counties) (Table 19), Sacramento TGA (Sacramento, El Dorado, and Placer Counties) (Table 20), San Jose TGA (Santa Clara County) (Table 21).

## Table 18: California Financial Resources for HIV Surveillance, Prevention, Care, and Treatment

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| CDC[e] to OA | OA Prevention Grant 12-1201 (Category A and Category B) | $17,422,227 | 1/1/15-12/31/15 | Category A: 18 LHJs and 37 CBOs<br><br>Category B: 29 organizations within eight LHJs | Testing, linkage to PrEP, PrEP support services, linkage to care, partner services, high impact prevention, condom distribution, social marketing, media | Pre-infection and all |
| CDC[2] to OA | OA Prevention Grant 15-1506 | $3,500,000 | 9/30/15-9/29/16 | Alameda HD, Orange HD, San Diego HD and Desert AIDS Project | PrEP education, navigation, and support services | Pre-infection |
| CDC[2] to OA | HIV surveillance | $3,219,925 | 1/1/15-12/31/15 | Statewide | Surveillance, monitoring, reporting, data to care | Pre-infection and all |
| CDC[2] to OA | Medical Monitoring Project | $796,535 | 6/1/15-5/31/16 | CPA | Supplemental surveillance of PLWH | All |
| CDC[2] to OA | National Behavioral Health Survey | $469,217 | 1/01/15-12/31/15 | Chicano Federation of San Diego County | Behavioral surveillance of high risk populations | All |
| CDC to CA STD Control Branch | STI Prevention, detection and Treatment | 10,052,701 | FY 2015 | Statewide | Surveillance, testing, treatment, prevention | Pre-infection and all |
| CDC to CA Tuberculosis Control Branch | TB Prevention, detection and treatment | 16,204,089 | FY 2015 | Statewide | Surveillance, testing, treatment, prevention | Pre-infection and all |

[c] Acronyms are defined at the end of the table.
[d] Funding periods vary between different funding sources and therefore do not always match the Office of AIDS state AIDS Chart.
[e] Does not include CDC funding to Los Angeles and San Francisco.

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| HRSA/HAB to OA | RW Part B Base Award | $32,257,238 | FY 2015 | 35 LHJs and nine CBOs | Core medical services, support services | All |
| HRSA/HAB to OA | RW Part B Supplemental Award | $8,700,000 | FFY 2016 | | | |
| HRSA/HAB to OA | RW Part B ADAP Award | $98,618,573 | FY 2015 | 36,047 clients provided medication in FY 13-14. | Medication & Insurance assistance | Viral suppression |
| HRSA/HAB to OA | RW Part B ADAP ERF Awards | $6,441,447 | FY 2015 | | Medication & Insurance assistance | Viral suppression |
| HRSA/HAB to OA | RW Part B Supplemental | $10,000,000 | FFY 2016 | | Medication & Insurance assistance | Viral suppression |
| Rebates to OA | RW Part B ADAP Rebates | $260,573,599 | SFY 2016-17 | | Medication Assistance | Viral Suppression |
| HRSA/HAB to OA | RW Part B EC Award | $163,159 | FY 2015 | Kern County | Core medical services | Retention/re-engagement, Viral suppression |
| HRSA/HAB to OA | RW Part B MAI Award | $1,227,956 | FY 2015 | 16 LHJs and Eight Subcontractors | HIV services targeted to people of color | All |
| HUD to OA | HOPWA | $43,635,703 | 7/1/14 – 6/30/15 | 17 Grantees, Formula and Competitive | Housing assistance and related support services | Retention/ re-engagement, Viral suppression |
| CA State General Funds to OA | HIV Prevention Demonstration Projects: PrEP/LTC | $3,000,000 | FY 16-17 | Los Angeles LGBT Center, San Francisco AIDS Foundation, San Diego County plus an Evaluator | Testing, linkage to care, retention, re-engagement, PrEP | Pre-infection, HIV-diagnosis, Linkage to care |
| CA State General Funds to OA | Syringe Exchange Supplies Clearinghouse | $3,000,000 | FY 16-17 | 49 LHJs/CBOs | Syringe exchange supplies, HIV test kits, HCV test kits | Pre-infection, HIV-diagnosis |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| CA State General Funds to OA | Hepatitis C Initiatives | $700,000 | FY 16-17 | TBD | HIV and HCV test counselor training and syringe exchange program TA | Pre-infection, HIV-diagnosis |
| CA State General Funds FY 2015 to OA | PrEP Navigator Funding | $2,000,000 | FY 2016-2017 | 9 LHJs/CBOs | PrEP education, navigation and support services | Pre-infection |
| CDC to OA | Preventive Health and Health Services Block Grant | $500,000 | SFY 2016-2017 | Alameda County, Orange County, San Diego County | Data to care, linkage to care, re-engagement | Linkage to care, Viral suppressio n |
| CA State General Funds & Reimbursements to OA | Medi-Cal Waiver Program Reimbursements | $778,000 | SFY 2016-17 | OA is funded by Medi-Cal | Home-based care | Retention in care |
| CA State General Funds / CMS to OA | Medi-Cal Managed Care for PLWH | Unknown | | | Medical care | All |
| CA State General Funds/ CMS to OA | FFS MediCal for PLWH | $504,713 | FY 2016-17 | | Medical care | All |
| CA State General Funds / CMS to CA DHCS | Medi-Cal Managed Care and FFS, Denti-Cal | $92 billion | SFY 2015-2016 | | Medical care | Pre-infection |
| CA State General Funds / CMS to CA DHCS | Family PACT | $540 million[f] | SFY 2015-2016 | | Family planning services | Pre-infection |
| SAMHSA | CMHS | $400,000 | FY2015 | | Mental health services for PLWH; capacity building | Retention in care |

[f] Total Family PACT funds, HIV is a portion of the total funds

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| SAMHSA | CSAP | $4,282,727 | FY2015 | | Substance abuse prevention and HIV prevention in minority communities | Pre-infection |
| SAMHSA | CSAT | $14,391,388 | FY2015 | | Substance abuse treatment and HIV/AIDS services for ethnic and racial minority populations and substance abusers. | Pre-infection and all |
| CA State General Funds / federal funds | Residential Care for the Chronically Ill | $78,000 | FY 2014-2015 | | Licensed facilities with a maximum capacity of 25 that provide care and supervision to PLWH | Viral suppression |
| CDC to CA Department of Education | DASH | $320,000 | 7/1/15–6/30/16 | CDE | TA and monitoring for ≈1,200 California School Districts | Pre-infection |
| CDC to Four Local Education Agencies | DASH | Unknown | 8/1/13–7/30/18 | Los Angeles, Oakland, San Diego, and San Francisco Local Education Agencies | Sexual health education emphasizing HIV and other STD Prevention | Pre-infection |
| CDC to CDE and Four Local Education Agencies | DASH: RFA-PS13-1308 School-based Surveillance | Unknown | | CDE, Los Angeles, Oakland, San Diego, and San Francisco Local Education Agencies | Youth Risk Behavior Survey and School Health Profiles data | Pre-infection |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| CDC to Los Angeles Unified School District | DASH: RFA-PS13-1308 Gay Straight Alliance Network | Unknown | | Los Angeles Unified School District | Providing TA to local education agencies establish safe and supportive environments for students and staff. | Pre-infection |
| CDC to CA Department of Education and four Local Education Agencies | DASH: RFA-1308: Adolescent Health - School-Based HIV/STD Prevention and Surveillance | Unknown | | CDE, Los Angeles, Oakland, San Diego, and San Francisco Local Education Agencies, | Activities to meet the HIV/STD prevention needs of young men who have sex with men | Pre-infection |
| CA State General Funds to California School Districts | State Mandates-AIDS Prevention Instruction | $1,000 | 7/1/15 – 6/30/16 | Available to ≈1,200 California School Districts | Comprehensive sexual health education & HIV prevention education in Middle and High School | Pre-infection |
| CA State General Funds | AIDS Screening, Treatment, and Other Services | $250,000 | FY 2014 - 2015 | | Testing, Treatment, Support Services | Pre-infection and all |
| CA State General Funds | AIDS Treatment and AIDS Facilities | $59,285 | FY 2014 - 2015 | | Treatment | In care; Retained in care; Viral suppression |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| CA State General Funds to CA Department of Corrections and Rehabilitation | Transitional Case Management for HIV/AIDS Parolees | $253,000 | FY 2014 - 2015 | | Benefits counseling, linkage to care emergency housing, transportation, and food vouchers for parolees with HIV. | Linkage to care; In care; Retained in care; Viral suppression |
| Multiple Sources to University of California, San Francisco[g] | CA STD/HIV Prevention Training Center | $1,350,000[h] | 10/1/15 – 9/30/16 | | TA and CBA to California HIV organizations | Pre-infection and all |
| Multiple Sources to University of California, San Francisco[i] | Pacific AIDS Education & Training Center | $6,699,383 | 10/1/13 – 9/30/14 | | TA and CBA to California HIV organizations | Pre-infection and all |
| CA State General Funds to University of California Office of the President | CHRP | $8,753,000 | 7/1/15 – 6/30/16 | 8 investigators for basic HIV research; 3 transgender women's PrEP demonstration projects | Research, demonstration projects | Pre-infection; Viral suppression |
| Multiple Sources to the University of California, San Francisco | Alliance Health Project | $949,756 | FY15-16 | Alliance Health Project | HIV Testing, Case Management, Research, Training | Pre-infection and all |
| HRSA/HAB to Part A areas | RW Part A Award | $59,461,959 | FY 2015 | Five EMAs and Three TGAs | 75% Medical Care 25% Support Services | All |

[g] The CA PTC funding amount comes from multiple sources that may include some funding recorded in other line items within this table, hence some funding amounts may be duplicated.
[h] This includes $825,000 from CDPH/OA.
[i] The PAETC funding amount comes from multiple sources that may include some funding recorded in other line items within this table, hence some funding amounts may be duplicated.

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| HRSA/HAB to Part A areas | RW Part A Supplemental Award | $29,790,621 | FY 2015 | Five MSAs and Three TGAs | 75% Medical Care 25% Support Services | All |
| HRSA/HAB to Part A areas | RW Part A MAI Award | $6,529,451 | FY 2015 | Five MSAs and Three TGAs | HIV services targeted to people of color | All (specifically for people of color) |
| HRSA/HAB to directly funded recipients | RW Part C EIS Grant Awards | $19,897,152 | FY 2015 | 41 CBOs within 23 LHJs | Early Intervention Services | Diagnosis; Linkage to care |
| HRSA/HAB to directly funded recipients | RW Part D Grant Awards | $5,770,033 | FY 2014 | Nine Agencies within Seven LHJs | HIV services for Women, Infants, Children and Youth | All |
| HRSA/HAB to directly funded recipients | RW Part F Dental Reimbursement Program | $1,454,071 | FY 2014 | University of California, Los Angeles; University of Southern California; Alameda County Medical Center; University of California, San Francisco | Dental services for PLWH | Viral suppression |
| HRSA/HAB to directly funded recipient | RW Part F Community-based Dental Partnership Program | $298,848 | FY 2014 | Loma Linda University | Dental services for PLWH | Viral suppression |
| HRSA/HAB to directly funded recipients | RW Part F: SPNS - Use of Social Media | Unknown | 2015 – 2019 | San Francisco Department of Public Health; University of California at Los Angeles | Identify, link & retain underserved, underinsured, hard to reach youth and young adults living with HIV | All |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| HRSA/HAB to directly funded recipients | RW Part F: SPNS-System-level Workforce Capacity Building | Unknown | 2014 – 2018 | San Ysidro Health Center; Family Health Centers of San Diego; University of California at San Francisco | System level changes to improve health outcomes along the HIV Care Continuum. | All |
| HRSA/HAB to directly funded recipients | RW Part F: SPNS-Culturally Appropriate Interventions among Latino(a)s | Unknown | 2013 -- 2018 | AIDS Project Los Angeles; Bienestar Human Services; University of California at San Francisco | Improve health outcomes among Latinos/as living with HIV disease | All |
| HRSA/HAB to directly funded recipients | RW Part F: SPNS-Building a Medical Home for Multiply Diagnosed HIV-positive Homeless Populations | Unknown | 2012 – 2017 | City and County of San Francisco; City of Pasadena; Family Health Centers of San Diego | Interventions for homeless PLWH to improve timely entry, engagement and retention in HIV care and supportive services. | All |
| HRSA/HAB to directly funded recipients | RW Part F: SPNS-Enhancing Engagement and Retention in Quality HIV Care for transgender women of color | Unknown | 2012 – 2017 | Bienestar Human Services; City and County of San Francisco; Friends Research Institute; Public Health Institute of Oakland; Tri-City Health Center; University of California at San Francisco | Interventions to improve timely entry, engagement and retention in HIV care and supportive services for transgender women of color. | All |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| CDC to directly funded recipients | CA Funding for 15-1502 | $1,052,501 | 7/1/15 – 6/30/16 | 14 CBOs | HIV prevention services for racial/ethnic minorities, behavioral groups at greatest risk of HIV infection | Pre-infection; Diagnosis; Linkage to care |
| CDC to directly funded recipients (HIV Prevention) | Direct Funding to CBOs 15-1509 | Unknown | | | Prevention services for MSM of color living with or at risk for HIV | Pre-infection and all |
| CDC HIV Prevention funding to Los Angeles County | HIV Prevention Grant 12-1201 | Unknown | | | | |
| CDC HIV Prevention funding to San Francisco County | HIV Prevention Grant 12-1201 | Unknown | | | | |
| Local County General Funds | Local Funds for HIV activities | Unknown | FY 16-17 | Up to 59 counties | Testing, linkage to care, retention in care, viral suppression | Pre-Infection, and all |
| Private Sources | Grants | Unknown | FY 16-17 | Unknown | Research, testing, linkage to care, retention in care, viral suppression | Pre-Infection, and all |
| Various Private Insurance | No Set Amount. Ad Hoc basis dependent on billing for covered patients | Unknown | FY 16-17 | Throughout California | Core Medical Services | All |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| Medicare | Federal Funds. No set amount. Ad Hoc Basis dependent on billing for Eligible Patients | Unknown | FY 16-17 | Throughout California | Core Medical Services | All |

| Funder[c] to Grantee | Funding Title | Annual Funding Amount | Funding Period[d] | Number of Sub-grantees | Type of Services Delivered | Component of HIV Care Continuum |
|---|---|---|---|---|---|---|
| Acronym definitions:<br>ADAP: AIDS Drug Assistance Program<br>AETC: AIDS Education and Training Centers<br>AHP: Alliance Health Project<br>APLA: AIDS Project Los Angeles<br>CA: California<br>CAPS: Center for AIDS Prevention Studies<br>CA DHCS: California Department of Health Care Services<br>CA PTC: California STD/HIV Prevention Training Center<br>CBA: Capacity Building Assistance<br>CBOs: Community-Based Organizations<br>CDC: Centers for Disease Control and Prevention<br>CDE: California Department of Education<br>CHRP: California HIV Research Project<br>CMHS: Center for Mental Health Services<br>CPA: California Project Area (All of California except for the Los Angeles and San Francisco Eligible Metropolitan Areas)<br>CSAP: Center for Substance Abuse Prevention<br>CSAT: Center for Substance Abuse Treatment<br>DASH: Division of Adolescent School Health<br>EC: Emerging Communities<br>EMAs: Eligible Metropolitan Areas<br>ERF: Emergency Relief Funds<br>Family PACT: Family Planning, Access, Care and treatment<br>FFS: Fee for Service<br>FY: Fiscal Year<br>HD: Health Department<br>HHS: U.S. Department of Health and Human Services<br>HOPWA: Housing Opportunities for People with AIDS<br>HRSA/HAB: Health Resources and Services Administration / HIV/AIDS Bureau<br>HUD: U.S. Department of Housing and Urban Development<br>PLWH: People living with HIV<br>PrEP: Pre-exposure Prophylaxis<br>LHJs: Local Health Jurisdictions<br>LTC: Link To Care<br>MAI: Minority AIDS Initiative<br>OA: Office of AIDS<br>RCFCI: Residential Care for the Chronically Ill<br>RW: Ryan White HIV/AIDS Program<br>SAMHSA: Substance Abuse and Mental Health Services Administration<br>SF DPH: San Francisco Department of Public Health<br>SPNS: Special Projects of National Significance<br>TA: Technical Assistance<br>TGAs: Transitional Grant Areas<br>UCLA: University of California, Los Angeles<br>UCSF: University of California, San Francisco | | | | | | |

## Table 19: San Bernardino/Riverside Transitional Grant Area Financial Resources for HIV Surveillance, Prevention, Care, and Treatment

| Funder | Funding Source Name | Annual Funding Amount | Funding Period | Number of Service Provider Agencies Funded | Type of Services Delivered | Component of Care Continuum |
|---|---|---|---|---|---|---|
| CDC | OA Prevention Grant 12-1201 (Cat. A and Cat. B) | $1,709,054 | 1/1/15-12/31/15 | Category A: San Bernardino County, Riverside County, Desert AIDS Project<br><br>Category B: Riverside County; Health to Hope Clinic; Riverside Co. Ambulatory Care Division; Cardea | Testing, linkage to care, partner services, high impact prevention, condom, distribution. social marketing and media | Pre-Infection and All |
| CDC | OA Funding for 15-1506 | $585,016 | 9/30/15 - 9/29/16 | Desert AIDS Project | PrEP education, navigation, and support services | Pre-Infection |
| CA State General Fund | Surveillance | $507,233 | 7/1/15-6/30/16 | Riverside & San Bernardino Counties | Surveillance, monitoring, reporting, data to care | Pre-Infection and All |
| HRSA/HAB | RW Part B Base Award | $1,896,606 | FY 2015 | Riverside & San Bernardino Counties | Core medical services and support services | All |
| HRSA/HAB | RW Part B MAI Award | $105,940 | FY 2015 | Riverside & San Bernardino Counties | HIV services targeted to people of color | All |
| HUD | HOPWA | $1,977,833 | 7/1/14 – 6/30/15 | City of Riverside | Housing assistance and related support services | Retention/ Re-engagement, Viral Suppression |
| CA State General Funds FY 2015 | PrEP Navigator Funding | $369,024 | FY 2016-2017 | Desert AIDS Project | PrEP Education, Navigation and Support Services | Pre-Infection |

| | | | | | | |
|---|---|---|---|---|---|---|
| HRSA/HAB | RW Part A Award | $6,976,286 | FY 2015 | San Bernardino/Riverside TGA | 75% Medical Care 25% Support Services | All |
| HRSA/HAB | RW Part A Final Supplemental Award | | FY 2015 | | 75% Medical Care 25% Support Services | All |
| HRSA/HAB | RW Part A Final MAI Award | | FY 2015 | | HIV services targeted to people of color | All (specifically for people of color) |
| HRSA/HAB | RW Part C EIS Grant Awards | $478,221 | FY 2015 | San Bernardino County | Early Intervention Services | Diagnosis Linkage to Care |
| HRSA/HAB | RW Part F Community-based Dental Partnership Program | $298,848 | FY 2014 | Loma Linda University | Dental Services for PLWH | Viral Suppression |
| California General Funds to CA Office of Family Planning | Family PACT | *No set amount. Ad Hoc basis dependent on billing insurances such as Medi-Cal for services* | FY 16-17 | Clinics located throughout San Bernardino / Riverside TGA | Core Medical Services | All |
| Various Private Insurance | No Set Amount. Ad Hoc basis dependent on billing for covered patients | Unknown | FY 16-17 | Throughout San Bernardino / Riverside TGA | Core Medical Services | All |
| Medicare | Federal Funds. No set amount. Ad Hoc Basis dependent on billing for Eligible Patients | Unknown | FY 16-17 | Throughout San Bernardino / Riverside TGA | Core Medical Services | All |

| | | | | | | |
|---|---|---|---|---|---|---|
| Medi-Cal Managed Care | Federal Funds. No set amount. Ad Hoc Basis dependent on billing for Eligible Patients | Unknown | FY 16-17 | Throughout San Bernardino / Riverside TGA | Core Medical Services | All |

## Table 20: Sacramento Transitional Grant Area Financial Resources for HIV Surveillance, Prevention, Care, and Treatment

| Funder | Funding Source Name | Annual Funding Amount | Funding Period | Number of Service Provider Agencies Funded | Type of Services Delivered | Component of Care Continuum |
|---|---|---|---|---|---|---|
| CDC | OA Prevention Grant 12-1201 (Cat. A and Cat. B) | $618,880 | 1/1/15-12/31/15 | Sacramento County; Golden Rule Services; Harm Reduction Services; CARES FQHC | Testing, linkage to care, partner services, high impact prevention, condom, distribution. social marketing and media | Pre-Infection and All |
| CA State General Funds | Surveillance | $236,540 | 7/1/15-6/30/15 | El Dorado, Placer and Sacramento Counties | Surveillance, monitoring, reporting, data to care | Pre-Infection and All |
| HRSA/HAB | RW Part B Base Award | 1,288,683 | FY 2015 | CARES FQHC; Communicare health Center | Core medical services and support services | All |
| HRSA/HAB | RW Part B MAI Award | 84,621 | FY 2015 | Sacramento County | HIV services targeted to people of color | All |
| HUD | HOPWA | 904,530 | 0/1/14 – 12/31/2014 | City of Sacramento | Housing assistance and related support services | Retention/ Re-engagement, Viral Suppression |

| | | | | | | |
|---|---|---|---|---|---|---|
| California General Funds to CA Office of Family Planning | Family PACT | *No set amount. Ad Hoc basis dependent on billing insurances such as Medi-Cal for services* | FY 2015 | 2 rural county clinics | Core Medical Services | Retention/ Re-engagement, Viral Suppression |
| Other Federal | Various Sources | $289,000 | FY2015 | 2 rural county clinics | Core Medical Services | Retention/ Re-engagement, Viral Suppression |
| SAMHSA | Community Development Block Grant | $600,000 | FY2015 | 1 LHJ; 1 CBO | HIV Testing and Outreach | Pre-Infection and Linkage to Care |
| HRSA/HAB | RW Part A Award | $2,934,919 | FY 2015 | 1 Clinic; 7 CBOs | 75% Medical Care 25% Support Services | All |
| HRSA/HAB | RW Part A Final Supplemental Award | | FY 2015 | | 75% Medical Care 25% Support Services | All |
| HRSA/HAB | RW Part A Final MAI Award | | FY 2015 | | HIV services targeted to people of color | All (specifically for people of color) |
| HRSA/HAB | RW Part C EIS Grant Awards | $466,216 | FY 2016 | 1 Clinic | Early Intervention Services | Diagnosis Linkage to Care |
| HRSA/HAB | RW Part D Grant Awards | $356,000 | FY 2016 | 1 Clinic | Women, Infants, Children and Youth Coordinated HIV Services | All |
| Private Donations | Community Fundraising | $489,000 | FY 2015 | 9 CBOs | Testing and Outreach, Core Medical and Support Services | All |
| Cares Foundation | Private Foundation | $1.2 million | FY2015 | 10 CBOs | Testing and Outreach, Core Medical and Support Services | All |

| | | | | | | |
|---|---|---|---|---|---|---|
| Sacramento County DHHS | County General Fund | $250,000 | FY2016 | 1 Clinic | Core Medical and Support Services | Linked & Retained in Medical Care, prescribed ART, Viral Suppressio n |
| Various Private Insurance | No Set Amount. Ad Hoc basis dependent on billing for covered patients | $64,875 | FY 2015 | CARES FQHC | Core Medical Services | All |
| Medicare | Federal Funds. No set amount. Ad Hoc Basis dependent on billing for Eligible Patients | $437,944 | FY 2015 | CARES FQHC | Core Medical Services | All |
| Medi-Cal Managed Care | Federal Funds. No set amount. Ad Hoc Basis dependent on billing for Eligible Patients | $987,967 | FY 2015 | CARES FQHC | Core Medical Services | All |

## Table 21: San Jose Transitional Grant Area Financial Resources for HIV Surveillance, Prevention, Care, and Treatment

| Funder | Funding Source Name | Annual Funding Amount | Funding Period | Number of Service Provider Agencies Funded | Type of Services Delivered | Component of Care Continuum |
|---|---|---|---|---|---|---|
| HRSA | RW Part A | $2,389,87 680,000 | FY2015 | 5 Agencies | Core Medical Services | All |
| HRSA | RW Part A MAI | $176,200 | FY2015 | PACE Clinic | Core Medical Services for PLWH of Color | All |
| HRSA | Part B | $813,485 | FY2015 | 2 Agencies | Outreach, Linkage to Care | Linked to Medical Care, Viral Suppression |
| HRSA | Part B MAI | $50,327 | FY2015 | PACE Clinic | Outreach, | Linked & |

| Funder | Funding Source Name | Annual Funding Amount | Funding Period | Number of Service Provider Agencies Funded | Type of Services Delivered | Component of Care Continuum |
|---|---|---|---|---|---|---|
| | | | | | Linkage to Care for PLWH of Color | Retained in Care |
| HRSA- | RW Part C Outpatient EIS | $798,984 | CY2015 | PACE Clinic | Outreach, Testing, Medical case management | All |
| Santa Clara County | General Fund | $381,587 | 2015 | 3 Agencies | HIV Testing, Linked & Retained in Care | HIV diagnosis, Linked & Retained in Care |
| Santa Clara County | General Funds-Transitional Housing | $398,252 | 2015 | Health Trust | Linked & Retained in Care | Linked & Retained in Care |
| Santa Clara County | Prevention | $170,000 | 2015 | 2 Agencies | HIV Testing, Linked & Retained in Care | HIV diagnosis, Linked & Retained in Care |
| Santa Clara County | Mental Health-Intensive Case Management | $200,000 | 2015 | Health Trust | Intensive Case Management for the Chronically Homeless | Linked & Retained in Medical Care, Viral Suppression |
| California General Funds to CA Office of Family Planning | Family PACT | *No set amount. Ad Hoc basis dependent on billing insurances such as Medi-Cal for services* | 2015 | Foothill Community Health Center | HIV diagnosis; linkage to care | HIV diagnosis; linkage to care |
| Medi-Cal | *No set amount Ad Hoc basis dependent on billing insurances such as Medi-Cal for services* | | 2015 | Foothill Community Health Center | Linked & Retained in Care | Linked & Retained in Care |
| Medi-Cal Managed Care | Federal Funds. No set amount. Ad Hoc Basis dependent on billing for Eligible Patients | | 2015 | Throughout San Jose TGA | Core Medical Services | All |

| Funder | Funding Source Name | Annual Funding Amount | Funding Period | Number of Service Provider Agencies Funded | Type of Services Delivered | Component of Care Continuum |
|---|---|---|---|---|---|---|
| Part of STD State Grant | | $3,152 | 2015 | SCC-Positive Connections & Crane Center | HIV diagnosis, Linkage to care | HIV diagnosis, Linkage to care |
| State | Self-pay by court ordered clients | $15,033 | 2015 | SCC-Positive Connections & Crane Center | Pt. Education and Prevention | Pre-Infection |
| HUD-HOPWA-PSH | (Competitive grant) | $413,964 | 2015 | Health Trust | Rent subsidies and supportive services to help clients secure/maintain housing | Linked & Retained in Care |
| HUD-HOPWA (Formula grant) | (Formula grant) | $796,755 | 2015 | Health Trust | Permanent rental subsidies, supportive services and housing placement | Linked & Retained in Care |
| SAMSHA | Funding ends in September 2016 | | | HIV Intervention Project | Pt. Education and HIV Testing | HIV diagnoses, linked to care |
| SAMSHA | Center for Substance Abuse Prevention | $271,991 | FY2015 | Asian and Pacific Islanders for Sexual Health Awareness and Substance Abuse Prevention (Project ASAP). | Capacity building initiative project for substance abuse, HIV and viral hepatitis prevention for API young MSM (ages 18-24) | HIV testing, linked to care |
| Various Private Insurance | No Set Amount. Ad Hoc basis dependent on billing for covered patients | Unknown | FY 16-17 | Throughout Santa Clara | Core Medical Services | All |
| Medicare | Federal Funds. No | Unknown | FY 16-17 | Throughout Santa Clara | Core Medical Services | All |

| Funder | Funding Source Name | Annual Funding Amount | Funding Period | Number of Service Provider Agencies Funded | Type of Services Delivered | Component of Care Continuum |
|---|---|---|---|---|---|---|
| | set amount. Ad Hoc Basis dependent on billing for Eligible Patients | | | | | |

## HIV Workforce Capacity in California

The HIV workforce in California is comprised of clinical and nonclinical providers working in HIV specialty clinics, primary care clinics, hospitals, and private practice. In addition, there are non-clinical staff providing HIV support services within public health departments and community-based organizations. HIV specialty clinics include publically-funded specialty clinics such as Ryan White clinics; in addition, primary care clinics, including publically funded clinics such as Federally Qualified Health Centers (FQHCs), also screen and treat HIV patients. HIV clinical providers include physicians, advanced practice nurses, nurse practitioners, physician assistants, dentists, nurses, and pharmacists. Currently there is no comprehensive listing of HIV clinicians who treat persons living with HIV (PLWH). Professional organizations such as the American Academy of HIV Medicine (AAHIVM) and the HIV Medicine Association (HIVMA) have lists of HIV specialists who have been certified, joined the organization and agreed to have their named listed on the organizations' websites. The Health and Human Services Administration lists 352 California RW providers funded through the various RW Parts for 2013. They provided care to 55,578 Californian PLWH in 2013.[1] Table 22 summarizes the number of professionals trained by the Pacific AIDS Education and Training Center (PAETC) between 2010 and 2015. These lists represent only a portion of professionals currently working with PLWH.

## Pacific AIDS Education and Training Center

The purpose of the national AIDS Education and Training Centers (AETCs) is to conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV. The PAETC is one of eight regional centers that have provided HIV-related education and capacity building since 1987. The area PAETC serves includes California, Arizona, Nevada, Hawaii and the Pacific territories. AETCs also train non-clinician staff, such as substance abuse professionals, case managers, medical assistants, and patient navigators with the understanding that in a health care setting, many different roles are crucial to successfully treating PLWH. PAETC has also provided systems level support to clinics. This support includes assisting clinics to implement routine HIV testing policies, procedures and integration with Electronic Health Records (EHRs) as well as to implement protocols to increase HIV patient retention. PAETC maintains data on HIV care providers trained by PAETC in California. During 2010-2015, PAETC trained 11,499 clinicians and 8,865 non-clinical staff (Table 22). The racial/ethnic composition of PAETC trainees includes 30 percent

identifying as Latino/Hispanic[i], 17 percent identifying as African American, 12 percent identifying as Asian/Pacific Islander, and 54 percent identifying as White. The geographic distribution of clinicians who received training from PAETC and HIV-specialty clinicians who are members of the American Academy of HIV Medicine (AAHIVM) or the HIV Medicine Association (HIVMA) is shown in Figure 6.

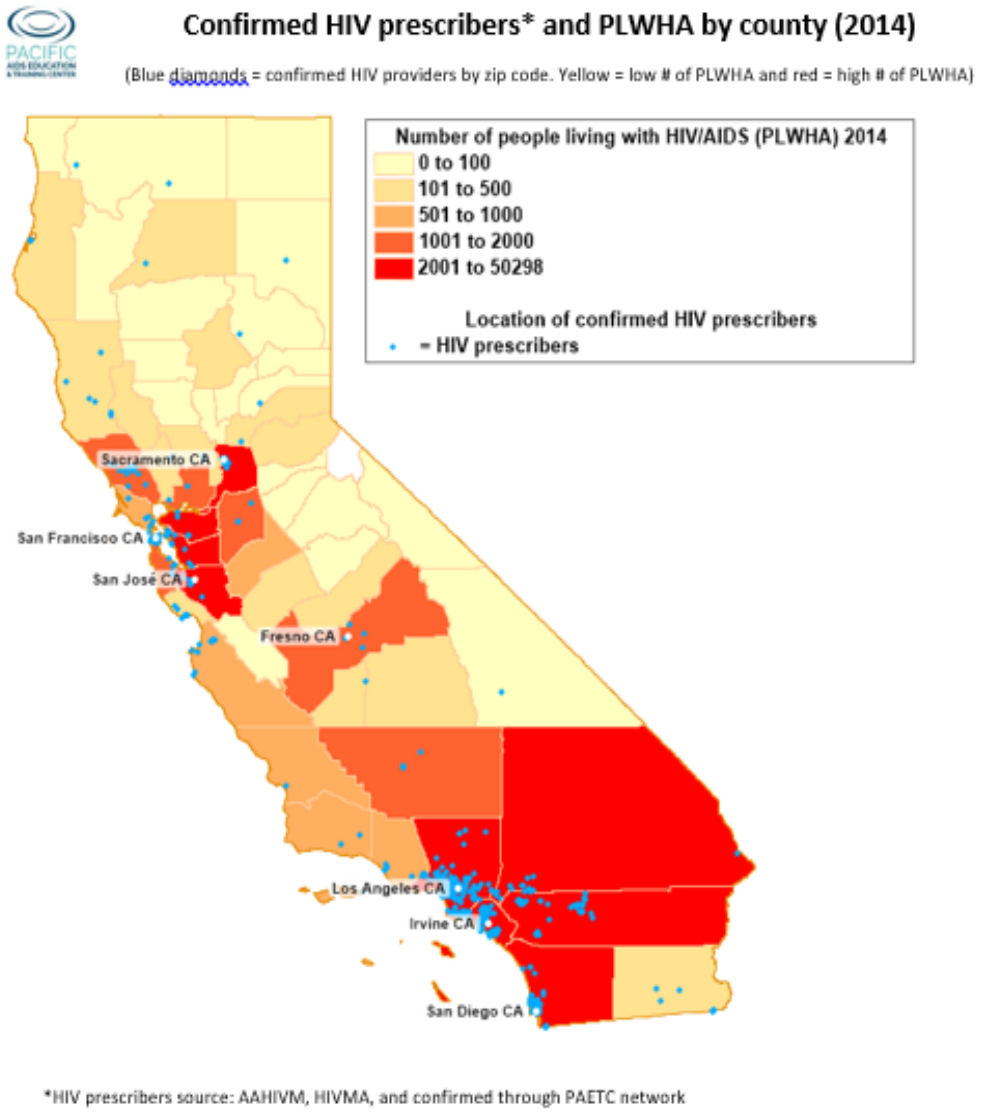
## Table 22. Clinicians and non-Clinicians Trained by the Pacific AIDS Education and Training Center, 2010 – 2015

| Professions | No. trained (2014-2015) | No. trained (2010-2015) |
|---|---|---|
| ***Clinicians*** | | |
| Physician | 848 | 4,571 |
| Nurse | 692 | 3,761 |
| Pharmacist | 184 | 927 |
| Advanced Practice Nurse (APN)* | 179 | 738 |
| Dentist | 155 | 953 |
| Physician Assistant (PA) | 85 | 549 |
| **Total Clinicians** | ***2,143*** | ***11,499*** |
| | | |
| ***Non-Clinicians**** | | |
| Social worker | 334 | 1,361 |
| Health educator | 253 | 980 |
| Mental health professional | 243 | 961 |
| Other public health professional | 232 | 1010 |
| Community health worker | 134 | 572 |
| Substance abuse professional | 131 | 619 |
| Other dental professional | 96 | 649 |
| **Total Non-Clinicians** | ***2,047*** | ***8,865*** |
| **TOTAL trained** | ***4,190*** | ***20,364*** |

*APN category includes Nurse Practitioners

**Excludes categories with less than 20 participants and those marked "other"

## Figure 6. Geographic distribution of People Living with HIV and HIV-specialty Clinicians — California[j]



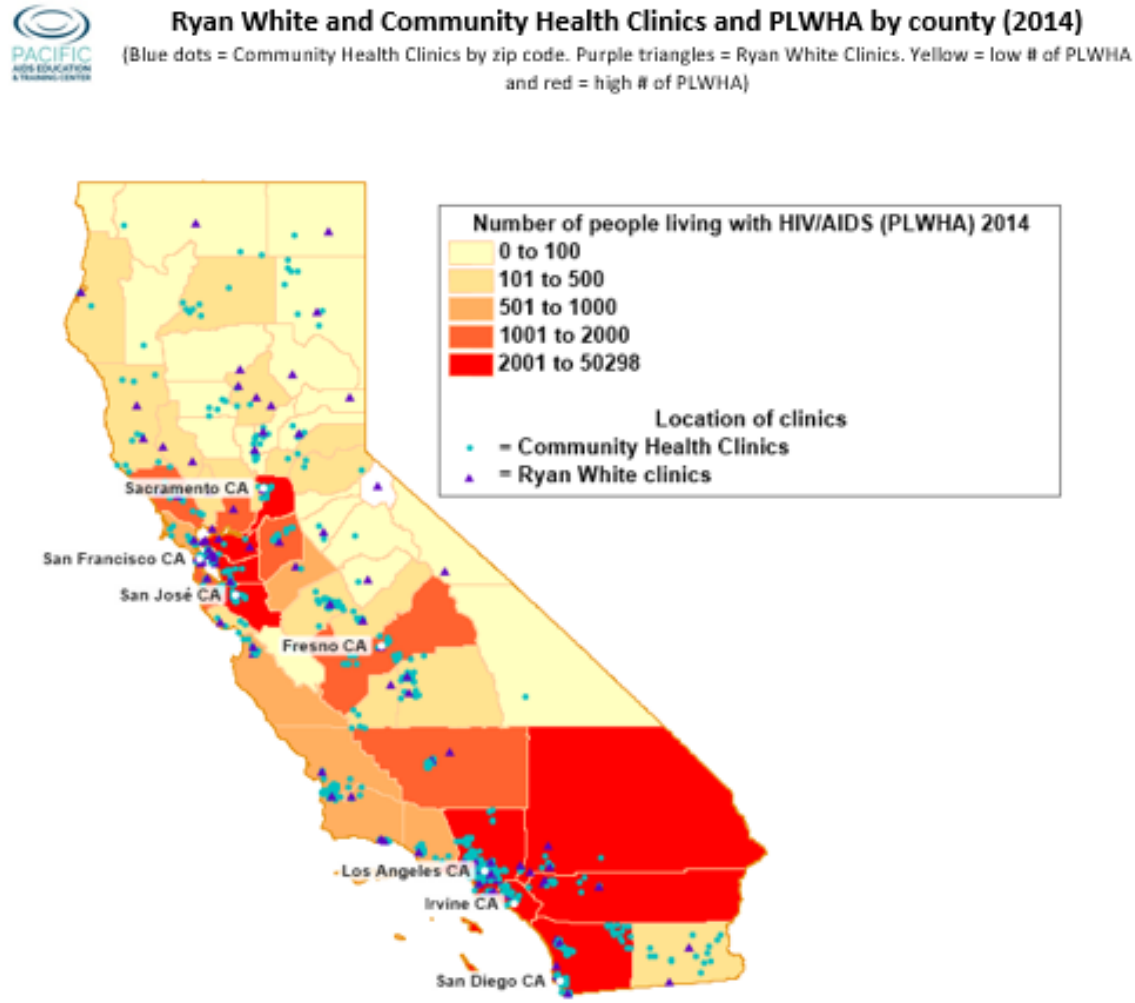

## Ryan White HIV Care Clinics

There are 226 Ryan White-funded sites in California, which provide HIV care for almost 45 percent of PLWH in California. Ryan White clinics have been shown to provide superior care to PLWH with viral suppression at 54.7 percent, compared to 53 percent for California as a whole in 2013.[1,2] Additionally, Community Health Clinics, which include Federally Qualified Health Centers (FQHC) and FQHC look-alikes, are another source of care for many PLWH and other at risk populations. Between the 176 California health centers, 4,065,289 patients were provided service in 2015, of whom 28,460 were HIV-positive.[3] The geographic distribution of Ryan White clinics and

[j] Confirmed providers were cross matched to two HIV credentialing organizations.

Community Health Centers in California generally correlates well with the distribution of PLWH throughout the State. (Figure 7)

### Figure 7. Geographic Distribution of People Living with HIV in 2014 and Ryan White and Community Health Clinics




## HIV Workforce Capacity in Local Jurisdictions

### Sacramento

While the Sacramento TGA has several FQHCs, many do not have HIV specialists. Cares Community Health, a newly designated FQHC and Ryan White Ambulatory Care Clinic, and the Kaiser Permanente health system provide comprehensive HIV specialty care to the vast majority of PLWH in the Sacramento area. University of California Davis Pediatric Infectious Disease, also a Ryan White clinic, provides pediatric specialty care to infants, children, and teenagers living with HIV. There are only a small number of Infectious Disease specialists in other Sacramento health systems and a few primary care providers in the rural counties of Placer and El Dorado who provide care to PLWH.

In addition to hospitals and private labs, the TGA has numerous HIV testing, education and prevention sites with staff certified to conduct HIV testing. Cares Community Health (Cares) conducts HIV testing. Cares has entered into cooperative agreements with the Sierra Foothills AIDS Foundation (SFAF) to provide testing kits for the TGA's rural counties, and the SFAF has obtained private funding for testing staff.

### San Jose

The San Jose TGA is fortunate to have three major hospitals that provide comprehensive HIV specialty care including Valley Medical Center's Partners in AIDS Care & Education (PACE) Clinic, Stanford's Positive Care Clinic and the Kaiser Santa Clara's HIV/AIDS Resource Center (HARC). In addition, there are nine FQHCs representing 48 various clinics. Within the TGA, there is a wide number of both rural and urban areas to serve. The largest concentration of consumers of HIV/AIDS services are in the urban areas.

The workforce pool in this TGA includes case managers and licensed professionals such as physicians (including psychiatrists), physician assistants, nurse practitioners, nurses, psychologists, dentists, registered dieticians, and social workers. In addition, there are paraprofessionals including direct care providers such as medical assistants, nurse assistants, patient care technicians, drug and alcohol counselors, and health educators.

There are also trained community workers/health educators who function as liaisons between health care and prevention services.

In addition to HIV care, the San Jose TGA has numerous HIV testing, education and prevention sites including the Public Health Department (routine opt-out HIV testing), local gay community center and bathhouse (targeted testing) as well as the needle exchange van (targeted mobile testing). HIV testing is also administered at annual events such as Gay Pride and National HIV Testing Day. Testing sites are equipped to refer and link clients to the appropriate services needed.

The Santa Clara County STD/HIV AIDS Program (SHAP) also provides trainings, TA, and capacity building for providers in the TGA, with some of their resources through the CDPH Office of AIDS as needed. These trainings, technical assistance and capacity building are on-going and are provided when needed.

## Resource and Funding Interaction

Assurance of continuity of HIV prevention, care, and treatment services is conducted by LHJs and OA which combine and coordinate funding from various sources to support overall HIV prevention, care and treatment program and the implementation of the Integrated Plan. The OA monitors Ryan White Part B funding through various mechanisms, including matching with Medi-Cal data, and ensures that it is the funder of last resort. It collaborates with DHCS, other state partners, and LHJs to ensure that prevention, care and treatment funding is meeting the needs of PLWH and at high-risk

of HIV infection effectively. This work is conducted through routine reports to the California and local planning groups and routine contract monitoring activities.

Due to variations at the local level, each LHJ is encouraged to ensure they are using their funding creatively to respond to the prevention and care needs of their local care continuum. For example, some smaller LHJs are doing less targeted HIV testing and placing their resources into partner services, where identification of new cases of HIV infection is more effective. Others are investing more in collaboration between their local epidemiologists and public health staff to monitor laboratory results indicating a client has not been in care, in order that staff can help find and re-engage the client to care. Funding from Care (MAI or EIS) and Prevention is being used to ensure early intervention services, linkage, and re-engagement services are available to all PLWH. Developing relationships between CBO staff and FQHCs or other medical clinics is increasing the collaboration to ensure people remain in care or return to care as quickly as possible. The joint care and prevention membership on the California HIV Planning Group also promotes collaboration and creative blending of resources to ensure HIV programming addresses all points on the continuum, beginning with pre-continuum prevention work with high-risk negatives.

### Sacramento Transitional Grant Area

The RW Program and the Sacramento County HIV/STD Prevention Program operate under the same division of the health department, working cooperatively to integrate prevention, care and treatment for persons living with, or at risk for, HIV/AIDS. Both programs have worked closely with community planning bodies to develop the RW Program's Early Identification of Individuals with HIV/AIDS (EIIHA) goals and objectives. In 2016, Cares Community Health expanded its prevention efforts by launching a *ZERO New HIV Infections TOGETHER* Initiative to reach the TGA's underserved populations with the goal to end new HIV cases, reduce disparities experienced by the mentally ill and help those without insurance to obtain it and live healthier lives. This integration of prevention and care planning is a cornerstone in the TGA's efforts to address the Continuum of Care for HIV/AIDS for all populations. With the RW CARE Program operating as Fiscal Agent for both Part A and B funding, all services, plans and strategies are coordinated.

In 2010, the Prevention and Care planning bodies were consolidated and now operate under the RW HIV Health Services Planning Council. The Council analyzes other funding sources to ensure that allocation of RW Part A funds are provided as a last resort. Members of the Council represent other publicly funded service programs, in addition to other RW Programs besides Part A (for example, Parts B, C, and D), to provide the Council with ongoing information on availability of, and changes to, existing services and funding sources. Strong collaborations with these providers enhance efforts to expand service availability; to identify service gaps not funded by other sources; to reduce duplication of service; and to ensure that RW CARE Act funds are the payer of last resort.

During this last year, the TGA experienced further efforts to integrate prevention and care planning at the local level when the Sacramento County Division of Public Health

merged its Ryan White, STD, HIV Prevention and Testing and Surveillance Programs. The merger of these units has enhanced the TGA's efforts to identify HIV+ individuals and to provide risk reduction counseling to those at risk of contracting HIV. All Communicable Disease and STD Investigators with Sacramento County Public Health have been cross trained to determine both the HIV and STD status of anyone who has tested positive for either an HIV or STD reportable condition. With the merger, an STD/HIV Stakeholder Group, now known as the Sacramento Workgroup to Improve Sexual Health (Sac WISH) was developed with the goal of intensifying the TGA's HIV and STD prevention, testing and treatment efforts. These community groups share resources, data and technical assistance in order to further the goals of the community to end new cases of HIV/STDS and reach the TGA's underserved populations. Representatives of these initiatives participate from the neighboring counties of Yolo, El Dorado and Placer as well, enhancing the efforts to provide a regional impact.

### San Jose Transitional Grant Area

*STD/HIV Prevention & Control Program* is the designated Ryan White Part A HIV/AIDS Program Administrative Agent for the TGA, and is ideally placed to facilitate and affirmatively assure coordination of HIV services and funding streams, and to ensure that the HIV Planning Council's priority setting and resource allocation process and comprehensive planning activities are well informed. STD/HIV Prevention & Control is also the sub-grantee for the Part B funds awarded to the County, and sub grantee for CDC Prevention funds awarded to the County for HIV prevention and STD prevention, which provides for seamless coordination and eliminates duplication within these funding streams. In addition, STD/HIV Prevention & Control, a program within the Public Health Department's Center for Infectious Disease, is a part of the County's comprehensive health services network, which provides for active coordination with Ryan White Part C funded services in the TGA, as well as with other federal, state and local funding streams administered by the County. STD/HIV Prevention & Control and all Ryan White HIV/AIDS Program service providers (funded under Parts A, B and C) meet on a regular basis to address and resolve issues, enhance service access, provide technical assistance, and promote consistent adherence to payer of last resort requirements.

To further enhance coordination of services, STD/HIV Prevention & Control established the *Systems of Care Roundtable* in 2009. Through the Roundtable, HIV care, support and prevention service providers throughout the TGA are able to exchange information on their services, identify and share best practices and issues of concern, and work collaboratively to maximize the number and accessibility of services, bring PLWH/A into care, and address unmet needs. The HIV Planning Council develops its priorities based on local surveillance, epidemiology trends, demographic data, needs assessments and a framework that considers over-met, met, under-met, and unmet needs. Within this process, the HIV Planning Council also considers data from other federally funded HIV/AIDS programs, including Medicaid, HOPWA, VA and others, as well as the current and anticipated availability of federal funding for those programs and services to PLWH/A in the TGA. This information is used, in concert with data from state and locally funded programs/services, to formulate allocations consistent with the HIV Planning Council's priorities. A table detailing the expected availability of public funding for

HIV/AIDS related care services in the San José, CA TGA from other Ryan White HIV/AIDS Program parts, federal, state and local sources in FY 2015, as well as anticipated funding for the FY 2016 budget period, is provided in the table below.

Coordination of services and funding streams has become a mainstay in producing the efficiencies necessary to both maintain existing services and create capacity within existing resources in order to bring additional PLWH/A into care. As one part of the TGA's planning efforts, STD/HIV Prevention & Control routinely performs an inventory and environmental scan of funding sources supporting the needs of PLWH/A in the TGA, including funding streams primarily or exclusively serving PLWH/A (e.g., HOPWA, other Ryan White parts, and CDC Prevention) as well as funding streams that serve PLWH/A as part of a broader population (e.g., Medicaid/MediCal; Medicare; CHIP/SCHIP; Veterans' Affairs; WIC; other state and local social service programs; SNAP/California Food Assistance Program; local, state and federal public health programs; and local and federal funds for substance abuse/mental health treatment). Included within the environmental scan is an analysis of relevant factors that may influence the future availability or proportional mix of funding from federal, state and local sources, such as implementation of health care reform programs and externally established goals, objectives and/or directives.

The HIV Planning Council uses the inventory and environmental scan in its annual assessment of the current and anticipated needs and resources available in all Part A service categories, and identification of key gaps in the HIV care continuum. In addition, the HIV Planning Council includes representatives from community agencies and providers of a range of services funded by multiple payer sources, which brings broad expertise on the array of payment sources for HIV-related services to the planning process, and assists the Council in maximizing the coordination of its Part A program allocations with existing services.

## Narrative Description of Needed Resources and Services

Discussion of needed resources and services is included in each of the subject briefs in Section 6.0 (page 66), Section 6.1(page 66), and Section 6.2 (page 90). Additionally needed resources and services identified by the Part A Transitional Grant Area co-authors can be found in the "Additional Information from Co-Authors" brief in Section 6.12 (page 112). The subject briefs contained in Section 6.3 through Section 6.11 will be released as separate documents when they are completed.

## References

1. HRSA. Ryan White HIV/AIDS Program State Profiles. 2016; http://hab.hrsa.gov/stateprofiles/Client-Characteristics.aspx Accessed 07/21/6016.
2. California Department of Health OoA. California Continnum of HIV Care - 2013. 2013:7.
3. HRSA. 2015 Health Center Data: California PRogram Grantee Data. 2016; Program Grantee Data for 2015. Available at:

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# 6.0 Assessing Needs, Gaps, and Barriers

Based on input from stakeholders and subject matter experts, twelve priority areas were selected for assessment in this edition of the California Needs Assessment. The priority areas are organized into area-specific briefs as follows:

6.1 Routine opt-out HIV testing in healthcare settings
6.2 Pre-Exposure Prophylaxis (PrEP)
6.3 Linkage to care for persons newly diagnosed with HIV
6.4 Partner services to support PLWH informing sex and needle sharing partners of potential exposure to HIV
6.5 Case management (including medical case management, non-medical case management, benefits counseling, patient navigation, and other similar patient support activities)
6.6 Housing
6.7 Mental health care and treatment
6.8 Substance abuse care and treatment
6.9 Quality of HIV medical care including attaining viral suppression, use of appropriate anti-retroviral therapy, and implementation of recommended sexually transmitted infection (STI) testing practices.
6.10 Retention in care
6.11 Re-engagement in care
6.12 Additional local needs, gaps, and barriers

Each priority area is covered in a separate section, and each section contains information on that specific priority area relative to the state of that particular service or activity in California as a whole, at the local health jurisdiction level, and among the priority sub-populations. There is also a discussion of data gaps and limitations, service and program gaps, resources available and needed, and barriers. Recommendations developed from these analyses were included in the Integrated Plan strategies and activities.

At this time, only the routine opt-out HIV testing and PrEP sections are included. The other sections are still under development and will be released individually as they are finalized.

Additional local information on needs, gaps, and barriers is located in Section 6.12.

# 6.1 Routine Opt-out HIV Testing

## Contents



## Background

In 2014, approximately one in every eleven Californians (9.1 percent) living with HIV infection were unaware of their HIV status.[1,k] Performing routine opt-out HIV testing (also called routine opt-out HIV screening, routine HIV testing or expanded HIV testing/screening) can reduce this fraction. Studies attribute early identification of HIV infection and greater awareness of HIV serostatus to decreasing the rate of new infections by up to 50 percent, increased quality of life years for PLWH, and gains in cost-savings from the number of new infections averted.[2-4] When people know their HIV status, then people living with HIV (PLWH) can be provided HIV care, treatment and prevention services that will lead to better personal health outcomes and decrease the risk of further HIV transmission, and people who are HIV negative and at risk for HIV can receive effective HIV prevention interventions, such as pre-exposure prophylaxis (PrEP). Routine opt-out HIV testing occurs as a part of a medical care visit. The clinician informs the patient that an HIV test will be performed as a routine part of the medical visit and, unless the patient declines, an HIV test is ordered.[5] The U.S. Preventive Services Task Force (USPSTF) has recommended routine opt-out HIV testing for all adults aged 15-65 years and determined there is a high certainty that the net benefit is substantial (a Grade “A” recommendation).[6,7] Similarly, the 2006 Revised

[k] In 2014, there were an estimated 138,879 Californians infected with HIV, of which 12,638 persons were unaware of their HIV infection.

Recommendations of the Centers for Disease Control and Prevention recommends routine opt-out HIV testing for adults, pregnant women, and adolescents.[8] In studies of emergency departments conducting routine opt-out HIV testing, more new HIV infections were identified than by targeted testing alone and it was shown to be cost-effective.[9-12,l] Additionally, in one setting where routine opt-out HIV testing was already well-established, disruptions to its implementation resulted in missed diagnoses.[13]

During 2011-2014, CDC and CDPH OA funded the Category B Expanded HIV Testing for Disproportionately Affected Populations Program, which supported 10 grantees having an approximate total of 46 testing locations in the state. The goal of the program was to identify Californians who were unaware of their HIV-positive status and who were unlikely to access targeted testing venues.[14] At these sites, which included urban and rural areas, emergency departments, local jails and Community Health Centers, approximately 76,000 tests were conducted during calendar year 2014.[15] The percentage of tests that led to a new diagnosis was 0.096 percent.[15] Testing volume differed by the type of healthcare setting, with CHCs administering the bulk of tests (86 percent).[15] Other results from the Category B Expanded HIV Testing for Disproportionately Affected Populations Program showed the frequency of newly identified infections (positivity rate) was higher among persons identifying as transgender compared to other genders.[15] The positivity rate was also higher among African Americans compared to other race/ethnicity categories.[15] The results suggest that routine opt-out HIV testing in California reaches populations disproportionately impacted by HIV and people that would not have been served by targeted testing alone.

### What Is the Need for Routine Opt-out HIV Testing in California?

According to the United States Census, there were between 26.2 to 28.3 million Californians aged 15-65 years in 2014 (the most current year available).[16] Based on the USPSTF recommendation, all of these individuals should receive an HIV test at least once in their lives.

### What Is the State of Routine Opt-out HIV Testing in California?

The Patient Protection and Affordable Care Act of 2010 made routine, opt-out HIV testing and other preventive health services available at no-cost to insured Californians by requiring health insurance plans to cover 100 percent of USPSTF A and B recommendations.[5,8,17-19] Medicare also covers routine opt-out HIV testing.[20] Among insured adults in California, more than 75 percent had a regular place of care in 2014 and, consequently, have access to routine opt-out HIV testing .[21]

Under California law, since January 1, 2014, primary care clinics have been required to offer HIV testing to each patient undergoing a blood draw who meets the criteria to be screened under the USPSTF recommendations. Clinics are exempt from this law if the

[l] CDC Revised Recommendations of 2006 defined targeted testing as performing an HIV test for subpopulations of persons at higher risk, typically defined on the basis of behavior, clinical, or demographic characteristics.

patient had been previously offered and declined the test within the past 12 months (Health and Safety Code (HSC) 120991 (a)).[22]

Additionally, minors 12 years and older may consent to medical care related to the diagnosis and treatment of reportable infectious diseases (including STDs). As of January 1, 2012, minors may also consent to medical care related to the prevention of a sexually transmitted disease (Family Code 6926). Parental knowledge and consent are not required.[23] For minors accessing medical services through parental health insurance plans, adolescents can request that the insurance Explanations of Benefits not be mailed to their parents, decreasing the likelihood of disclosing their use of medical services (Civil Code 56.107).

Medical providers and laboratories are not required to report rates of HIV testing, making efforts to determine its level of adoption and rates of new infections identified through routine opt-out HIV testing challenging. To estimate these levels for California, data were obtained from a variety of sources including national and California-specific surveys, peer-reviewed scientific journal articles, and reports issued from state and federal governments, and research institutions.

Implementation of routine opt-out HIV testing varies by age and race/ethnicity. According to the 2014 CDC Behavioral Risk Factor Surveillance System (BRFSS), among Californian adult residents, less than 41 percent reported having had an HIV test in their lifetime, with the lowest level occurring in adults, aged 65 years and up (19.1 percent), and the highest level in adults, aged 25-44 years. African Americans had the highest levels of HIV testing uptake while non-Hispanic whites and non-Hispanic others showed the lowest levels of HIV testing uptake (Table 23).[24] The most recent 2014 California Health Interview Survey (CHIS) shows that among adults under 70 years with at least two sexual partners in the past year and adult men who are gay or bisexual, testing uptake was higher (70.6 percent, CI: 64.8 percent - 76.3 percent).[21]

### Table 23. Percentage of Adults Reporting Ever Being Tested for HIV by Age Group, California, 2014

| Age group | Percent | Lower CI | Upper CI |
|---|---|---|---|
| Overall | 40.5 | 39.0 | 42.1 |
| 18-24 | 28.7 | 24.5 | 32.9 |
| 25-34 | 54.7 | 50.9 | 58.5 |
| 35-44 | 56.1 | 52.1 | 60.0 |
| 45-54 | 47.4 | 43.7 | 51.2 |
| 55-64 | 34.6 | 31.2 | 38.0 |
| 65+ | 19.1 | 16.8 | 21.4 |
| **Race/ethnicity** | | | |
| White, non-Hispanic | 39.8 | 37.8 | 41.7 |
| Black, non-Hispanic | 59.5 | 53.1 | 65.9 |
| Hispanic | 42.3 | 39.4 | 45.1 |
| Other, non-Hispanic | 31.0 | 26.1 | 35.8 |
| Multiracial, non-Hispanic | 50.3 | 40.5 | 60.1 |
| Source: Behavioral Risk Factor Surveillance System (BRFSS) | | | |

The Family Planning, Access, Care, and Treatment program (Family PACT) is a funding source administered by the California Department of Health Care Services, Office of Family Planning for community-based clinics and community providers to support reproductive health care services. During fiscal year 2012-2013, it served 2.8 million clients; eighty percent of clients reported a family income below 100 percent of the Federal Poverty Level and 77 percent of clients were under 35 years of age. The majority of clients were women (85 percent).[25] The majority (64 percent) of clients was Latino, 20 percent were white, seven percent were African American, seven percent were Asian or Pacific Islander, and three percent were other racial/ethnic groups.

Family PACT can reimburse for providing a patient an HIV test in the context of a family planning visit. Thirty-two percent of female Family PACT patients were tested for HIV compared to 67 percent of male patients. Among women, HIV testing was highest among African American patients (40 percent) and lowest among white patients (25 percent).[25]

Numerous studies examining the impact of electronic medical records (EMR) technology on routine HIV testing have found that EMR leads to multiple fold increases in testing and high rates of patient acceptance of testing, especially with rapid HIV testing methods.[26-31] Health information technology (HIT) improvement funds are supporting the implementation of EMR and streamlined laboratory ordering systems.[32] As of December 2015, 89 percent of hospitals and 54 percent of office-based physicians had demonstrated meaningful use of certified health IT in California.[33,34] Numerous studies examining the impact of EMR technology on routine opt-out HIV testing have found that EMR leads to multiple fold increases in testing and high rates of patient acceptance of testing, especially with rapid HIV testing methods.[26-31]

## Local Jurisdictions

The minimum number of Californians who should receive routine opt-out HIV testing (aged 15-65 years) by selected local health jurisdictions is shown in Table 24. These estimates do not include persons aged 65 years (American Community Survey (ACS) data were not available for this age group). Thus, the local need for routine opt-out HIV testing is expected to be larger than that shown in Table 24. Detailed breakdowns by race/ethnicity for these jurisdictions are available in Table 25 – 27.

### Table 24. Minimum Number of Persons Who Are Eligible for Routine Opt-out HIV Testing by Selected TGAs, California, 2014[1]

| Transitional Grant Area (TGA) | County | Persons aged 15 - 64 years |
|---|---|---|
| Inland Empire | Riverside County | 1,517,276 |
| | San Bernardino County | 1,419,484 |
| Sacramento | El Dorado County | 119,637 |
| | Placer County | 236,090 |
| | Sacramento County | 991,437 |
| San Jose | Santa Clara County | 1,293,851 |
| [1]ACS Data: Population estimates for persons aged 65 years and margins of error for the one-year, 2014, ACS estimates were not available as of 16 August, 2016. | | |
| Source: California, American Community Survey (ACS) | | |

## Riverside and San Bernardino Transitional Grant Area (Riverside and San Bernardino Counties)

Riverside County HIV/STD Program worked with the county-run Family Care Centers to develop a routine HIV testing policy that included a standing order for testing.[m] This policy was adopted by the clinics in 2013. The HIV/STD program is currently working with three of the ten clinics to provide focused support and technical assistance to improve their testing rates. Riverside County HIV/STD Program is also working with the Health to Hope clinics (two fixed sites and a mobile medical unit) to build their capacity to provide routine HIV testing to their clients. They serve disenfranchised individuals throughout the County. In addition, Riverside County HIV/STD Program provides support and information to private providers requesting information on routine HIV testing.

Get Tested Coachella Valley (GTCV) is a three (3) year region-wide public health campaign initiative launched in 2014. GTCV is dedicated to dramatically reducing HIV by making voluntary HIV testing a standard in routine medical practice and ensuring linkage to care. The initiative encourages all adolescents and adults in the Coachella Valley to ask their healthcare provider for an HIV test — or get a free, confidential HIV test at events and community locations throughout the Coachella Valley: HIV Test

[m] The county-run Family Care Centers are funded by Family PACT.

Bermuda Dunes, HIV Test Cathedral City, HIV Test Coachella, HIV Test Desert Hot Springs, HIV Test Indian Wells, HIV Test Indio, HIV Test La Quinta, HIV Test Mecca, HIV Test Palm Desert, HIV Test Palm Springs, HIV Test Rancho Mirage, HIV Test Thermal, and HIV Test Thousand Palms. GTCV community partners include the Riverside County Department of Public Health; major regional hospitals; local medical clinics, doctors and pharmacies; leaders of community- and faith-based organizations, local government, educational institutions, businesses, foundations; and caring individuals. By 2015, GTCV clinical testing increased to 32 medical offices and 124 medical providers, all of whom committed to making voluntary HIV testing a routine standard of care for all patients. Data collection from the program is ongoing. An evaluation upon the completion of the program is scheduled for 2017. The program findings will become available then.[35]

Routine, opt-out HIV testing has been the standard within the San Bernardino County Department of Public Health Clinics and Federally Qualified Health Centers (FQHC) for many years.

### Sacramento Transitional Grant Area (El Dorado, Placer, and Sacramento Counties)

Sacramento Transitional Grant Area has the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan, which continues through fiscal year 2016. The plan includes supporting increased availability of testing through non-publically funded providers in cooperation with Cares Community Health.

### San Jose Transitional Grant Area (Santa Clara County)

Routine opt-out HIV testing is implemented at 48 sites within nine local FQHCs. Santa Clara County is in the planning process for the Getting to Zero Call to Action. A focus area is routine opt-out testing which would include the following expected outcomes: reduce barriers to HIV status awareness, increase the number of providers able to effectively screen for and address STDs and HIV, and reduce the transmission of HIV and other STDs through early diagnosis and treatment.

The Santa Clara County STD/HIV AIDS Program collaborates with many agencies in the community to provide consistent and broad messaging around HIV prevention. This includes the, “HIV Test? I’m on it” campaign a novel HIV testing campaign targeting Latino men who have sex with men (MSM), African American MSM, and African American women and the “GYT (Get Yourself Tested)”, a national, youth-focused STD testing campaign that promoted STD testing. Together, these campaigns have helped connect Santa Clara County residents to STD and HIV testing services.

Many providers indicated that they provide HIV testing. While this is true, it appears that they are providing risk based or patient requested testing. They are not providing the Centers for Disease Control and Prevention and the United States Preventive Services Task Force recommended routine opt-out HIV screening to everyone aged 15-65 years. A push for integrated, routine opt-out HIV screening in all primary care settings is

needed. This requires enhanced electronic infrastructure and staff education. The San Jose TGA has collaborated with HIV/AIDS care and prevention stakeholders to identify priority areas for the Getting to Zero initiative. Universal HIV testing has been identified as a priority area.

Special attention should be given to the San Jose TGA's Asian population, to encourage routine opt-out HIV testing. As of 2014, the Asian and/or Pacific Islander communities made up 10 percent of PLWH in Santa Clara County (Table 12) compared to 3.8 percent in California (Table 2). Furthermore, with respect to newly diagnosed PLWH, 16 percent diagnosed in the San Jose TGA were Asian and/or Pacific Islander (Table 13) compared to 7 percent statewide (Table 4).

## Table 25. Estimated Number of Persons, Aged 15 – 64 Years, Who Are Eligible and in Need of an HIV Test by Race/Ethnicity, Riverside and San Bernardino Counties, California, 2006 – 2010

| County | Race/Ethnicity | Eligible Persons (N) | Persons Needing an HIV Test (N) | Lower CI | Upper CI |
|---|---|---|---|---|---|
| Riverside County | Total | 1,363,934 | 846,719 | 843,387 | 850,050 |
| | American Indian/Alaska Native alone | 13,979 | 8,728 | 7,832 | 9,623 |
| | Asian alone | 87,005 | 53,404 | 52,182 | 54,627 |
| | Black/African American alone | 89,825 | 56,075 | 54,727 | 57,421 |
| | Hispanic/Latino (of any race) | 597,009 | 374,342 | 372,392 | 376,291 |
| | Native Hawaiian/Other Pacific Islander alone | 4,670 | 2,896 | 2,418 | 3,374 |
| | Some other race alone | 252,628 | 157,808 | 154,404 | 161,212 |
| | Two or more races | 42,397 | 27,357 | 25,679 | 29,036 |
| | White alone | 873,430 | 540,452 | 536,282 | 544,623 |
| San Bernardino County | Total | 1,344,756 | 835,581 | 832,216 | 838,946 |
| | American Indian/Alaska Native alone | 14,183 | 8,820 | 7,968 | 9,672 |
| | Asian alone | 89,144 | 54,737 | 53,590 | 55,884 |
| | Black/African American alone | 121,831 | 76,399 | 74,947 | 77,852 |
| | Hispanic/Latino (of any race) | 620,753 | 389,123 | 386,997 | 391,248 |
| | Native Hawaiian/Other Pacific Islander alone | 4,244 | 2,641 | 2,115 | 3,166 |
| | Some other race alone | 251,722 | 157,295 | 153,756 | 160,832 |
| | Two or more races | 45,461 | 28,980 | 27,342 | 30,617 |
| | White alone | 818,171 | 506,711 | 502,385 | 511,036 |

The table is based on the USPSTF recommendation that persons aged 15 - 65 years receive an HIV test. American Community Survey (ACS) population estimates for persons aged 65 years were not available.

Sources: Population estimates and 95% confidence intervals (CIs) are from ACS 2006-2010. The adolescent fraction that responded "no or not sure" to ever receiving an HIV test is from YRBSS 2015. The adult fraction that responded "no" to ever receiving an HIV test is from BRFSS 2014. The CI corresponding to each age group was multiplied by the corresponding fraction from YRBSS or BRFSS and the products summed to obtain an upper and lower CI for ages 15 - 64 years. All data sources were limited to California.

**Table 26. Estimated Number of Persons, Aged 15 – 64 years, Who Are Eligible and in Need of an HIV Test by Race/Ethnicity, Sacramento Transitional Grant Area (El Dorado, Placer, and Sacramento Counties), California, 2006 - 2010**

| County | Race/Ethnicity | Eligible Persons (N) | Persons Needing an HIV Test (N) | Lower CI | Upper CI |
|---|---|---|---|---|---|
| El Dorado County | Total | 120,903 | 74,629 | 73,480 | 75,780 |
| | American Indian/Alaska Native alone | 1,330 | 819 | 445 | 1,194 |
| | Asian alone | 4,199 | 2,585 | 2,260 | 2,911 |
| | Hispanic/Latino (any race) | 13,107 | 8,177 | 7,874 | 8,481 |
| | Some other race alone | 4,389 | 2,749 | 2,287 | 3,209 |
| | Two or more races | 3,337 | 2,108 | 1,640 | 2,576 |
| | White alone | 106,621 | 65,743 | 64,681 | 66,803 |
| Placer County | Total | 218,547 | 134,928 | 133,571 | 136,283 |
| | American Indian/Alaska Native alone | 2,109 | 1,299 | 947 | 1,650 |
| | Asian alone | 13,358 | 8,204 | 7,783 | 8,626 |
| | Black/African American alone | 3,200 | 1,986 | 1,668 | 2,305 |
| | Hispanic/Latino (any race) | 26,010 | 16,235 | 15,793 | 16,677 |
| | Native Hawaiian/Other Pacific Islander alone | 657 | 397 | 152 | 645 |
| | Some other race alone | 8,618 | 5,301 | 4,686 | 5,915 |
| | Two or more races | 5,674 | 3,641 | 3,070 | 4,213 |
| | White alone | 184,931 | 114,099 | 112,702 | 115,496 |

Table continues on the next page…

**Table 26. Estimated Number of Persons, Aged 15 – 64 years, Who Are Eligible and in Need of an HIV Test by Race/Ethnicity, Sacramento Transitional Grant Area (El Dorado, Placer, and Sacramento Counties), California, 2006 - 2010**

| County | Race/Ethnicity | Eligible Persons (N) | Persons Needing an HIV Test (N) | Lower CI | Upper CI |
|---|---|---|---|---|---|
| Sacramento County | Total | 944,421 | 582,440 | 579,914 | 584,965 |
| | American Indian and Alaska Native alone | 136,155 | 5,974 | 5,340 | 6,608 |
| | Asian alone | 136,155 | 83,986 | 82,511 | 85,459 |
| | Black or African American alone | 97,866 | 61,052 | 59,770 | 62,335 |
| | Hispanic/Latino (any race) | 186,260 | 116,058 | 114,898 | 117,217 |
| | Native Hawaiian/Other Pacific Islander alone | 9,619 | 6,225 | 5,870 | 6,580 |
| | Some other race alone | 78,450 | 48,617 | 46,833 | 50,399 |
| | Two or more races | 38,544 | 24,678 | 23,152 | 26,204 |
| | White alone | 573,714 | 351,909 | 349,140 | 354,677 |

The table is based on the USPSTF recommendation that persons aged 15 - 65 years receive an HIV test. American Community Survey (ACS) population estimates for persons aged 65 years were not available.

Sources: Population estimates and 95% confidence intervals (CIs) are from ACS 2006-2010. The adolescent fraction that responded "no or not sure" to ever receiving an HIV test is from YRBSS 2015. The adult fraction that responded "no" to ever receiving an HIV test is from BRFSS 2014. The CI corresponding to each age group was multiplied by the corresponding fraction from YRBSS or BRFSS and the products summed to obtain an upper and lower CI for ages 15 - 64 years. All data sources were limited to California.

### Table 27. Estimated Number of Persons Aged 15 – 64 Years Eligible for and in Need of an HIV Test by Race/Ethnicity, San Jose Transitional Grant Area (Santa Clara County), California, 2006 - 2010

| County | Race/Ethnicity | Eligible Persons (N) | Persons Needing an HIV Test (N) | Lower CI | Upper CI |
|---|---|---|---|---|---|
| Santa Clara County | Total population | 1,200,711 | 736,514 | 733,654 | 739,375 |
| | American Indian and Alaska Native alone | 6,840 | 4,239 | 3,685 | 4,793 |
| | Asian alone | 390,427 | 238,399 | 236,433 | 240,365 |
| | Black or African American alone | 33,216 | 20,412 | 19,667 | 21,155 |
| | Hispanic or Latino (of any race) | 306,047 | 189,764 | 188,320 | 191,209 |
| | Native Hawaiian and Other Pacific Islander alone | 4,899 | 2,987 | 2,634 | 3,338 |
| | Some other race alone | 128,038 | 79,335 | 76,935 | 81,735 |
| | Two or more races | 35,485 | 22,627 | 21,199 | 24,054 |
| | White alone | 601,806 | 368,519 | 365,390 | 371,647 |

The table is based on the USPSTF recommendation that persons aged 15 - 65 years receive an HIV test. American Community Survey (ACS) population estimates for persons aged 65 years were not available.

Sources: Population estimates and 95% confidence intervals (CIs) are from ACS 2006-2010. The adolescent fraction that responded "no or not sure" to ever receiving an HIV test is from YRBSS 2015. The adult fraction that responded "no" to ever receiving an HIV test is from BRFSS 2014. The CI corresponding to each age group was multiplied by the corresponding fraction from YRBSS or BRFSS and the products summed to obtain an upper and lower CI for ages 15 - 64 years. All data sources were limited to California.

## Priority Populations

### Persons in Correctional Facilities

Routine opt-out HIV testing information about persons housed in detention facilities is limited. All persons entering the California Department of Corrections prison system are offered an HIV test upon initial processing. Among 17,436 inmates who were processed for incarceration during April–September 2012, 77 percent were screened for HIV infection; however, screening rates varied substantially between processing facilities from 47 percent to 93 percent. Among inmates who were tested, 135 (one percent) tested positive, including ten (0.1 percent) with newly diagnosed infections.[36]

From the Category B Expanded HIV Testing for Disproportionately Affected Populations Program, of the nearly 9,600 routine tests performed, 0.30 percent of the tests identified persons with new HIV infections among local jail sites compared to 0.10 percent among non-jail sites. [15,n] Although the Category B Expanded HIV Testing for Disproportionately Affected Populations Program is not representative of screening trends throughout California, the higher positivity yield highlights the importance of routine screening at correctional facilities.

From October to December of 2015, there was an average of 75,056 inmates per day that were housed in county jails (excluding Type I sites) and holding areas.[37,38, o] No systematic data were available on routine opt-out HIV testing and persons entering or exiting local correctional facilities. Additional consideration of this population is discussed in the Barriers section of this brief (see Page 81).

### Transgender Persons

In the most current year available (2014), there were an estimated 218,400 adult Californians identifying as transgender and, of this total, 188,200 persons were aged 18 – 64 years.[39] For the same year, surveillance data reported 60 Californians who were transgender and newly diagnosed with HIV (1.2 percent of newly diagnosed persons).[40] Population data on routine opt-out HIV testing among transgender persons are not available.

From the Category B Expanded HIV Testing for Disproportionately Affected Populations Program, the frequency of newly identified infection (positivity rate) was three percent among transgender persons; substantially higher than among other genders (males, 0.2 percent; females, 0.03 percent).[41]

[n] The local jail sites in the CDC and CDPH OA funded the Category B Expanded HIV Testing for Disproportionately Affected Populations Program include county and city jails.
[o] Type I jail sites are local, locked detention facilities that hold both non-sentenced and convicted adult inmates up to 96 hours.

### MSM of Color

During 2014, surveillance data reported 2,264 Californians who were MSM and newly diagnosed with HIV from all race and ethnicity categories except non-Hispanic/non-Latino white (45.3 percent of newly diagnosed persons).[40, p]

From the Category B Expanded HIV Testing for Disproportionately Affected Populations Program, there were 37 newly identified confirmed positive test events among MSM of color, demonstrating that persons with risk behaviors access HIV testing through routine testing in addition to, or possibly in lieu of, targeted testing programs. Additionally, the vast majority (76 percent) of newly identified confirmed positive test events in MSM were among MSM of color.[41]

### Young MSM

During 2014, surveillance data reported 693 Californians who were aged 13 to 24 years, MSM, and newly diagnosed with HIV (13.8 percent of newly diagnosed persons).[40]

From the Category B Expanded HIV Testing for Disproportionately Affected Populations Program, there were 48 newly identified confirmed positive test events among young MSM (age 13-24 years), demonstrating that persons with risk behaviors access HIV testing through routine testing in addition to, or possibly in lieu of, targeted testing programs.[41]

## Data Gaps and Limitations

To obtain race/ethnicity by age group data, the most current Census population estimates available used ACS 2006 – 2010. Some age groupings in the Census data precluded the age ranges recommended by the USPSTF on routine opt-out HIV testing. For example, population estimates for persons aged 65 years were not available. As a result of these limitations, the estimates provided in the tables are more likely to represent the lower range of possible values while the upper range is expected to be much larger.

To calculate the estimate of persons needing an HIV test, the proportion of persons responding "No" or "Not sure" to the ever tested question was used (BRFSS and YRBSS). An assumption in applying the proportion to the population estimates was that the proportion is constant across all subgroups (e.g., counties, race/ethnicity categories). In fact, such a proportion is expected to vary across subgroups. Without actual data available on the subgroups, however, these estimates provide a "best guess" on the lifetime prevalence of routine opt-out HIV testing and can serve as an aid for planning and development purposes.

Data on routine opt-out HIV testing in health care settings are limited. Currently, the Behavioral Risk Factor Surveillance System (BRFSS) is the best source of state-wide data in California. BRFSS assesses HIV testing but does not differentiate between the

[p] Individuals who are newly diagnosed may have been infected recently or years ago. For more information, see https://www.cdc.gov/hiv/pdf/prevention_ongoing_surveillance_terms.pdf.

types of setting where testing occurs. BRFSS data are based on self-report, which may underestimate actual screening rates. Additional limitations of BRFSS data include that information is not available at the county or regional level in California, for key subpopulations (e.g., MSM, transgender persons), and by payer type (e.g., Medi-Cal, private insurance).

Survey questions that assess "ever tested" status do not take into account persons who should be screened more than once in their lifetimes, namely people who inject drugs and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, transgender persons, and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.[8]

Data on other key populations of interest are not available from BRFSS or other data sources. There are no data available on routine opt-out HIV testing among persons entering and exiting local correctional systems. Additionally, there are no data available on routine screening among pregnant women, a population where HIV screening is strongly recommended and absolutely critical to prevent perinatal HIV transmission.[8]

Data on the percentage of health care settings utilizing electronic clinical reminders in their electronic medical records systems to conduct routine opt-out HIV testing are not available.

### Program and Service Gaps - Statewide

In 2014, there were 29.6 million adults residing in California.[16] In the same period, an estimated 60 percent had never been tested for HIV (Table 23). Thus, approximately 17.6 million adults in California have not received an HIV test and are eligible for routine testing. Additionally, some portion of the adults who have been already been screened should be screened more than once in their lifetime.

Adolescents, aged 15-17 years, comprise 1.56 million residents.[16] According to the 2015 Youth Risk Behavior Surveillance System (YRBSS), while 32.3 percent (28.5 percent of females; 36.0 percent of males) of Californian, high school students reported ever having sex, 91.3 percent have never been tested for HIV. Applying the USPSTF recommendation, this leaves an estimated 1.4 million adolescent Californians who are eligible for routine HIV testing.[16,42,q] In addition to being sexually active, this demographic group engages in high risk behaviors (e.g., condomless sex, substance use), which place them at risk for HIV and other sexually transmitted infections, and are more likely to delay seeking care than older adults.[43-45] Studies of adolescents receiving routine opt-out HIV testing demonstrate consistently high acceptance.[31]

Thus, the total number of Californians in need of HIV screening at least once in their lifetime is at least 19.0 million adults and adolescents.

[q] This estimate is based on data from the 2014 (most current year) Census population estimate for Californians aged 15 – 17 years and the 2015 Youth Risk Behavior Surveillance System for California.

### Program and Service Gaps - Local Level

Based on the USPSTF recommendations, the number of persons who need HIV testing at least once in their lives for selected local health jurisdictions is shown (Table 25-Table 27).

### Program and Service Gaps – Priority Populations

Insufficient information is available about the frequency of routine opt-out HIV testing in local correctional facilities (i.e., city and county jails), or among transgender persons, MSM of color, and younger MSM in California, so delineating the gaps at this time is not possible.

### Barriers - Statewide

Eleven percent of adults did not have any health insurance coverage at any time during 2014 in California; being uninsured varied by race/ethnicity with Latinos having the highest rates of being uninsured (16 percent).[46-48] Insurance status also varied by age, with persons aged 18-24 years having the highest rate of being uninsured (26.4 percent) compared to any of the other age groups.[48] The lack of insurance coverage presents barriers to accessing routine opt-out HIV testing and other medical services. The uninsured of any age are much less likely to have a usual place of care compared to their insured counterparts, making it less likely that they would receive a routine opt-out HIV test.[48] The uninsured are more likely to delay seeking health care services, use emergency departments or urgent care centers for their primary care needs, and incur greater out-of-pocket costs for those services.[49]

Barriers to provider uptake of clinical guidelines relate to clinician knowledge, attitudes, and behaviors.[50] In settings where routine HIV testing is state-mandated, its adoption by providers remains low.[51,52] Provider-identified barriers to administering routine HIV screening include a lack of awareness or familiarity (e.g., with current HIV laws), a lack of agreement (e.g., a perception of patients not being at risk and therefore not in need testing), a lack of self-efficacy (e.g., desiring additional education/training), and/or external barriers (e.g., patient motivation, time requirements, staffing, costs, inadequate resources, linkage to care services for patients with positive results, and disruptions to patient flow).[27,29,30,53-57] In addition, patient-provider communication can serve as a barrier or motivator to testing. Providers play critical roles in patient acceptance of HIV testing and the communication scripts they employ influence the decisions of patients.[58] When offered an HIV test as a part of routine health care, several studies have found patient acceptance to be very favorable.[26,59-64]

In the Category B Expanded HIV Testing for Disproportionately Affected Populations Program, the project sites identified sustainability or inadequate funding of routine opt-out HIV testing as a major barrier.[14] Successful, routine opt-out HIV testing involves comprehensive services (e.g., clinical consultation, staff support, and laboratory testing). Insufficient third-party reimbursement of these services left sites struggling to cover costs. For patients who did not qualify for health insurance or were unable to pay

for services, testing sites were unable to seek reimbursement and, in those cases, had to absorb the costs.

Currently, California jails (i.e., county and city jails) are not required to implement routine opt-out HIV testing for inmates entering and exiting the jail system. To initiate the process, persons who are incarcerated have to request a visit to the medical clinic. The costs associated with HIV testing are absorbed by the jail system. Jails do not receive third-party reimbursement for HIV testing services.

Additionally, policy barriers present challenges to provider and health insurance implementation of routine opt-out HIV testing. Unlike chlamydia screening in women, routine opt-out HIV screening is currently not a HEDIS® measure.[65,66] HEDIS® measures are used by companies, employers, governmental agencies, and other consumers to evaluate provider performance and insurance plans.[67]

## Barriers – Local Level

### Riverside and San Bernardino Transitional Grant Area (Riverside and San Bernardino Counties)

Specific barriers that have impacted Riverside County include: the frequent changing of administrative structures for Riverside County Hospital and Care Clinics; barriers to routine testing reimbursement; convincing providers to stop using risk as the reason to test and to offer the test universally; and educating providers about delivering positive test results. One of three hospitals in the Coachella Valley is actively working toward HIV routinization starting with emergency room patients. Another hospital has reported financial barriers to implementation.

To a varying degree, the statewide barriers identified previously have also impacted San Bernardino County. Some private providers continue to send patients to county public health facilities for testing even when patient health insurance plans will cover the test in private provider labs. Consequently, these practices have resulted in non-reimbursable costs to public health facilities or additional, out-of-pocket cost to the patient. The lack of HIV specialists is another potential barrier. In the San Bernardino County area, there are only a few HIV specialists to whom newly, identified, positive patients can be referred.

### San Jose Transitional Grant Area (Santa Clara County)

As part of the Getting to Zero Call to Action effort, Santa Clara County has identified the following barriers to routine opt-out HIV testing: stigma; a lack of HIV educational opportunities for HIV care staff and providers, especially with regard to counseling patients on HIV test results and navigating third-party payer systems to recoup the unreimbursed costs of routine opt-out HIV tests and laboratory services; a lack of standing orders for routine opt-out HIV testing; and a lack of organizational champions to address barriers.

## Recommendations

1) Improve universal adoption of routine opt-out HIV testing in California
2) Work with the National Committee for Quality Assurance to include routine opt-out HIV testing as a HEDIS® measure, which would accelerate the universal adoption of routine HIV testing.
3) Work with health insurance administrators and providers to ensure that third-party reimbursement for routine opt-out HIV testing services is timely and covers the total screening costs (laboratory services, clinician consultations, and staff support), either through increased reimbursement or inclusion of screening costs in capitated rates or bundled payment calculations.
4) Work with the California Department of Insurance and Covered California to increase the percentage of Californians who are insured.
5) Work with electronic health record providers to address the gaps in health information technology so that routine opt-out HIV testing is integrated into patient and provider reminder systems to boost the adoption of statewide, routine opt-out HIV testing.
6) Educate and train insurers, health care administrators, and providers on routine opt-out HIV testing.
7) Collect additional data on routine opt-out HIV practices and policies in individual health care systems to determine how best to close these gaps.
8) Work with the Survey and Certification Group at the Division of Laboratory Services Center for Clinical Standards and Quality, Laboratory Field Services at the Division of Laboratory Science California Department of Public Health, local health departments and clinical laboratories to “gold” certify laboratories that monitor and report rates of HIV testing and positivity yields.

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# 6.2 Pre-exposure Prophylaxis

## Contents



The development of HIV pre-exposure prophylaxis (PrEP) provides an additional prevention resource to decrease the likelihood of HIV infection among HIV-negative individuals. When used daily, as prescribed, PrEP is effective at reducing the likelihood of HIV infection by over 90 percent. PrEP does not replace other risk reduction options such as reducing the number of risk exposures, consistent use of condoms, and suppressing viral load through use of HIV medication among those who are HIV infected. However, this biomedical intervention will assist many for whom traditional risk reduction options may be insufficient to avoid infection. After reviewing clinical trials demonstrating the effectiveness of PrEP, the United States Public Health Service released comprehensive clinical practice guidelines for PrEP in May, 2014.[1] Currently, one medication, co-formulated emtricitabine/tenofovir (Truvada®) has been approved by the federal Food and Drug Administration for PrEP. Additional oral medications, as well as topical intravaginal gels, intravaginal rings that elute antiretroviral medication, and parenteral injections of long-acting medications are all being studied as PrEP medications.[2] The National HIV/AIDS Strategy for the United States: Updated to 2020 (NHAS) added a goal to provide full access to PrEP and post-exposure prophylaxis (PEP).[3] PEP is giving antiretroviral medications to individuals who had a potential exposure to HIV. PEP must be initiated within 72 hours of the exposure to be effective and the CDC advises it should only be used in emergency situations.[4] OA supports the use of PrEP as a critical first-line intervention for those individuals at greatest risk of HIV exposure, including gay, bisexual, and other men who have sex with men (MSM), transgender persons, persons who inject drugs (PWID), and heterosexuals at high risk for infection.

## What is the Need for PrEP in California?

The CDC estimates that, nationally, at risk individuals with an indication for PrEP include approximately 24.7 percent of HIV-negative sexually active adult men who have sex with men,18.5 percent of persons who inject drugs, and 0.4 percent of HIV-negative heterosexually active adults.[5] The CDC[r] defined an indication for PrEP as follows:

- MSM: Men who have two or more male sexual partners in the previous 12 months, and engaging in any condomless anal sex, having a diagnosis of a sexually transmitted infection during the previous 12 months, or in an ongoing sexual relationship with an HIV-positive male partner.
- High-risk heterosexually active adults (high-risk heterosexuals ): Sex with two or more opposite sex partners in the past 6 months, and either 1) sex with an HIV infected partner or 2) condomless sex in the last 4 weeks and sex with a high-risk partner, defined as a man who has sex with both women and men, in an ongoing sexual relationship with an HIV-positive partner and/or infrequently uses condoms during sex with one or more partners of unknown HIV status who are known to be at substantial risk of HIV infection (IDU or bisexual partner).
- People who inject drugs (PWID): Injection drug use and sharing a needle that had previously been used by another person.

The CDC then applied those criteria to National Health and Nutrition Examination Survey (NHANES) for MSM and high-risk heterosexuals, and to the National Survey on Drug Use and Health (NSDUH) for PWID to generate an estimated proportion of the group with an indication for PrEP.[5] Using the same criteria as CDC and applied to California population estimates, we calculated the number of HIV-negative MSM, PWID and high-risk heterosexuals in California who have an indication for PrEP (Table 28).

To determine the size of the MSM population in California, we used two data sources: the California Health Interview Survey (CHIS), which estimates that 4.3 percent of adult men ages 18 – 70 years in California are gay or bisexual, and a recent study based on multiple national and local surveys, which estimated the size of the MSM population for each county in California.[6,7] Using these estimates and U.S. Census data, we estimate that there are between 512,821 and 582,053 MSM California residents, and approximately 104,000 – 121,000 with an indication for PrEP (Table 28).

To estimate the size of the heterosexually active adult population in California, we used CHIS data which estimates that 94.8 percent of the adult population has exclusively heterosexual sex.[8] Using the CDC estimate that 0.4 percent of heterosexually active adults have an indication for PrEP, we estimated that this is equivalent to approximately 106,000 heterosexual Californians (Table 28). However, this estimate is disproportionate with the prevalence of HIV in heterosexuals in California and is likely an overestimate. This is, in part, due to using national data to estimate indications for PrEP since the national HIV epidemic is more concentrated in heterosexuals than is

[r] The U.S. Public Health Service PrEP Clinical Practice Guidelines do not define specific recommended indications for PrEP use by Transgender people.

seen in California (26 percent of newly diagnosed HIV cases nationally are high-risk heterosexuals versus 18 percent of newly diagnosed cases in California).[9]

To estimate the number of persons who inject drugs in California, we used the national estimate of injecting behavior in last 12 months derived by Lansky et al.: 0.03 percent.[10] Based on this and the CDC estimate that 18.5 percent of PWID have an indication for PrEP, we estimate 12,208 PWID have an indication for PrEP.

### Table 28. Estimated Number of Persons who Have an Indication for PrEP in California

| Population | Estimated population size[1] | Number of people living with HIV | Estimated number of HIV-negative persons | Estimated number of persons with indication for PrEP[2] |
|---|---|---|---|---|
| MSM | 512,818 – 582,053 | 92,661 | 420,157 – 489,392 | 103,779 – 120,879 |
| High-Risk Heterosexual | 26,403,762 | 18,542 | 26,385,220 | 105,541 |
| PWID | 83,556 | 17,567 | 65,989 | 12,208 |
| TOTAL | 27,000,136 – 27,069,371 | 128,770 | 26,871,366 - 26,940,601 | 221,528 – 238,628 |

1) Population size estimates based on California Health Interview Survey, Rosenberg et al., Lansky et al., and U.S. Census data
2) Based on CDC estimates for percentage of population with indications for PrEP

In total, OA estimates that approximately 220,000 – 240,000 individuals living in California have an indication for PrEP.

### What is the Acceptability of PrEP in High-risk Populations?

While PrEP awareness is increasing, it is not yet universal. Multiple studies conducted in urban areas between 2006 and 2016 found awareness ranged from 15 percent among a sample of people living with HIV (PLWH) to 85 percent among a sample of gay men using a geosocial-networking application (Grindr).[11-15] Later studies found a higher level of awareness than the earlier studies. The 2014 Kaiser Survey, "HIV/AIDS In The Lives Of Gay And Bisexual Men In The United States" noted that of men ages 35 and older, 64 percent stated PrEP should be used widely, while in men under the age of 35, only 43 percent thought PrEP should be used widely.[11] Surveying men participating in the U.S. PrEP Demo Project, researchers found 92 percent were interested in continuing to take PrEP.[16]

Golub et al. found that after an educational presentation about PrEP, MSM of color and transgender women of color rated barriers to PrEP (long-term impacts of PrEP and short-term side effects, impact on future drug resistance and concerns that PrEP does not provide complete protection against HIV) as more important than white counterparts. Participants of color also considered facilitators to taking PrEP (free access to PrEP, access to support services such as regular HIV testing, sexual health care/monitoring, and access to one-on-one counseling) as more important than their white counterparts.[17] This illustrates the need for patient education and access to services to assist individuals considering PrEP as an option in their HIV prevention strategies.

Few studies of PrEP awareness among people who inject drugs (PWID) could be found in the literature. An international study among MSM, serodiscordant couples, female sex workers, young women, and PWID found all were willing to use PrEP, adopt it as soon as it becomes available, and use it despite potential side effects.[18] The International Network of People Who Use Drugs (INPUD) interviewed PWID in 33 countries and indicate participants believe that PrEP should be available, but the first priority stated was to scale-up access to harm reduction services, including clean needles and injection equipment.[19] OA recognizes PrEP as an additional prevention option for PWID, in addition to facilitating access to sterile syringes through syringe exchanges and pharmacy sale without a prescription.

Similarly, the literature regarding acceptability of PrEP among persons engaged in heterosexual sex with high risk partners is sparse. In a review of current and planned PrEP trials and demonstration projects, as of November 2014, only one of the ten projects intended to include heterosexual women.[20] A study of knowledge, attitudes and acceptability of PrEP among PLWH at an Urban Philadelphia HIV clinic found lower awareness of PrEP among non-MSM (15.3 percent compared with 28.8 percent among MSM), but after education regarding PrEP, 88.8 percent stated they would be "extremely likely/likely" to recommend PrEP to a negative partner, with no significant differences between groups.[12]

When PrEP is used by high-risk heterosexual women, education and adherence support is critical because of the difference in achieving effective levels of emtricitabine/tenofovir in vaginal compared with rectal tissue. Data suggest that maximum intracellular concentrations of emtricitabine/tenofovir are reached after approximately 20 days of daily oral dosing in blood, approximately 7 days in rectal tissue, and approximately 20 days in cervicovaginal tissues.[21]

### What is the Current State of PrEP in California?

The effectiveness of PrEP at reducing HIV infections has been established, but considering whether PrEP is cost-effective must also be considered. A review of the literature on cost-effectiveness reveals variables that impact whether PrEP is a cost-effective intervention for specific populations. The use of antiretroviral medication for PLWH and the percent of PLWH who are virally suppressed impacts the cost-effectiveness of PrEP as well.[22-24] Analysis within MSM populations note that despite reduction of the number of new HIV infections, cost-effectiveness is only shown when PrEP is delivered only to high-risk MSM rather than to the MSM community in general.[25-29] While PrEP is effective in reducing new infections among PWID, cost analysis suggests it is more effective to increase use of ART and access to clean syringe supplies.[5,24,30] Targeting PrEP to high-risk heterosexuals, such as women with male partners who are HIV-infected trying to conceive is also more cost effective.[29] Appreciating the variation of cost-effectiveness of PrEP among different populations, OA is focusing its efforts toward the highest risk MSM and transgender women. This does not exclude supporting PrEP usage within PWID and high-risk heterosexuals but

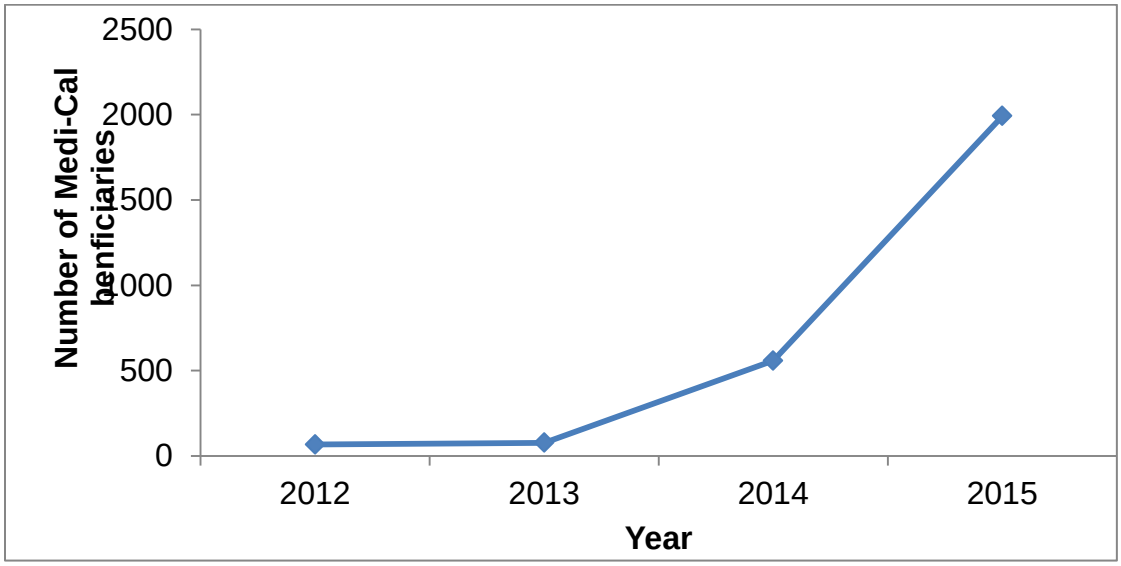
appreciates focusing resources to ensure the most effective outcomes from the use of PrEP in California.

In California, PrEP is covered by most public and private health insurance, including Medicare and Medi-Cal.[31] There are also two national patient assistance programs, one by Gilead that only supports the cost of the medication and the other by the Fair Pricing Coalition, which supports the costs of both medication and clinical monitoring.[32,33] Despite the existing patient assistance resources, some people still find financing PrEP a barrier due to costs for insurance deductible and co-pays.[34-36] In June 2016, state funding for a PrEP Drug Assistance Program to cover medication co-pays and deductibles and accompanying medical out-of-pocket costs for low-income persons in California was approved. The program is expected to be launched in spring 2017.

The current number of people on PrEP in California is difficult to quantify. In the 2014 MSM NHBS Special Report, three percent of MSM nationally reported taking anti-HIV medicines before sex to prevent HIV infection in the last 12 months.[37] According to NHBS data from 2014, 2-10 percent of MSM surveyed in major California cities (Los Angeles, San Francisco and San Diego) reported taking PrEP.[37] In a Kaiser survey conducted the same year, one in ten men surveyed reported knowing someone, including themselves, who had taken PrEP.[11] In 2015 researchers estimate that 31 percent, approximately 5,000 people, of those at substantial risk of HIV infection in San Francisco were on PrEP.[38] As of June 2016, the Bay Area Reporter estimated that 6,000 San Franciscans were on PrEP.[39] There are an estimated 2,000 – 4,000 persons on PrEP in Los Angeles County.[40]

Statewide Medi-Cal data demonstrate a substantial increase in the number of patients receiving Truvada without any other HIV medication, which likely represents PrEP use (Figure 8).

**Figure 8. Total Number of Medi-Cal Beneficiaries Receiving PrEP, California — 2012–2015**



While many MSM and some transgender women in California have accessed PrEP through studies and demonstration projects, continuing PrEP after initially receiving it can be challenging. A follow-up survey from the U.S. PrEP Demo Project found 92 percent were interested in taking PrEP post study, however only 51 percent had spoken to their health care provider and fewer (40 percent) had taken PrEP post-study. Insurance and provider access were identified as limiting factors in continuing PrEP post-study.[16] Recent funding of PrEP navigator programs may assist individuals continuing PrEP post-study as well as helping individuals access PrEP who have not been in clinical trials or demonstration projects.

In addition to PrEP access through health insurance plans, there are multiple PrEP-related projects occurring in California. Three PrEP demonstration projects for MSM, in Los Angeles, San Diego, and Oakland, funded by California HIV Research Program (CHRP) are completing their third and final year. CHRP has also begun a PrEP demonstration project targeting high risk women. It aims to enroll 185 participants. Three PrEP demonstration projects of three years duration for transgender people are commencing, with funding by CHRP; study sites will include one in Southern California, and two in the Bay Area, with one utilizing a site in Sacramento as well. The goal is to enroll 700 transgender persons between the three studies.[41] Additionally, OA is funding three demonstration projects that provide outreach, HIV and HCV screening and linkage to care and enrollment in PrEP at the Los Angeles LGBT Center, the San Francisco AIDS Foundation and the San Diego County Health Department. OA is also funding nine sites to develop PrEP navigation programs in locations throughout California. Finally, CDC competitively awarded funding (PS 15-1506) to Los Angeles, San Francisco, and OA (for four metropolitan statistical areas specified by CDC: Alameda, San Diego, Orange and Riverside/San Bernardino) for PrEP services targeting MSM and transgender persons. A major focus of these projects is building capacity (client and provider knowledge, provider willingness to prescribe, to refer) as well as client services for PrEP navigation.

The need for additional PrEP providers has been a consistent message from the HIV community. An on-line California PrEP Directory was created by UCSF's HIVE and posted at PleasePrEPMe.org. After initial development funded by other sources, OA is providing some funding to continue and expand PleasePrEPMe.org. Currently the website lists at least 1,400 PrEP providers in more than 200 clinics throughout California as of July 1, 2016, including all Planned Parenthood clinics.[42] Community input from OA-hosted Town Hall Forums in June 2016 noted that some Planned Parenthood clinics are still developing their protocols to initiate PrEP services and services are not available at all sites. The estimated number of PrEP providers is likely an under-estimate as only those who choose to be included in the directory were counted.

The need for additional PrEP awareness and training among non-HIV specialty health care providers is clear. A December 2012 on-line survey of physicians in 13 metropolitan areas with the highest incidence of HIV, including Los Angeles and San

Francisco, found only 28 percent of physicians would be willing to prescribe PrEP to MSM, 30 percent to at-risk women and 45 percent to HIV-negative patients in serodiscordant relationships.[43] A 2013 survey found only 9 percent of the members of the Infectious Diseases Society of America's Emerging Infections Network had actually prescribed PrEP (n = 573). Twelve percent of those surveyed stated they did not support the use of PrEP and 14 percent stated that would not provide PrEP. Reasons why physicians would not provide PrEP included worry about adherence and the risk for future resistance (77 percent), concern about cost and reimbursement issues (57 percent), not wanting to use potentially toxic drugs in healthy persons (53 percent), and belief that there is insufficient evidence for the efficacy of real-world PrEP (53 percent).[44] In August, 2015, OA sent a Dear Colleague letter to all California licensed family practice, general practice, infectious disease, obstetrics and gynecology, and pediatric physicians informing them of the efficacy of PrEP, OA support for the use of PrEP, and clinician resources to assist clinicians who prescribe PrEP.

## Local Jurisdictions

Using similar criteria derived from the California Health Interview Survey (CHIS) and the NHBS data applied to California population estimates, we calculated the estimated number of MSM who have an indication for PrEP by Local Health Jurisdiction (LHJ) (Table 29). OA did not generate LHJ-specific estimates for PWID and high-risk heterosexuals with an indication for PrEP due to lack of LHJ-specific population data for these groups.

### Table 29. Estimated Number of MSM with an Indication for PrEP by LHJ

| Local Health Jurisdiction | Estimated # MSM w/Indication for PrEP(1) | Local Health Jurisdiction | Estimated # MSM w/Indication for PrEP(1) |
|---|---|---|---|
| Alameda | 5,509 | Placer | 758 |
| Amador | 15 | Plumas | 10 |
| Butte | 249 | Riverside | 10,095 |
| Calaveras | 34 | Sacramento | 4,920 |
| Colusa | 23 | San Benito | 96 |
| Contra Costa | 2,638 | San Bernardino | 3,368 |
| Del Norte | 15 | San Diego | 10,368 |
| El Dorado | 337 | San Francisco | 7,655 |
| Fresno | 897 | San Joaquin | 650 |
| Glenn | 45 | San Luis Obispo | 349 |
| Humboldt | 156 | San Mateo | 2,183 |
| Imperial | 144 | Santa Barbara | 585 |
| Inyo | 12 | Santa Clara | 5,339 |

| | | | |
|---|---|---|---|
| Kern | 806 | Santa Cruz | 486 |
| Kings | 159 | Shasta | 169 |
| Lake | 115 | Sierra | 1 |
| Lassen | 68 | Siskiyou | 39 |
| Los Angeles | 31,222 | Solano | 331 |
| Madera | 136 | Sonoma | 904 |
| Marin | 513 | Stanislaus | 373 |
| Mariposa | 48 | Sutter | 100 |
| Mendocino | 87 | Tehama | 67 |
| Merced | 197 | Trinity | 47 |
| Modoc | 5 | Tulare | 359 |
| Mono | 40 | Tuolumne | 133 |
| Monterey | 630 | Ventura | 999 |
| Napa | 165 | Yolo | 371 |
| Nevada | 94 | Yuba | 103 |
| Orange | 8,559 | | |

There is substantial variation in availability of PrEP among different jurisdictions. As noted earlier, there are still some LHJs without any PrEP providers listed in the state directory.

### Inland Empire TGA (Riverside and San Bernardino Counties)

As noted in Table 2, it is estimated that 13,463 MSM have an indication for PrEP within the Inland Empire.

Desert AIDS Project in Palm Springs operates a sexual health clinic (The Dock) that provides both PrEP and PEP. It is currently serving an average of 25 clients seeking PrEP each week. In addition, the Desert AIDS Project receives CDC 15-1506 funding through OA for additional PrEP activities, and was also awarded state general funds for PrEP navigation.

### Sacramento TGA (Sacramento, El Dorado, and Placer Counties)

An estimated 6,015 MSM have indications for PrEP within the Sacramento TGA (Table 29). The Gender Health Center in Sacramento will be one of the Transgender PrEP TRIUMPH study sites funded by CHRP. The CARES Community Health clinic, newly designated as a Federally Qualified Health Center, prescribes PrEP, as does the Kaiser Permanente health system. While these two clinics are the only providers identified on PleasePrEPMe.org, California's on-line PrEP Directory, they serve approximately 87 percent of the diagnosed HIV-positive clients in the Sacramento TGA. The clinics provide a gateway for partners of HIV-positive clients who may be candidates for PrEP. CARES Community Health Clinic also operates a free STD clinic which identifies high-

risk individuals who may be candidates for PrEP and provides information about how to locate a PrEP provider within client's health insurance network.

With funding from the local CARES Foundation, the CARES Community Clinic launched a 'Zero Together Initiative' in June 2016. The Zero Together initiative is a community coalition comprised of local non-profit organizations, the Sacramento County Public Health HIV/AIDS programs, rural county HIV/AIDS organizations and AETC representatives to advance information and activities to reduce new HIV infections. In 2015, the Zero Together initiative held a PrEP Town Hall in partnership with the Sacramento Gay and Lesbian Center; participated in the 2016 Gay Pride celebration, promoting PrEP by having parade walkers behind a transit bus wrapped in advertisement of the PrEP initiative. Some transit buses have exterior and interior transit advertisements about PrEP. The Initiative also launched a PrEP website GetPrEPSac.org with information on what PrEP is as well as patient and provider resources. In addition, the grant provided funding for social media outreach including Facebook ads on all gay men's newsfeeds, targeted ads on websites viewed by gay men, and ads on gay hook-up sites. These ads have had a "click through rate" of over 4 percent, which is excellent. CARES Community Health also focused its STD clinic social media advertising to encourage gay men to get tested for HIV and STDs.

A Provider Tool Kit developed by the San Jose TGA is now being modified for use in the local Sacramento area and will be available on the Sacramento PrEP website. Once the Tool Kit has been modified for local use, the Zero Together coalition will be hosting a sexual health workshop for providers in the spring of 2017.

The Sacramento Workgroup to Improve Sexual Health (Sac WISH), a community work group comprised of local non-profits, community based clinics, school districts, county STD/HIV program representatives and State of California agencies have been receiving on-going PrEP awareness training for non-HIV specialty health care providers.

### San Jose TGA (Santa Clara County)

An estimated 5,339 MSM have an indication for PrEP within the San Jose TGA (Table 29). The San Jose TGA has conducted a local PrEP assessment and environmental scan that examined PrEP related attitudes and practices among providers, at-risk individuals, and other stakeholders in Santa Clara County. The purpose of the assessment was to identify strategies to support stakeholders in leveraging PrEP as an HIV prevention strategy. The assessment found that although PrEP is being routinely offered at Kaiser Santa Clara and Planned Parenthood, Santa Clara County is in need of a PrEP navigation system that will increase community and provider awareness and understanding of PrEP, support providers in order to enable them to provide PrEP, facilitate linkage to PrEP services for potential consumers and assist both consumers and providers in obtaining coverage for PrEP medication and related services.

Based on the findings and recommendations from the assessment, a strategic communication plan was developed to provide a roadmap for local PrEP-related communication activities. The plan includes overarching goals, key messages, and

general approach for PrEP communication efforts, for both the provider and potential consumer audiences.

A PrEP provider toolkit was also developed for healthcare providers, administrators, and patients. The toolkit will assist in leveraging PrEP as an HIV prevention strategy. The toolkit includes resources on clinical guidelines related to PrEP, to talking with patients about sex and PrEP, screening interested individuals, what patients need to know about PrEP, administrative procedures such as billing and insurance, and patient education. The media toolkit provides a communication plan drawing key findings from the assessment to provide a strategic roadmap for communication activities.

The San Jose TGA also held a PrEP Forum for potential, new, and existing PrEP providers in the jurisdiction with Dr. Oliver Bacon, MD, MPH, Deputy Director of the Capacity Building Assistance Program for high impact HIV prevention at the San Francisco Department of Public Health. Dr. Bacon along with the Public Health Department presented on the PrEP Needs Assessment Findings for Santa Clara County. This was followed by provider panel discussing local implementation of PrEP and lessons learned, facilitated by Gabriel Rendón, Capacity Building Manager at Asian Pacific Islander American Health Forum. Dr. Bacon returned to Santa Clara to address the Infectious Disease Grand Rounds at Santa Clara Valley Medical Center. The Public Health Department provided resources and tools for those present.

The San Jose TGA along with HIV/AIDS prevention and care stakeholders in the jurisdiction have collaborated to identify priority areas to focus on for the 'Getting to Zero' initiative. The group identified PrEP as a priority area. While PrEP services will be made available to all high-risk persons, the high-risk populations that will be prioritized are men who have sex with men, with particular focus on Latino and African American men in the 25 – 44 year old age group, young MSM, and transgender women.

The TGA has hired a PrEP navigator. The navigator will assist patients and providers with accessing PrEP and improve knowledge around PrEP. This will reduce new HIV infections, improve health outcomes, reduce HIV-related health disparities, and achieve maximal results in addressing the HIV epidemic in Santa Clara County. In addition, a Health Education Specialist has been hired to promote PrEP related actives.

There are three local funding around PrEP-- public and patient outreach, social marketing, and research and evaluation. These allocations will be awarded for 2-4 years for $75,000 per year.

## What is the State of PrEP among Priority Populations?

### Transgender Persons

Population estimates of the transgender population vary. The most recent estimate, from the Williams Institute, concludes there are between 117,742 and 385,582 transgender Californians.[45] Despite not having a well-founded population measure, the

CDC cites a meta-analysis conducted by Baret et al. who estimated HIV prevalence among transgender women in five high-income countries, including the United States was 22 percent.[46,47] In 2013, among the 3.3 million test events funded by CDC targeted testing programs nationally, the highest percentages of newly identified HIV-positive persons were among transgender persons. The CDC described factors that contribute to the high risk of HIV infection in transgender persons to include violence, stigma, discrimination, limited health care access, and negative health care encounters.[47] Despite recognizing the increased risk of HIV infection among the transgender population, the CDC does not explicitly name transgender persons as having a specific indication for PrEP. In discussing special populations within the 2015 STD Treatment guidelines, the CDC notes:

> Providers caring for transgender women should have knowledge of their patients' current anatomy and patterns of sexual behavior before counseling them about STD and HIV prevention. Most transgender women have not undergone genital affirmation surgery and may retain a functional penis; in this instance, they might engage in insertive oral, vaginal, or anal sex with men and women…Clinicians should assess STD- and HIV-related risks for their transgender patients based on current anatomy and sexual behaviors.[48]

CDPH supports the use of PrEP among transgender persons as stated in the August 2015 Dear Colleague letter.

There is some concern within the transgender community as to whether sufficient study of transwomen has been done to conclude PrEP is safe and effective, especially with regards to interactions with hormone therapy. Emtricitabine/tenofovir has been used to treat HIV-positive transwomen for over 10 years without any gender-specific adverse events noted and pharmacokinetic studies did not identify any impact on levels of oral contraceptives.[49] However, relatively little examination of PrEP use in transgender persons has occurred to date. A sub-analysis of transgender women from the iPrEx Study concluded PrEP was as effective in preventing HIV acquisition in transgender women when taken routinely, but there were barriers to adherence, particularly among those at the highest risk.[50] Studies of PrEP use in transgender women populations should be designed and tailored specifically for this population, rather than adapted from or subsumed into studies of MSM. The CHRP funded PrEP demonstration projects targeting transgender women will include a pharmacokinetic study of PrEP medication and feminizing hormones drug interaction. (Personal Communication with George Lemp, Director, CHRP, 4/11/16)

### Incarcerated Population

The total California Department of Corrections and Rehabilitation (CDCR) population as of May 31, 2016 was 179,746.[51] In addition, the population in California's 123 local jails has been increasing steadily as a result of corrections realignment, increasing 20 percent since May 2011 to a near record census of 83,280 in June 2014. The majority of local jail inmates are male (87 percent) and 62 percent are either awaiting trial or

have yet to be sentenced. However, realignment eliminated the maximum stay of one year in county jails and lower-level state felons transferred to local jails can be housed there for an indefinite period.[52] Proposition 47, which reduces penalties for certain offenders convicted of non-serious and nonviolent property and drug crimes, passed in November 2014 and initially decreased the jail population by nine percent in the first year since it was passed. Regardless of the overall jail population, the Public Policy Institute of California highlights that the justice system, particularly county jails, may be a point of opportunity to reach uninsured individuals who have not otherwise been reached, and enroll them during their stay so that they have health coverage on release.[53] This enrollment would facilitate access to PrEP for high-risk individuals.

### MSM of Color

MSM of color make up 53 percent of MSM living with HIV in California. The prevalence of HIV among all African Americans is three times higher than that of whites in California. The disparate rate of HIV infection is an indication for the need for PrEP among African American MSM. However, no estimates of indications for PrEP by race/ethnicity were available at the time this document was developed.

There are few estimates of the size of the MSM of color population. Lieb and the Southern AIDS Coalition MSM Project was the only recent model to estimate racial/ethnic populations of MSM found in the literature.[54,55] Table 30 shows their original estimates for California calculated by Lieb et al. in 2007and estimates using their model based on 2010 California Census data projected for 2014.[56-61]

**Table 30. Estimated number of MSM Californians by Race/Ethnicity**

| Population | Estimated percentage of California MSM population | 2014 Population Estimates |
|---|---|---|
| White | 51.6% | 264,616 – 300,339 |
| Black | 5.1% | 26,154 – 29,684 |
| Hispanic | 35% | 179,487 – 203,722 |
| Asian | 6.9% | 35,385 – 40,161 |
| American Indian/ Alaska Native | 0.3% | 1,538 – 1,746 |
| Native Hawaiian/ Other Pacific Islander | 0.2% | 1,026 – 1,164 |
| Unknown or multi-racial | 0.9% | 4,615 - 5,238 |
| TOTAL | 100% | 512,821 – 582,053 |
| Note: Population size estimates based Lieb et al. estimates applied to MSM estimates derived from the California Health Interview Survey, Rosenberg et al., and U.S. Census data | | |

Concerns related to the acceptability of PrEP in communities of color have been documented, with mixed conclusions. Black and Latino young MSM were more likely than Whites to state they would not use PrEP because of side effect concerns in one

study.[62] Another study found PrEP acceptability did not differ based on age or race/ethnicity.[17]

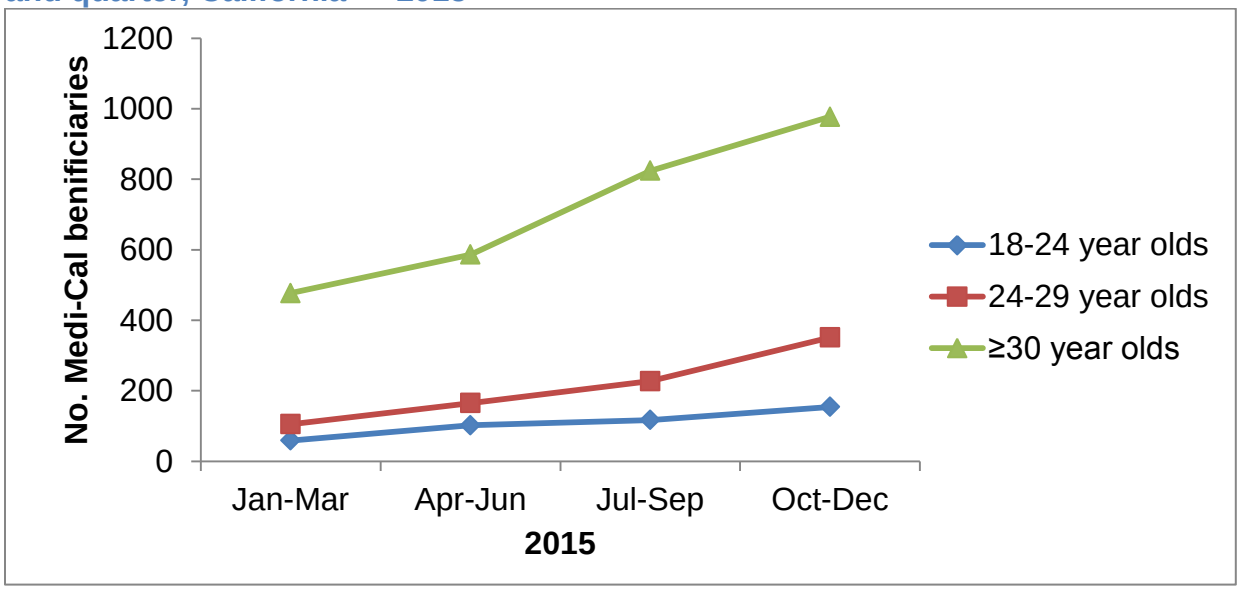
At this time, data about PrEP use among MSM of color is limited. However, it is possible that PrEP adoption does vary by race/ethnicity given health disparities. The majority of United States iPREx participants were white, with most Black and Hispanic participants enrolled from South America. In demonstration projects funded by the State of California that includes linking MSM to PrEP, two sites have reported on their first 10 months of activities. MSM of color accounted for 44 percent of those enrolled in PrEP at the LA LGBT Center and 39 percent through the County of San Diego. In 2015, 58 percent of the Truvada-only prescriptions provided through Medi-Cal were provided to persons of color. However, 81 percent of the Medi-Cal population were persons of color in 2013, suggesting that whites are disproportionately accessing PrEP through Medi-Cal.[63] As the eight new PrEP Navigation Programs funded by state dollars are started, all of which have a mandate to focus on MSM of color and transgender women of color explicitly, more insight will be gained about uptake of PrEP among MSM of color.

### Younger MSM

Truvada is approved for use in children weighing more than 77 pounds, which includes most adolescents, and is commonly used for HIV treatment in this group. However, PrEP use among adolescents has not been specifically studied. California Family Code § 6926 allows minors 12 years of age or older to consent for medical care related to the diagnosis or treatment of certain communicable diseases, such as HIV and sexually transmitted infections. This includes prescribing PrEP. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent and can only share the minor's medical records with the signed consent of the minor.[64]

Four hundred and thirty-two adults aged 18-24 years received Truvada monotherapy through Medi-Cal in 2015, and 848 people aged 24 – 29 years received it. The percentage of this population that is MSM is not available. Figure 9 illustrates Medi-Cal Truvada-only prescriptions filled per quarter by age groups in 2015. Fewer younger individuals, ages 18 – 24, were obtaining Truvada than older persons.

**Figure 9. Truvada-only prescriptions among Medi-Cal beneficiaries by age group and quarter, California — 2015**




Surveys of awareness of PrEP among young MSM noted low awareness (27- 30 percent).[62,65] Although internationally the iPrEx Study included a substantial number of younger MSM (ages 18 – 24), there was limited enrolment among young Black and Latino MSM.[20] The Adolescent Trial Network conducted a PrEP feasibility study in Chicago, which found that youth ages 18 – 22 years old were interested in taking PrEP, but overall adherence was about 50 percent.[66] In a review of ten different PrEP trials, Amico and Stirratt concluded the most consistent correlate regarding adherence to PrEP appears to be age: younger trial participants demonstrated worse study adherence than older trial participants.[67]

The Adolescent Trial Network is now studying whether PrEP adherence in two parallel studies can be improved with either of two evidence-based HIV-prevention interventions, one individualized and the other a group intervention (ATN 110 for participants aged 18 to 22 years old and ATN 113 for those aged 15 to 17 years old). One of the study sites is in Los Angeles. Almost half (49 percent) of the participants in ATN 110 are Black, 27 percent are Latino and 5 percent are transgender women; 33 percent of the participants in ATN 113 are Black and 49 percent Latino.[20]

The Connecting Resources for Urban Sexual Health (CRUSH) Demonstration Project in Oakland, California sponsored by CHRP is targeting young MSM of color for PrEP, ages 18 to 24. Results are yet to be published. The Los Angeles LGBT Center has a PrEP and Linkage to Care project funded by OA. They are targeting younger African American Men of Color through the House and Ball Community.[s] A survey of House

[s] The House and Ball network throughout the United States develops an alternative family structure for primarily young African American and Latino individuals of diverse sexual and gender identities. Older men of the community take on the roles of parents and mentor the younger men. The houses compete against each other during balls focused around dance, athletics, gender expression and creativity. Often

and Ball Members showed 55 percent (37 out of 67) were “somewhat likely” or “very likely” to take PrEP.[65] The LA LGBT Center has enrolled 514 men on PrEP in its first ten months of the project, 14 percent age 16 – 24 years. Another PrEP and Linkage to Care program funded by OA is directed by San Diego County. Of those linked to PrEP providers in the first 10 months in San Diego, 16 percent were age 18 to 24 years. While this project reported that only 65 percent of those who were linked to a provider filled PrEP prescriptions, age was not a factor in whether or not prescriptions were filled.

### Data Gaps and Limitations

As stated above, there are currently no established estimates for the number of persons with an indication for PrEP among racial and ethnic minorities or young adults/youth.

Additionally, a complete count of the number of health care providers prescribing PrEP in California is not available. Finally, the actual number of persons in California currently taking PrEP in California is unknown, and a system to monitor PrEP use and seroconversions despite taking PrEP does not exist.

Information addressing PrEP use among PWID and high-risk heterosexuals is lacking. Escudero et al. conducted a review of the literature and found only one study beyond the Bangkok Tenofovir Study with empirical data related to PWID, and recommended additional study of PWID and PrEP be done.[18,68] Challenges and barriers in researching PWID have been cited, including legal vulnerabilities and fears of the PWID related to government and other public organizations.[69,70]

### Program and Service Gaps

We estimate that 223,302 – 240,403 people in California, including all major risk groups (MSM, PWID, and high risk heterosexuals), have an indication for PrEP. While not all individuals with an indication will be interested in taking PrEP, studies and rapid increases in PrEP use in San Francisco and among Medi-Cal clients indicate that acceptability is high. Each of the current 200 clinical sites identified on PleasePrEPMe.org as prescribing PrEP would have to care for approximately 1,000 clients each to meet this need.

### Barriers

Stigma related to taking PrEP is a decreasing but still present barrier.[71] Within the gay community, acceptance of PrEP is on the rise. The stigmatizing label “Truvada-whore” has been re-appropriated by self-identified PrEP users in order to challenge the negativity of the original label.[72] However, reports of healthcare providers’ and public health workers’ negative judgements regarding those seeking PrEP are still described.[13,43,44,72-74]

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the balls will have a theme, including an opportunity to promote public health and contemporary social issues.

Insufficient provider knowledge of PrEP and reluctance of non-HIV providers to prescribe ART medications makes it challenging as patients ask their providers for PrEP.[44,72,73,75] Provider willingness to prescribe PrEP varies according to patient group, with more providers willing to prescribe to MSM and fewest willing to prescribe to high-risk heterosexuals or PWID.[73] People who inject drugs experience stigma and challenges accessing supportive services, as well as finding non-judgmental medical care.[73]

The use of PrEP among high-risk heterosexuals is hindered by the assumption PrEP does not work in women based on the two failed trials (FEM PrEP and VOICE),[68] prioritization of PrEP for MSM first[76], and provider reluctance.[73] While the FEM PrEP and VOICE did not show efficacy, adherence was identified as a problem in both of those studies. PrEP has been demonstrated as effective in women as men, when adherence rates are comparable.[1,77]

Funding PrEP is identified as a challenge for some clients, including those without insurance who do not know of the PrEP Medication Assistance Programs (Gilead's program pays for the medication but not clinical or laboratory costs; the Fair Pricing Coalition program will pay for medication and co-pays for clinical and laboratory costs).[32,33] Within the LA LGBT PrEP and LTC demonstration project, co-pays and deductibles for clients who have Bronze or Silver Covered California health plans, or other insurance plans with high deductibles and copays, has been a barrier. In addition, some clients are required to pay for the medication and wait for reimbursement, which has also been a barrier to PrEP usage. Undocumented individuals may be eligible for both the Gilead and the Fair Pricing Coalition programs as long as proof of U.S. residency can be provided and the other qualifying criteria are met.[16,34-36]

The capacity of CBOs to assist clients with benefits navigation varies, as does knowledge of various insurance plans and how to determine the deductibles and copays that will be associated with PrEP.

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# 6.12 Additional Local Needs, Gaps, and Barriers

## Contents



## Sacramento Transitional Grant Area

The impact of overall federal, State and municipal budget reductions in HIV Related Services during the Recession has a continued impact on PLWH throughout the TGA. While budgets are gaining ground, the number of HIV-positive clients coming into care has also increased. Many RW Care and Treatment agencies rely on HIV Prevention and Testing funds to meet the diagnostic goals of the Continuum of Care, and care and treatment providers continue to be faced with increased waiting lists and service demands. The Sacramento County Public Health Division experienced a 65 percent reduction in local government funding during the five year recession period, and has just begun to obtain additional local funding to staff those Public Health positions eliminated during the recession, specifically those related to surveillance. Unfortunately, as of July 1, 2009, more than 66 percent of state funds for testing were eliminated and many county testing sites were closed. Both rural counties of the TGA, El Dorado and Placer Counties, have closed their testing sites. To ensure that HIV testing and education in the TGA continued, government-funded testing sites including Cares, using largely private funding, are responsible for ensuring that activities to identify HIV+ individuals throughout the TGA are implemented. As highlighted in the Sacramento Region HIV/AIDS Needs Assessment published in June of 2014, trends in RW funding on Care and Support Services over time identify that funding on Support Services has significantly declined over time, and Service Gaps for those services have increased. Highlights from the analysis of trends in Need/Receive Gaps over a ten year period in the TGA are presented below.

### Transportation

The need for transportation services has widened. Depending on the type of transportation needed, the various gaps grew from 28-37 percent in 2003 to as high as 59 percent in 2013. The Sacramento TGA is a large three-county area covering 4,287 square miles. Municipal transportation systems are extremely inadequate and rates for daily bus vouchers are very high. The HIV Health Services Planning Council (HHSPC) continues to explore alternate transportation delivery systems and has increased allocations to transport patients to appointments over the past three years.

### Housing

As in many other California counties, low-income housing has limited availability in the three county region of the Sacramento TGA. Constantly rising rents limit the number of landlords willing to accept Section 8 housing assistance vouchers, and lower income housing units are generally located in the outskirts of the larger metropolitan areas not served by municipal transportation systems. HHSPC Council members sit on various Boards of housing agencies and advocate for numerous low-income housing initiatives as well as winter shelter funding for the homeless. Ryan White funding is also used to leverage low-income HUD housing by providing field-based case management to HIV-positive clients in those units. RW case managers provide detailed housing information assistance to clients. The Gap for housing information assistance dropped from 53 percent to 35 percent between 2011 and 2013. Despite providing housing information, the current Needs Assessment identified 37 percent of respondents reporting a Service Need for Housing, and of those who reported a need, 35 percent reported a Need/Receive Gap.

### Emergency Financial Assistance

Since FY 2007, RW Emergency Financial Assistance expenditures have been under $50K per year. Prior to that time, they were funded at $150-$200K annually. This is a direct result in the increased need for funding of core services and lack of increases of federal allocations. Consequently the Need/Receive Gap was one of the highest reported in the most recent Needs Assessment with 78 percent of respondents indicating a need and a gap of 47 percent not receiving the service. This gap in this category continues to increase as PLWH have to contribute more of their limited available income toward housing and transportation.

### Oral Health Care

In the June, 2014 local Needs Assessment, Oral Health care ranked high in both Service Need (#3) and Service Need/Receive Gap (#2). Given these findings, it was clear that efforts needed to be addressed to understand why the high service need for Oral Health Care was not being well met in the TGA. Significant research revealed a shortage of dentists willing to accept Denti-Cal. The TGA has one Ryan White Dental Clinic, but its capacity to serve clients was limited by the number of available dental chairs. Since the finding of the most recent Needs Assessment, the HHSPC has increased RW funding for Oral Health Care by 225 percent from $276,580 in 2013 to $626,464 in 2016. With the additional funding, the Dental clinic was able to expand its capacity by purchasing a dental van to accommodate more dental chairs and dental technicians were hired to provide routine care while dental staff concentrated on more serious dental procedures. Insufficient provider capacity continues, but the wait time for dental services has been substantially decreased as a result of these recent measures.

### Residential Substance Abuse

Although Residential Substance Abuse care ranked #10 in terms of reported Need (9 percent of respondents) in the most recent local Needs Assessment, it was ranked #4 for Need/Receive Gap, as 38 percent of those who are in need are not receiving the service. The Sacramento TGA and surrounding rural counties have an extremely limited number of Residential Substance Abuse treatment beds, and pregnant women have the

highest priority for placements in existing facilities. With minimal beds and a general population exceeding 2 million, placements for the HIV+ clients, the 2nd priority population, are limited. Currently, the RW funded Ambulatory Care clinic is presenting an application to the local CARES Foundation to request assistance in paying for residential treatment at a private facility. At the local level, County government is expanding its availability of Outpatient Substance Abuse, but capacity for Residential bed providers continues to be an unmet need in the three-county region.

### Hospice and Long-Term Care Facilities

In FY 2014, the RW system of care experienced the closure of the only AIDS hospice facility. Additionally, finding placements for HIV+ patients in long-term care facilities continues to be a challenge as Medi-Cal facilities have long waiting lists. The most recent Needs assessment indicated that people ages 45+ are overrepresented among RW clients (62.6 percent as compared to their representation among the TGA's general population (33.6 percent). Within the Ryan White system of care in FY15, 15.6 percent of clients were over the age of sixty. With the aging of the HIV+ population in this TGA, the concern over the availability of affordable long-term care beds continues to grow. Further magnifying this concern, the reimbursement rates for the California AIDS Waiver program that funds important services to keep clients in their homes has led to the loss of providers at the local level, increasing the likely need for long-term beds despite sparse inventory. Engaging out of care clients

The TGA has had success in bringing high-risk clients into care using a field-based Medical Case Management (MCM) model. Since FY 2003, the HHSPC has increased funds directed to this model. While field-based MCM is significantly more costly than office-based services, it has proven to be a cost-effective method of getting the TGA's most at-risk and underserved clients into care, retaining them in care and ensuring that they have full access to the care continuum. The Medical Case Managers refer clients to Benefits Counselors who work on a daily basis with the changing landscape of governmental and local services to improve the support system of HIV+ clients.

### San Bernardino/Riverside Inland Empire Transitional Grant Area (Inland Empire HIV Planning Council – IEHPC)

The Inland Empire TGA has two of the larges Counties (San Bernardino and Riverside) in the nation, encompassing 27,408 squares miles, both counties geography is made up of urban, rural, mountain ad desert regions. The size of the TGA impacts services such as Transportation and Housing. The TGA is also impacted by In-Migration when providing services. The reported number of PLWHA in the TGA (8,980) includes only those that were diagnosed in the TGA. Local statistics, Needs Assessment findings, and analysis of various diagnosis and service provision databases indicate that many more PLWHA move into the TGA after they have been diagnosed. Far more move into the TGA then those that move out. The latest estimate: 35.4 percent of PLWHA in the TGA were diagnosed outside the TGA = 4,925 PLWHA. This "additional" population has to be considered when determining the true disease "burden" on the HIV/AIDS care system.

### Case Management and Non-Medical Case Management

National Alliance of State & Territorial AIDS Directors (NASTAD) study (June 2014) concluded the following: 1) While new health coverage options have been made available through the ACA, the Ryan White Program continues to offer the most robust case management services for PLWH; 2) Credentialing requirements for case management providers within benchmark QHPs, traditional fee-for-service Medicaid and the Ryan White Program varies widely in each state [10 states analyzed, CA not included]; 3) Eligibility for case management in state Medicaid programs is often reserved for specific populations based on level of need; and 4) The majority of benchmark QHPs analyzed offer very limited case management services.

This study supports the continuing need for RW-funded Medical Case Management (MCM) as the primary source of support and assistance for those that need intense care coordination. MCM services are anticipated to continue to see an increase in usage as the TGA acclimates to the ACA. As the TGA transitions and health outcomes continue to improve, intense care coordination will be required to ensure clients do not fall out of care and/or experience a decline in health outcomes. In addition, coordination will be increasingly challenging and time-consuming as RW-funded MCM staff are required to connect with outside/non-RW systems of care on behalf of their clients that are in care with facilities such as Kaiser and other local health organizations.

Non-Medical Case Management services have seen a relatively consistent client level. Although increased funding has, over the past several years, lead only to an increase in surplus funds, this is most likely due to several staff vacancies experienced in 14/15 as well as HRSA restrictions placed on spending that have just recently been lifted . With this new allowance for spending, recently filled staff vacancies, and clients transitioning to ACA services as well as expanded state and federal programs, the program is likely to see an increase in activity over the next year as case manager's work with clients to connect them to available benefits and keep them in care.

## Housing

The Planning Council's 2014 Needs Assessment ranked Permanent Housing in the top 5 services needed in the TGA. In April of 2016 the Planning Council hosted a Town Hall meeting with representatives from Riverside and San Bernardino Housing Authorities to begin a conversation on housing needs for PLWHA. It was noted that Riverside HOPWA contracts were not executed in 14/15 until very late in the year once again. The current year looks to be plagued with similar administrative issues that may cause HOPWA to be unavailable for part or all of the year. Some other housing funding sources experience similar administrative issues. If other sources are not available, Ryan White funded housing may be needed at an increased level to address temporary housing needs of HIV+ individuals in the meantime. The Council is working towards building a partnership with the HOPWA program.

## Oral Health

There are two Ryan White-funded dental services for PLWHA in the TGA. Maintaining good oral health is critical to the overall health and wellbeing of PLWHA. Even PLWHA with dentures should be screened for oral cancers and other infections, which can impact their ability to maintain proper nutrition as well as to take medication as prescribed.

Beginning May 1, 2014, several benefits were restored through Denti-Cal to beneficiaries age 21 and older. The return of these benefits resulted in a 25 percent decrease in dental clients as many basic services previously funded by RW funds are billable to Denti-Cal. However, access to Denti-Cal providers remains a barrier to receiving care. According to the Medi-Cal Dental Services Rate Review (July, 2015) from the California Department of Health Care Services, Denti-Cal providers have decreased over 14 percent since 2008. Therefore, it is expected that RW funded services will remain necessary to cover services during transition as well as for those that are ineligible for services, and, once enrolled, to cover necessary services that remain uncovered by Denti-Cal.

The Planning Council has modified its Standard of Care eligibility to better address the needs of clients in the TGA in order to ensure clients are able to receive necessary treatment of the services not covered by Denti-Cal.

## Medical Transportation

The impact of the Affordable Care Act has expanded the services for PLWH, however with that expansion of services, there has been an increase in travel in order to receive services. The geography of the Inland Empire TGA has mountain passes that break up the counties from urban, mountain, rural and desert with very limited public transportation. Gasoline prices also impacts transportation as well as, the miles driven to go to appointments within the TGA. (for some clients, an appointment is 130 miles roundtrip).

The Planning Council is revising its Standard of Care in order to increase travel vouchers.

## San Jose Transitional Grant Area

The San Jose TGA has identified additional needed resources and/or services, and steps taken to secure them.

### Housing

Currently housing assistance in the San Jose TGA for PLWH consists of the following:

- Permanent supportive housing that creates affordable housing by allowing clients to pay for no more than 30 percent of their income towards rent, while the remaining rent is subsidized.
- Transitional housing, which has a 2 year limit, and assists participants locate and secure housing by assisting with housing search and providing advocacy with landlords.
- Emergency housing assistance which is only provided per assessed emergency and there must be a demonstrated need that cannot be assisted by any other resources in the community. The assistance provided is short-term and intended to typically be one-time assistance that is provided to help with a sudden, unexpected expense.
- Short-term housing is a temporary rental assistance program that can provide assistance for up to 6 months and is provided to low-income household's living with HIV/AIDS to establish their own emergency savings safety net while moving towards self-sufficiency.

Permanent Housing in Santa Clara County continues to be a recurring problem for PLWH due to a long wait list and unavailable units for rent. Currently, the wait list for housing could take 3-4 years for permanent housing. Rising rents in Santa Clara County continues to be an issue for PLWH currently getting vouchers for housing. This is also topped with the lack of rentals in the county.

The TGA is exploring new opportunities to collaborate or consolidate efforts, which would maximize the effectiveness of the funding, leverage other existing funding, and promote a coordinated effort across housing services. The TGA will be reaching out to the Office of Supportive Housing, the Housing Authority and the City of San Jose in the coming year to collaborate with existing programs.

### Psychosocial Support Groups

Based on information obtained from focus groups (Spanish speaking men, English speaking men, English speaking women) conducted in the summer and fall of 2015, the creation for more peer level support groups is a very important psychosocial need. These support groups are important because they assist clients in making informed decisions, coping better with illness and dealing more effectively with discrimination. They also improve the quality of their lives, and prevents further transmission of HIV infection.

Currently, there is a men's Spanish speaking group meeting twice a month, an English speaking men's group that meets weekly, a coed walking meditation group, a young adult (18-24 years old) and lunch group that met weekly. The walking meditation group

is currently on hold due to staffing issues. The lunch group continues to meet weekly without a facilitator.

Qualitative data from the focus group members indicate there is a need for a women's support group. Based on this information, the mental health service provider is aware of the need, but lacks the capacity to create more groups. Once the capacity issue is solved (hiring of new staff) the service provider can address the issue of creating a much needed women's support group and/or expanding the current men's group.

### Dental

Dental services have been reported in the Resource Inventory as being inadequate to meet the need of the HIV/AIDS community. With the shift to the Affordable Care Act, many PLWH/A now qualify for Denti-Cal. But in Santa Clara County, there is a shortage of dentists willing to accept Denti-Cal. This is due to a variety of reasons such as lower reimbursement rates. Providers who do accept Denti-Cal do not provide a full spectrum of dental services. For example, a Dental Cal provider might provide preventative services but may not cover fillings and/or crowns. This in turn leads to many PLWH/A with a limited source of dental services or no services at all. Consumers have reported to the HIV Planning Council membership that they are "unable to find a dentist who takes the insurance" (Denti-Cal). So a large number of Ryan White consumers utilize the Ryan White dental van for their oral hygiene care. Further investigation is needed.

### Education in Schools

HIV/AIDS education in Santa Clara County schools has been a struggle. Schools and school districts have been reluctant to implement a comprehensive HIV/AIDS curriculum for students. A small group called Positively Speaking connects trained PLWHA speakers to schools (middle school through colleges). Speakers provide HIV education and information to students from an experiential level.

Public Health prevention staff has been working with the Santa Clara County Adolescent Pregnancy Prevention Network, Santa Clara County Office of Education and Bay Area for Community Health Education to support and educate instructors and develop an implementation work plan for Assembly Bill 320-expanding sex education in schools. Expanding sex education in schools (including STI's, PrEP and LGBTQ issues) will inform students with medically accurate, comprehensive, and age appropriate information.

### Limited Pool of Resources

One challenge is the extremely limited pool of qualified agencies and organizations in Santa Clara County interested in being a Ryan White service provider. During the most recent request for proposal process, only one qualified agency submitted a proposal, or was found to be qualified, in each of the funded service categories. The reason most often cited for not submitting a proposal was excessive unfunded administrative burden. The net result is a limited selection of providers, compounding barriers to gaining access (such as geographic) to services, and increasing the burden on existing providers to serve a culturally and linguistically diverse population. The Grantee reports they are looking at options to help alleviate this problem.

### Language

Foreign-born individuals with HIV are most successfully treated by experienced HIV health care providers with robust language and cultural competencies. More than 50 languages and dialects are represented in Santa Clara County. The percentage of individuals in the TGA who speak a language other than English at home is 52.1 percent compared to 44.3 percent for California overall and 21.0 percent for the U.S.[t] This rich linguistic diversity presents challenges countywide. HIV/AIDS care is complicated by translation needs and requires multilingual/multicultural workforces and ongoing training throughout the provider network in cultural competency. This need is reflected in the TGA's Standards of Care for Medical and Non-Medical Case Management and will be incorporated into all Standards.

### Stigma

Stigma has long been considered as one of the great barriers for HIV testing, prevention and care. The San Jose TGA sees stigma in multi-layers which includes: minority identities, racial/ethnic identities, and sexual identities. This results in minority groups from getting tested.

The San Jose TGA's Getting to Zero Call to Action has set stigma as a priority area. This includes culturally sensitive and culturally grounded prevention strategies. The strategies include:

- Better identify the nature of the stigma surrounding HIV
- Identify which stigmatizing behaviors we want to address
- Investigate the nature of stigma that might affect specific HIV+ populations, like older adults, people of color, etc.
- Pay attention to intersecting identities
- Prioritize groups most affected by stigma
- Collect stories via digital tools to share the experiences of PLWH and how stigma affects them (incorporate resiliency, not just deficiency approach)

### Pre-exposure Prophylaxis

The San Jose TGA has conducted a local PrEP assessment and environmental scan that provided PrEP related attitudes and practices in Santa Clara County. The purpose of the assessment was to: explore how PrEP is viewed and used by providers, at-risk individuals, and other stakeholders; and identify strategies to support stakeholders in leveraging PrEP as an HIV prevention strategy. The assessment found that although PrEP is being routinely offered at Kaiser Santa Clara and Planned Parenthood, Santa Clara County is in need of a PrEP Navigation system that will increase community and provider awareness and understanding of PrEP, support providers in order to enable them to provide PrEP, facilitate linkage to PrEP services for potential consumers and assist both consumers and providers in obtaining coverage for PrEP medication and related services.

[t] U.S. Census Bureau, 2012 American Community Survey, 1-year estimates

Based on the findings and recommendations from the assessment, a strategic communication plan was developed to provide a roadmap for local PrEP-related communication activities. The plan includes overarching goals, key messages, and general approach for PrEP communication efforts, for both the provider and potential consumer audiences.

A PrEP provider toolkit was also developed for healthcare providers, administrators and patients. The toolkit will assist in leveraging PrEP as an HIV prevention strategy. The toolkit includes resources on clinical guidelines related to PrEP, to talking with patients about sex and PrEP, screening interested individuals, what patients need to know about PrEP, administrative procedures such as billing and insurance, and patient education. The media toolkit provides a communication plan drawing key findings from the assessment to provide a strategic roadmap for communication activities.

The TGA also held a PrEP Forum for potential, new and existing PrEP providers in the jurisdiction. This was held in June 29, 2016. Dr. Oliver Bacon, MD, MPH is Deputy Director of the Capacity Building Assistance Program for high impact HIV prevention at the San Francisco Department of Public Health was the keynote speaker. He addressed the providers during a talk called “PrEP: A Powerful Prevention Tool and Recent National and International Findings”. During the meeting the Public Health Department reported the Needs Assessment Findings for Santa Clara County. This was followed by Gabriel Rendón, Capacity Building Manager at Asian Pacific Islander American Health Forum, who moderated a provider panel discussing local implementation of PrEP and lessons learned.

On July 15, 2016 Dr. Bacon returned to address the Infectious Disease Grand Rounds at Santa Clara Valley Medical Center. The Public Health Department provided resources and tools for those present.

The San Jose TGA along with HIV/AIDS prevention and care stake holders in the jurisdiction have collaborated to identify priority areas to focus on for the, ‘Getting to Zero’ call to action. The group identified PrEP as a priority area. While PrEP services will be made available to all high-risk persons, the high-risk populations that will be prioritized for this intervention are men who have sex with men, with particular focus on Latino and African American men in the 25 – 44 and upper portion of the 13 - 24 age cohorts, and transgender women.

The TGA has hired a PrEP Navigator to complement the foundation work already completed. The Navigator will assist patients and providers to access PrEP and improve knowledge around PrEP. This will reduce new HIV infections, improve health outcomes, reduce HIV-related health disparities, and achieve maximal results in addressing the HIV epidemic in Santa Clara County. The TGA has also hired a Health Education Specialist to promote PrEP related actives. There are three allocations of funding around PrEP-- public and patient outreach, social marketing, and research and evaluation. These allocations will be awarded for 2-4 years for $75,000 per year.

## Targeted Assessment 2016: Renewal/Recertification Process

### Introduction

The Targeted Assessments are a series of focused brief anonymous surveys with Ryan White clients that will identify gaps in Ryan White services and provide concrete guidelines for service providers to address these gaps. The assessments will be on-going and will address all funded service categories in Santa Clara County. A follow-up assessment will be administered 6 months after the initial assessment, to monitor if the gaps have been addressed by the service provider and if there is an improvement in services provided.

The first Targeted Assessment focused on the Ryan White Renewal/ Recertification Process. It was administered at the Ryan White, non-medical/medical case management service provider for 7 weeks, between February 22nd and April 8th, 2016. The assessment will be administered again in six months (September 2016) to assure all gaps in services were addressed.

### Methodology

The assessment was administered over a period of 7 weeks between last week February and first week of April, 2016 with bulk of survey administered in March. Any client who was due for recertification/renewal of Ryan White card in March was eligible for taking the survey. All case managers were made aware of the process and were encouraged to let their clients take the survey after their appointment for renewal/recertification. The assessment consisted of five questions regarding the Ryan White renewal/recertification process. The assessments were in English and Spanish and in print form (See attached survey tool Appendix A). Clients were able to fill out the survey (5-6 minutes to complete) in a confidential area of the office and once completed, were instructed to fold it in half and place in a locked box at the reception desk. The questions were designed to gather information on the recertification from the client's perspective; The completed surveys were collected once a week and given to the analyst for manual entry into an excel database. Simple frequencies were used to analyze the collected data.

### Results

Sixty-six (66) Ryan White participants were identified as eligible to recertify during the survey period (March 2016). Forty-nine percent, (n=32) of surveys were completed, of which 75 percent (n=24) were in English, and 25 percent (n=8) in Spanish. Six clients who completed the survey were home bound. Out of the 66 up for renewal, four clients refused to take the survey, nearly 22 percent (N=14) did not make their renewal/recertification appointment, four clients recertified before/after the survey was being administered, three completed their renewal at a different Ryan White provider site, two clients were deceased and one client was discharged. One factor that contributed to the low numbers of completed assessments was a new mail-in (6 month) renewal/recertification process the service provider had implemented. It was indicated that nine clients of the 66 eligible chose to use this process. No assessments were administered to those clients who chose the mail-in process.

A majority of respondents (88 percent) reported no difficulty in gathering necessary documents. Three respondents reported having difficulty sometimes and one respondent reported to always have difficulty to gather documents for renewal/recertification. Two individuals responded that they didn't understand what forms were required and two reported that it was too hard to get the required forms.

Most of the respondents, (84 percent) felt that they got all the help they needed during the renewal/recertification process. Some respondents reported feeling they didn't get the help they needed; or got help only some of the times and few reported they felt they *never* got the help they needed. Further assessment of those respondents who felt they didn't get all the help they needed revealed that the person helping them expected them to bring all the forms or documents. One person even commented that "The online services for SSA (Social Services Agency) are always frozen. Even when you're just cleared access the hour before."

Only 69 percent of survey respondents felt that they received assistance from the person helping them to get documents from other agencies. Nineteen percent (19 percent) indicated they didn't need any help, and 6 percent of clients felt they didn't get the help they needed.

When asked if in the last 12 months someone followed up with them regarding missing forms or documents required for recertification/renewal, only 66 percent of respondents said yes. Of the 19 percent who responded that no one followed up with them to help with missing documentation, they also said that they had to follow-up with the agency themselves. One respondent stated that they had themselves called or came back to let the case manager know what was going on. Three of the respondents did not know if anyone followed up with them to assist with missing document.

When survey respondents were asked who helped them with the recertification/renewal process, 28 percent (n=9) individuals named their Benefits Counselor, 22 percent (n=7) named their Case Manager, 13 percent (n=4) named their Social Worker, 3 percent (n=1) named the Front Desk person, 3 percent (n=1) chose "Other" and named "my partner", and 9 percent (n=3) didn't respond to the question. 22 percent (n=7) chose multiple staff as having helped them with the recertification/renewal process.

Among those who chose multiple staff as having helped them, there were multiple permutation and combination of staffs who seemed to be involved in helping with the recertification/renewal process. For example, one respondent reported that the benefits Counselor, Case Manager, Social Worker, and Front Desk person *all* helped them with the Recertification Process. Another respondent named the Benefits Counselor, Case Manager, and the Social Worker as people who helped them. A third person named both the Benefits Counselor and the Case Manager. Another individual reported the Benefits Counselor and the Front Desk Person assisted them. Another respondent named the Case Manager and the Social Worker as people who helped them. One individual reported the Benefits Counselor and the Social Worker assisted them to recertify. One individual checked that the Case Manager, Social Worker, and "don't

know" helped them. The last multiple-responses individual named the Benefits Counselor and checked "don't know".

Overall, when considering all the times each type of staff assisted, the Benefits Counselor was named in 44 percent of the responses Case Manager in 28 percent of responses, Social Worker in 16 percent of responses, Front Desk Person in 9 percent of responses. "Don't know" was selected in 16 percent of responses.

### Summary

According to Target Assessment results, a majority of clients are getting the assistance needed and obtaining the necessary documents and/or forms required for the Ryan White renewal process. However, the assessment also identified a few gaps in service in this process. Those gaps included the need for a better tracking method for case managers to document and have a better understanding if clients are being recertified/renewed and if not, why?, clients having to follow-up themselves on missing documents and/or forms during the renewal process and internal communication and/or communication with clients. The follow recommendations will allow the service provider to address the gaps identified:

1. The service provider shall develop a tracking method for case managers in order to increase knowledge of the client renewal process (e.g. made appointment, missed appointments, deceased, mail-in renewal, etc.). This will assist staff with monthly eligibility status for clients.

2. Case managers will conduct prompt follow-up with outside agencies for clients with missing documentations and/or forms during the renewal process (refer to non-medical/medical case management standards of care.) This will ensure clients will have timely access to the services needed.

3. Communication: both staff to staff and staff to client.

    a. Moving forward, the case manager service provider will actively use the tracking method for the renewal/recertification process during case coordination and/or case conferencing (refer to non-medical/medical case management standards of care). The importance of communicating through these channels will let case managers know the client eligibility status during their renewal month.

    b. Case management staff will proactively communicate and reach out to the clients prior to the date of renewal appointment and also promptly follow-up with those clients who missed their appointments. Staff shall clearly document the communication and follow-up process. Staff will also clearly communicate with the clients the name and title of the point person responsible for their recertification/renewal.

## Focus Group Summaries

### Summary of 2015 Focus Groups

Santa Clara conducted focus groups with 1) high risk youth, 2) mainstream youth, 3) Spanish Speaking men, 4) English speaking women and 5) English speaking men. The high risk youth group (6 participants, ages 18-22) took place at the, 'Drop-In Center' at the Bill Wilson Center. The mainstream group (7 participants, ages 18-33) was conducted at Gavilan College. Both groups focused on questions on HIV prevention and education. Both the English men (4 participants, ages 49-64, two did not fill out demographic form) and Women's group (5 participants, ages 51-73) took place at The Health Trust's Learning and Living Center. The Spanish Men's (5 participants, ages 37-68) group took place during their Positive Connection Support Group meeting. These adult groups focused on question regarding HIV/AIDS care.

The focus groups were designed as a primarily qualitative effort to explore gaps in service areas and factors that lead up to these gaps. Data was gathered through a combination of audio recordings and notes taken during the groups. Data was compiled and vetted through personnel conducting the focus groups. Data was analyzed to identify common themes for gaps in services and also captured positive things going on within service areas.

Most of the participants were aware and receive HIV/AIDS services in Santa Clara County. One man said, "As far as Santa Clara County, it's the place to be as far as medical care (PACE, VMC, and Stanford)." Participants in the men's Spanish group all said they are very thankful Positive Connections is offered. They all agreed the support group and the social workers are very helpful and a great resource. The woman's group had positive comments on services being provided in Santa Clara County. Participants described living with HIV/AIDS in Santa Clara County as good. "Opposed to other counties, much better." The care is much better, easier to find and easier to get." In regards to prevention messaging, the youth said, "Messaging has to be cool and their style" to catch their attention. All participants did agree on focusing on younger kids (school-aged) for education and prevention.

Although, the adult groups seem to have a good grasp on services for PLWH in Santa Clara County, there were specific areas of gaps identified in both core and support services. Listed below are the gaps identified in care and prevention.

#### *Gaps*

Service Provider Specific

- Trust only Brand name condoms
- Reach out to youth earlier with education and messaging (Gap in sex education at schools)
- Testing should be incentive driven
- Messaging needs to be 'hip, cool' to relate to targeted youth
- Care focus needs to be streamlined (case management)
- Communication between providers needs to improve (communication gap)

- Ryan White paperwork needs to be easier and less of it
- Dental service is hard to obtain with Denti-Cal (providers do not accept it)
- Permanent housing has a long wait list

#### *Generic*

- Peer level communication
- Providers need not to be 'judgmental'
- More bilingual providers
- Relaxed and welcoming atmosphere at clinics
- Providers need to be same gender as clients
- Education on diseases should come from an expert in that field
- Support groups are important and a need (Spanish speaking men, English speaking women and men)

Addressing these gaps will be the focus of on-going, "targeted needs assessments" being administered beginning in January 2016. The assessments will ask specific question regarding these gaps and identify what is going on during that specific time period. A follow up assessment will be administered 6 months later to see if a corrective action has taken place to address the gap. The "targeted needs assessments" will be conducted every four months during the year and will cover all funded service categories (core & supportive).

### Summary of High-risk Youth Focus Group

#### *Summary of Key Findings*

The prevention youth focus group included 6 high-risk youth (4 males & 2 females) ages 18-22 who participate in local programs in Santa Clara County (SCC). The youth were well informed of prevention services in SCC including were to obtain "free" condoms, STD/HIV testing and information. Although they know of services being provided, the youth seemed still misinformed on HIV/STD's. They did say they only like to use, "…brand name condoms, like Trojans." In regards to prevention messaging, the youth said, "Messaging has to be cool and their style" to catch their attention. All participants did agree on focusing on younger kids (school-aged) for education and prevention.

#### *Sources of Information About HIV*

- Youth programs (Planned Parenthood, Street Smarts)
- Library
- Internet
- Doctors
- Back of a condom wrapper
- Family and children services

#### *Condoms*

Although youth do know where to get free condoms in SCC, they are still having unprotected sex. Reasons for not using condoms includes, "don't' like the way they feel"

and “not going to use a brand name condom.” On participants did say, “If not a Trojan or a brand name, I would rather jack (steal) them…” They also prefer clear packaging so they can, “…check for holes.”

### *Drugs and Sex*

Participants said many youth are using drugs and having sex. Although, the youth know of the consequences for both, they still engage in risky behaviors. One male responded, “If a partner does not want to use condoms, females (are) usually okay with it.” Participants also indicated that incentivizing getting tested for HIV/STD’s would result in more youth getting tested. “If incentives were provided, all would get tested.”

### *Talking About HIV*

According to the youth, HIV and STD’s are not talked about among peers. “No one brings up the topic.” A big stereo type is, “homosexuals get HIV” and the “LGBT community is where HIV comes from.” The participants did say partners need to communicate. The youth were comfortable with the Doctor who provides services at the, Drop-in Center. “…want a more relaxed clinic, easy to talk to. A provider who can be more approaching. A more welcoming environment…” They also mentioned

### *Reducing the Risk of HIV/STDs*

According to the youth, sex education in school (classes) starting in elementary would assist with risk factor discussion. Some sexually active individuals, “…check condoms for holes” to lesson risk factors. One individual said, “sex is not my priority right now” on reducing the risk of HIV/STD’s. The youth know of the over aching risks of being sexually active, but still engage in the risky behaviors. The consequences are an afterthought. Two individuals stated, “went through a phase of promiscuity, after done was terrified of getting HIV” and “Was tested while incarcerated, gave a relief to be negative.”

### *Strategies to Assist with HIV/STD Education and Prevention Messaging*

*Reach youth earlier:* All participants agreed, STD/HIV education should start in elementary school and continue in middle and high school. A curriculum that starts in elementary and continues through high school would keep youth engaged on the topics of HIV and STD’s.

*STD & HIV messaging:* Campaigns and messaging needs to relate to and have shock-value to capture their attention. The “cool, hip and trendy” messaging grabs their attention. Venues such as libraries, buses, stadiums, public transportation and colleges are good venues for campaigns.

*Utilizing the internet:* Participants said often used sites (Google, Facebook, etc.) would increase awareness for HIV/STD’s. Pop-up ads with very, “blunt, pictures/images would stick in the back of their minds.” Finding out what sites the youth are utilizing and coming up with a “cool” message would grab attention. The youth felt the current internet contributes/increases the risk of HIV/STD’s due to, “Easy access to technology,” and the fact that, “Sex sells.” *HIV/STD education:* The participants did say education should include, “…the disease process, how the medication works” and “how it affects your immune system.” All participants agreed information must be coming from

an expert. “Whether in person or on the internet, information should…have a credentialed person.”

## Summary of Mainstream Youth Focus Group

### *Summary of Key Findings*

The prevention young adult focus group included 7 young adults (one male and six females), aged 18-33 years, who attended Gavilan Junior College in Gilroy, California. Plan Parenthood is visible in the South County and is used by the young adults for prevention and education services. One female said, “Went to Planned Parenthood, feel unjudged.” It was also stated, “Teens feel more comfortable with Planned Parenthood (staff) than doctors.” Although they know of services being provided, the young adults seemed still misinformed on HIV/STDs. More education on STD/HIV is needed on campus. “(young adults) need someone they feel comfortable with and can guide them to appropriate resources.”

### *Sources of Information About STD/HIV*

- Planned Parenthood
- Doctors
- School nurses
- Health classes

### *Condoms*

Although young adults do know where to get free condoms in the south county, they are still having unprotected sex. Reasons for not using condoms includes, “Guys will say it feels better without condoms” and “Guys don’t care, they just want what feels good. Girls can get so obsessed with that person so they don’t use condoms.” All participants know that they can get condoms from school, doctors and Planned Parenthood.

### *Drugs and Sex*

Participants said many youth are using drugs and having sex. Although the youth know of the consequences for both, they still engage in risky behaviors. One young adult responded, “Now kids are just doing all kind of stuff. Teens look up to celebrities, rap music they will copy.” Another participant said, “Teens don’t realize that sex isn’t the only way to get AIDS. Teenagers need more information on different ways of getting AIDS.”

### *Talking About HIV*

According to the group, HIV and STDs are not talked about among peers. It comes up as a joke and not taken seriously. No serious conversations are made. Social media paints picture of celebrities having multiple partners promotes sexual activity. “Majority of parents do not talk about it.” Planned Parenthood has gained a reputation in the south county, “Went to Planned Parenthood, feel unjudged.” Another responded, “Learned a lot from the LVN nurse at the school.” The group believes more information is needed on campus and having people talk about it is also a need. “Make them feel

comfortable when they go to the doctor. Peers talking to them. Need encouragement to talk about it." They also agreed that HIV and STDs are serious things.

#### *Reducing the Risk of HIV/STDs*

According to the group, sex education in school (classes) starting in elementary would assist with risk factor discussion. One individual said, "A van to give out condoms, mobile, go to high school." All agreed that making it more visible and available on campus would benefit students. "Meeting people who are infected with HIV and have them talk about it" would send a strong message. Young adults are aware of the risks of being sexually active, but still engage in the risky behaviors. They all believe if the more risky behaviors are talked about, "… will make it more comfortable and normal to talk about."

#### *Strategies to Assist with HIV/STD Education and Prevention Messaging*

*Reach youth earlier:* All participants agreed, STD/HIV education should start in elementary school and continue in middle and high school. A curriculum that starts in elementary and continues through high school and junior college would keep youth and young adults engaged on the topics of HIV and STDs.

*STD & HIV messaging:* Campaigns and messaging needs to relate to them to capture their attention. "Shouldn't use adult scenarios in order to capture teenage audience. Should use someone young like them so they can relate."

*Utilizing the internet:* Participants said that the often used sites (Google, Facebook, etc.) would increase awareness for HIV/STDs. The participants also mentioned that peer to peer education would assist in getting the message across "…make a video and have it go viral to get the word out." Finding out what sites the youth are utilizing and coming up with a "cool" message that would grab attention. The young adults felt the current internet contributes/increases the risk of HIV/STDs due to, "There's no prevention, just promotion. Need to change this," and "Promote in a positive way. Get the word out."

*HIV/STD testing:* The participants did say incentives would motivate and empower testing, "Health fairs with incentives, for example giving blood in high school get a free t-shirt.

### Summary of Spanish-speaking Men's Focus Group

#### *Summary of Key Findings*

Participants overall were happy with HIV/AIDS services in Santa Clara County. One common gap that the group expressed was the language barrier. This could be services in Spanish to Spanish-language information. Participants all said they are very thankful Positive Connections is offered. They all agreed the support group and the social workers are very helpful and a great resource.

#### *Experience Living with HIV/AIDS in Santa Clara County*

All participants shared a good experience living with HIV/AIDS in Santa Clara County. A majority of the group were diagnosed and referred immediately to PACE Clinic and/or

Positive Connections. These participants did not delay in getting the services needed to treat HIV/AIDS. One person said, “I feel well…feels like he is treated like family,” when obtaining services. Overall, the participants’ experience with living with HIV/AIDS has been a positive one.

### *HIV/AIDS Services Used in Santa Clara County*

As stated above, all participants were diagnosed and entered into care immediately. The group all said, they take their prescribed medication. “…doing well, and receives meds on time,” and “… takes all meds.”

### *Services*

- Pace (Partners in AIDS Care & Education, an HIV Clinic)
- Ryan White
- ADAP
- The Health Trust
- Positive Connections

### *Experience Using Services*

The group expressed somewhat of a gap in services with Spanish speaking staff and information in Spanish. They said, “Need more Benefit Counselors that speak Spanish.” One participant stated, “Go to all appointments accompanied by Positive Connection staff.” Multiple participants said, “I get a translator” when needed for appointments. All agreed that Positive Connection is an invaluable resource. “Positive Connections has guided men through services…” The services and support group is offered in a gentle and inviting manner.

### *Barriers to Getting Care*

As stated above, the participants all agreed there should be more Spanish speaking counselors. Participants do use translators when needed. The group also said more information in Spanish is needed. One participant said, “I would like to receive meds a month ahead of time.” Again, the

Positive Connection Program has been a great success. The social workers and the information passed along is well received. One participant said, “Has no one outside of the clinic for emotional assistance…” another one stated, “Has no one. Has guided himself.” This brings up the issue of support outside of the clinic. One individual said, “I have a partner, but does not talk about HIV.” Many of the clients do not have a support system set-up outside of services. “

#### *Strategies for Services and Raising Awareness*

- Have more Spanish speakers providing services
- Have all providers evaluate services
- Have volunteers speak on HIV/AIDS experiences
- Test at the Mexican Consulate
- Educate the general public on HIV/AIDS
- Media spots should focus on getting tested
- More media to inform people about HIV

### Summary of Women’s Focus Group

#### *Summary of Key Findings*

Participants were overall happy with HIV/AIDS services in Santa Clara County. In general, the group knows where to obtain services. A few of the participants were still learning about HIV/AIDS services in the county. A key finding was the need for a support group for women. PACE used to have a women’s support group, but now there is nothing available. All the women agreed that a women’s group would be beneficial.

#### *Living in Santa Clara County with HIV/AIDS*

Participants described living with HIV/AIDS in Santa Clara County as good. “Opposed to other counties, much better. The care is much better, easier to find and easier to get.” The few women in the group did share they were still learning about what services are available. Several women did say they had not disclosed their positive status to their families. “I feel judged, so she does not disclose her status.” “Women with HIV tend not come out as much. Men dominated. It’s hard to get women together.” As stated above, all women shared the need for support outside of the clinic. They all feel comfortable with their providers. “Doctors talk to me about HIV/AIDS. I feel comfortable. The doctor is very open.” “I have a close relationship with the doctor and benefit person.”

#### *Awareness of HIV/AIDS Services*

All the women had a general awareness of services for HIV/AIDS. Most of the women, talk with their providers, “…If something comes up, I’ll talk to my doctor.” All the women did agree, that if there was one single person that could help guide or navigate them through care would assist greatly. Communication between providers is essential. “More communication between PACE and The Health Trust. I get different answers to what’s available.” Some of the women learn about the different services through, “Word of mouth.”

### *Use of Services*

- Food basket
- Pace
- Mental Health
- Health Trust
- Legal services
- Transportation
- Housing
- Dental
- Medication

### *Experience Using HIV/AIDS Services*

All participants expressed frustration with dental services. “Stopped getting care from the Dental Van. Still there, because have Dental-Cal insurance the Dental Van does not take. Haven’t had dental care in 1 ½ years.” On women stated, “Difficult to get glasses for vision problem,” and “Women’s mental health is lacking.” All the women in the group expressed the need for affordable housing. “Finding housing. Rent is being raised. Difficult to find due to low income,” and “Long waiting list for housing, 3-4 years.” One participant said, “Was previously homeless. Since then have an apartment now. Makes a big impact on her care. It was hard to stay in care when homeless.” A few women remarked they do not enjoy having to, “disclose HIV status on paperwork.” Another woman said, “Difficult to understand because reading and writing skills are limited.”

### *Mental and Emotional Health*

The mental and emotional part of living with HIV/AIDS is difficult. As stated before, the need for a women’s support group topic came up numerous times. “I still don’t know enough about what else is available as far as mental health and supports groups. I wish I knew more about (mental Health) services.” All the women feel there is a stigma with women living with HIV/AIDS. “If a man gets HIV, oh well he was messing around. If it’s a woman the stigma is worse. Makes women more sensitive and afraid to come out with their status.” A few of the participants have not shared their status with family members. “I don’t want to be judged by them,” and “Lack of education with family members and culture will have them saying (to her) it’s contagious, get out.”

### *Experience Finding Out HIV Status and Getting Care*

All participants were diagnosed and received care immediately. Only one woman has stopped getting care for about a year and has reentered care. “I stopped care for one year. I wanted to see how I would feel. She felt normal.” Another stopped her medication for a period of time while she traveled to the US. A majority of the participants did not think they were at risk for HIV.

### *Strategies to Make Services Easier and Raise Awareness*

- Educate in schools at an early age
- More information that is outspoken
- More pamphlets

- More people speaking out
- Important for females to speak out
- Let people know it's out there and it's part of your life whether you're affected or not

## Summary of English-speaking Men's Focus Group

### *Summary of Key Findings*

Most of the participants were aware and receive HIV/AIDS services in Santa Clara County. One man said, "As far as Santa Clara County, it's the place to be as far as medical care (PACE, VMC, and Stanford)." The group did express a lot of frustration with appointment wait times, phone wait time and paperwork. Participants would like a streamlined process to deal with their frustrations or a centralized person who knows and can assist with everything. Many also felt there needs to be more support groups for both men and women where people can talk and socialize.

### *Living with HIV/AIDS in Santa Clara County*

All participants except one was diagnosed and entered into care immediately. The one participant tested positive but blocked it out (ignored it) and did not want to tell anyone. He ignored it for 10 years and remained healthy until he got sick. He was quickly connected to services in Santa Clara County and remains in care. Another group member was laid off and had no insurance and had to stop care for 18 months. His son linked him to the Express Clinic at VMC for services. As stated above, participants are frustrated with making appointments, referrals and long waits on the phone. On group member shared, "(I) received a letter for an appointment, showed up and they said they didn't have any appointments. Can take up to six months to get an appointment." Participants also shared the need for gender specific providers. One group member stated, "(I) can be nervous with female doctors because (I) have a hard time talking about sexual things with her." They also said that there is a certain, "way" people look at people living with HIV/AIDS. "Men vs. women with HIV is different. Straight men are automatically assumed gay. Dating is difficult once they know your status. Women have a hard time, they are considered whores." The group also shared the need for more bilingual and bicultural staff at providers.

### *Services Used in Santa Clara County*

- Medication
- Food Basket
- PACE
- The Health Trust
- Housing
- Dental
- Vision
- Support groups

### *Experience Using HIV/AIDS Services*

Participants expressed difficulty maneuvering through the, "system." One group member commented, "(I) have to play the game, getting referred in then getting a letter and then having to see the Health Trust…" They also said the Food Basket is one thing that works seamlessly, while Cardiology appointment are hard to get. Participants did say they gain knowledge of services through word of mouth and Social Workers/Therapists. A few said they have gained knowledge from members on the Planning Council. Dental care continues to be problematic for individuals with Denti-Cal. Not many providers accept that insurance. "Dental care is hard to get…Denti-Cal, nobody takes it. Co-pay is very expensive. (I) have to explain everything to the benefit person again to get an appointment." As stated before, the amount of duplicating information that is needed for appointments and/or referrals seems to be a recurring theme. Participants also like the idea of going back to reapplying for Ryan White (card) once a year instead of every 6 months.

### *Barriers to Getting HIV/AIDS Services*

*Lack of information for minorities:* Group members all stated they would like to see more, "culture integration with groups, and languages." Reach out to more cultural communities (Asian, Blacks, Etc.).

*Housing:* Participants all agreed a person's living situation is a very important factor for being stable and staying in care. "If I don't' have a stable place to be, (I) start failing of skipping meds, Hard to keep it steady when couch surfing." Participants agreed, it's very difficult to keep housing due to financial issues. Current the waiting list for housing is 3-4 years.
*Prevention:* Participants were unaware of some prevention efforts going on in Santa Clara County. They did not have knowledge of the Needle Exchange Program, where to get non-latex condoms and female condoms.

*Staff turnover:* Participants also expressed frustration on high turnover rates of direct service staff at providers. One group member stated, "PACE is a teaching facility. So you can't follow your doctor. If you do it's an all-day process. Transportation is an issue." They said it's difficult to build trust over and over again.

*Unfriendly staff:* Unfriendly front desk staff and/or counselors is a barrier for services. One participant stated, "… may have a hard time understanding me. I don't fit their panel. They don't expect someone like me to walk in with the kind of questions I ask*."*

### *Strategies to Raise Awareness*

Participants all agreed that talking about HIV/AIDS more will raise awareness. Reaching students in high school, middle schools and at more cultural communities in the county is needed. Reaching out to people of color will also help raise awareness. Having providers communicate better will assist in raising awareness in Santa Clara County, so all providers know what services are being offered.

Prevention messaging venues:

- Youth centers
- Billboards
- Clinics
- Where people hang out (i.e., coffee shops, community centers, malls, above urinal ad's)
- Bus benches

# Appendix A: 2016 Virtual Town Halls for the California Needs Assessment for HIV

In June 2016, the California Department of Public Health Office of AIDS (OA) and the Ryan White Part A Coauthors of the San Bernardino/Riverside Transitional Grant Area (TGA), Sacramento TGA, and Santa Clara TGA, in collaboration with the Pacific AIDS Education and Training Center (PAETC) hosted three virtual Town Hall meetings to discuss the California Needs Assessment for HIV and engage with stakeholders throughout the State. The results from the California Needs Assessment for HIV will be used to help develop the California Integrated HIV Surveillance, Prevention and Care Plan.

Using Adobe Connect on-line teleconferencing technology, participants offered their input on the California Needs Assessment for HIV during each virtual Town Hall. Through this technology, participants talked with each other in real-time, and shared resources, lessons learned, and experiences without having to accommodate the demands and expense of traveling to an in-person meeting. Thus, the virtual process offered an efficient, interactive and effective means to obtain a broad range of perspectives from different geographic regions.

The Town Hall meeting objectives were:

1. To ensure that the California Needs Assessment for HIV identifies the most pressing HIV needs, gaps and barriers in California
2. To ensure that the California Needs Assessment for HIV represents the perspectives and experience from persons living with HIV/AIDS, all the Parts of the Ryan White HIV/AIDS Program, members of a Federally recognized Indian tribe, public agency representatives, HIV community representatives, providers, and public health partners.

To ensure engaging stakeholders at all levels across agencies, organizations, and consumers, an invitational letter from Dr. Juliana Grant, Chief of the Surveillance, Research and Evaluation Branch, OA, reached out to Ryan White Grantees (all Parts and programs), members of a Federally recognized Indian tribe as represented in the State, providers, representatives from public agencies, local AIDS directors, county behavioral and mental health directors, directly-funded eligible metropolitan statistical areas (EMSA) for the Housing Opportunities for Persons with AIDS (HOPWA), the California Planning Group, local planning councils, HIV patient advocates, representatives from the Syringe Exchange Programs, and OA Prevention grantees. Invitation letters were sent the week of May 23-27 with follow up reminders occurring the week preceding each Town Hall. Invitees were asked to pre-register for one of the Town Halls, scheduled for June 7, with a focus on the Central Valley; June 9 with a focus on Northern California; or June 14, with a focus on Southern California. The California STD/HIV Prevention Training Center (CAPTC) provided technical support services for the Adobe Connect technology that included a presentation to all participants, followed by small break-out groups focusing on specific topic areas from the California Needs Assessment for HIV, and reconvening to provide a summary of

input received. All forums were recorded and closed captioning was provided for all components of the forum.

### Registrants

Over 400 invitations were sent to stakeholders and 178 people registered for one of the three virtual Town Halls. This broke down to: 17 people on June 7 (Central Valley); 64 people on June 9 (Northern California); and 97 people on June 14 (Southern California). There was representation from throughout California including urban, suburban and rural areas and from a variety of settings, such as AIDS service organizations, local health jurisdictions, correctional facilities, hospitals, providers, community-based organizations, Federally Qualified Health Centers (FQHCs), HIV specialty clinics, American Indian tribes, substance abuse services, faith-based settings, and HIV Planning Councils. Registrants included nurses, program managers, administrative staff, case managers, advocates, public health professionals, and program managers. This range of participants enabled OA to capture a variety of experiences regarding access to services and providers, quality of care, and populations experiencing disparities who are most affected by the HIV epidemic.

### Agenda

Each 90-minute Town Hall used the same structure of a 10-minute welcome, introduction, agenda review, meeting objectives and instructions; a 15-minute overview of identified California HIV/AIDS needs-to-date with interactive polling questions (presented by Dr. Grant); and concurrent, small-group, break-out sessions that focused on:

- Routine testing, PrEP and partner services (Group 1)
- Mental health and substance abuse services (Group 2)
- Quality of Care and retention/re-engagement in care (Group 3)
- Linkage to care, case management and housing (Group 4).

Each break-out session provided brief, more in-depth information on the topics areas, with an opportunity for discussion by speaking or using the written chat feature. After the break-out sessions, all participants rejoined the virtual Town Hall to hear the brief report-backs from each group and a conclusion. Participants were then asked to complete an on-line evaluation using polling questions. (NOTE: Because of the small number of participants at the June 7 Town Hall, participants did not break into small groups but rather everyone had the opportunity to comment on the entire list of topic areas.)

### Cumulative Results

To start out the discussion, a polling question was posed to participants, asking them what their number one HIV need was, based on their experience. Overall results from the three Town Halls are as follows:
Housing was the top need identified (32/76 participants). This was followed by mental health and substance abuse services (18/76 participants). The participants identified

transportation; PrEP; overall prevention services; oral health; more HIV testing and linkage; post-incarceration services; lack of specialists in rural areas; one-stop shopping; and extra services for the aging population.
The following is a collection and summary of comments, findings and experiences reported from each small group.

### Group 1: HIV Testing; PrEP; Partner Services

HIV Testing

- While HIV testing is happening through Testing Campaigns, emergency departments (EDs), hospitals, private providers, homeless programs, and public health clinics, universal screening is still not a priority in EDs or clinics. Gaps in routine testing still exist, including in FQHCs.
- Low positivity rates decrease ongoing universal testing in health care settings.
- Many providers are still unaware of CDC guidelines for HIV testing. Providers still use perception of risk rather than routine HIV testing guidelines as a way to not offer testing, and sexual history taking remains very uncomfortable for providers. The Coachella Valley Get Tested initiative is finding it's difficult to change the mind set of providers, who still want to do some sort of risk-based testing (this perception is based on results from a local survey of providers) rather than routine testing with patients who don't seem to have any risk factors.
- There are still many regions in CA where routine testing implementation is still in the discussion stage, for example in Santa Clara. The county is developing a Getting to Zero initiative to address this problem.
- Even where HIV testing policies are in place, providers are not consistently implementing these policies.
- Some mentioned working on a system with ACA managed care plans to implement routine HIV testing. Despite huge hurdles there is some progress occurring.

PrEP

- Some PrEP providers will not prescribe if a patient is known to be using drugs.
- Participants stated there is a lack of providers in Fresno to prescribe PrEP for those without private insurance.
- Stigma remains a barrier as is providers who do not prescribe PrEP. Providers also lack information to inform patients about PrEP.
- Young MSM of color are not asking for PrEP. Shame associated with taking PrEP is common. A problem with PrEP outreach is that the people who need PrEP the most are not being reached.
- Older people are experienced and know about the complications of co-pays, insurance coverage, etc., but younger people don't know how to manage the system and this creates a barrier. People who are accessing PrEP have experience with the health care system and are more savvy. We need to reach other people who don't have this background, especially younger people.
- Another barrier for young people is that they may be covered on their parent's health insurance and they are afraid that their parents would find out about a PrEP prescription.

Partner Services

- A very major problem is that partner services are only offered at diagnosis, not on an on-going basis. Partner services could easily be needed at a later point. Partner services is not a priority at initial diagnosis, when people are overwhelmed and feel the most internalized stigma; partner services/disclosure is not their primary concern. The system needs improvements to offer them at a later point and in different settings, such as at support groups, in jails, food banks, and not just in healthcare settings. They need to be creative in their outreach.
- There is a lack of linkage/knowledge of partner services among private providers. It helps when agencies are using public health investigators and navigators to offer partner services; they work with private providers to offer PS and help with disclosure.
- Partner Services are understaffed and lack linkages with case managers and HIV care services.
- A participate stated there is a need for better communication between the HIV clinic and county public health in Fresno. If someone wants PS, clinic contacts the county to make the referral and has no idea if the link was made, if follow-up was provided, etc.
- In some cases PS are not being used enough.

### Group 2: Mental Health/Substance Abuse Services

- There was widespread consensus of the existence of huge gaps between need and availability of services.
- There were a number of comments focusing on lack of access to mental health (MH) and substance abuse (SA) services for those in managed care plans and those on Medi-Cal. Those with insurance via ACA cannot get MH services because the referrals don't work or no one will take the low insurance payments. Participants reported a big need for MH and SA services that will accept Medi-Cal. Limited in-patient beds for mental health was noted as a need. People get lost in transitions between Medi-Cal providers, Ryan White providers, Kaiser, etc., needing to negotiate different systems for different services. For example, with managed care plan patients can't have two appointments, such as for primary care and MH services in the same day. Providers cannot bill for two appointments on the same day. . However, you can bill dental and medical appointments on the same day.
- Stigma and shame remain re: mental health. The issues are very complex (trauma, abuse).
- Social isolation for older PLWH.
- Managed care plans have minimal SA services, so clients stop looking for help. County mental health systems in the Central Valley have few SA services and nothing specific for PLWH.
- There is not enough staff for complex MH needs. The need is acute in rural areas. Mental health providers in small cities and in rural areas lack experience working with gay men. Many noted lack of access to psychiatrists, or very long

wait times, which is especially acute in rural areas. In some cases those with psychosis are seen sooner in hospitals than through outpatient providers.

- Data on depression was presented in the slides. Participants reported many mental health conditions such as anxiety, personality disorders, post-traumatic stress disorder (PTSD), historical trauma among Native populations, co-occurring MH with SA, especially meth use. The impact of the loss of a generation dying because of AIDS and the effect of this loss on MH was recognized by the participants. PTSD is very common among PLWH. Santa Rosa Kaiser reported that 1/3 of new intakes and transfer patients have PTSD.
- Implementing Trauma-informed Care was mentioned as a successful intervention.
- When making MH referrals, you often lose people- maybe 50% are actually linked to MH services.
- Need "just in time" SA treatment services- when someone is ready to treat their addictions, they are ready in that moment and those services are not often available. They need same day, timely access to "recovery beds." The common cycle of using drugs, getting treatment, back to using, etc. is a challenge so when people want to stop the cycle, they need immediate help.
- Payment for SA/opiate treatment programs is not always available; if a county does not have a program there may be no other option since in some counties drug treatment services do not accept Medi-Cal.
- A big disparity in syringe exchange access was noted. People drive over 100 miles from Central Valley to Berkeley, SF, etc. due to lack of services in their region. There remains a need for needle exchange programs. Some agencies are getting creative by offering HIV and hep C testing services with syringe exchange, but others are running into legal barriers (e.g., barriers such as needing a public comment period, taking several years to get going). There are no methadone maintenance programs in the Central Valley either.
- The level of need/diagnosis also results in different experiences, such as if someone is experiencing mild or moderate issues (which can often be addressed by LCSWs on staff), verses severe behavioral health issues. Those with greatest needs most often miss appointments.

### Group 3: Quality of HIV Care; Retention/Re-engagement

Quality of Care

- The need to renew ADAP every 6 months is creating a gap in ARV coverage in some cases, and is a hardship, especially for those unstably housed or with low incomes. It takes a team effort to avoid this gap in care.
- For the transgender populations HIV care needs to be integrated with primary care.

Retention and Re-engagement

- There is a critical need for retention/re-engagement services for people released from correctional facilities. Staff turnover in linkage between corrections and clinics is a communication challenge, resulting in gaps in care and continued retention. Prisons need someone on staff to communicate directly with Public

Health when someone is released back into the community, especially if they are moving back to counties far from the prison. Inmates sometimes (often) do not get a 30-day supply of HIV meds when released and they show up in clinic a month later for meds. Some counties (Orange) have a good system for linkage from jail because the county HIV clinic has good communication. Another good system is a collaborative led by the [local] public health department re: retention that includes corrections and community service providers.

- Rural areas with limited staffing have a hard time finding people lost to follow-up. There is a need for better communication between counties as people move around. Weak public health systems in rural counties result in people lost to follow-up.
- Retention is also a problem when patients are released from the hospital. There isn't necessarily a system in place. These patients are very vulnerable.

### Group 4: Linkage; Case Management; Housing

Linkage

- It was reported that In Sacramento heterosexuals have worse outcomes and are out of care more than IDUs.
- Challenges especially with young MSM re: linkage; hard to locate once they leave with test results.
- Trust and confidence in the system is a problem among Latinos- there is a need to build initial trust to access services.

Case Management

- Paperwork burdens for case management are overwhelming;
- There is a need for training of case managers in rural areas.
- There are issues linking case managers with Private providers.

Housing

- Housing is a critical issue in every region of California both in terms of affordability and availability. Rent caps for housing are nowhere near market rates. Vouchers do not come close to covering the cost of market rate rents.
- Housing is linked to almost every other needs assessment issue, from zero tolerance drug/alcohol policies for emergency housing to retention in care for formerly incarcerated who are not eligible for public housing.
- Legal aid is needed for people facing eviction from housing- people don't know their legal rights and how to fight evictions.

## Priority Populations

The California Needs Assessment for HIV presented information on MSM, transgender persons, MSM aged 13-24 years, and persons who are incarcerated (i.e., special populations). It was anticipated that for each California Needs Assessment for HIV topic area (e.g., linkage to care, housing, etc.), the needs of special populations would be addressed in the break-out discussions, therefore, it was decided a break-out session focused on special populations was not necessary.

## Attendance

The Town Halls had a total number of 94 participants out of 178 who registered (53 percent participation), with the following break-down: 9 people on June 7 (Central Valley); 29 people on June 9 (Northern California); and 55 people on June 14 (Southern California). Fewer people participated in the Town Halls than originally registered and a number of participants had more than one person listening in the room with them, as noted on a polling question asking for this information.

Additional feedback was solicited by a question on the evaluation form: "*Other needs that were not identified that you think are critical*":

Oral health; transportation; transgender services; better coordination between public, private and Ryan White services; funding for case management and HIV outreach; more funding for intensive case management by mental health/substance abuse professionals; lack of integration from state to county to cities; for incarcerated populations, access to consistent prevention education and prevention services; syringe access in Central Valley; comprehensive services for those aging and living with HIV; assistance for isolated senior folks to get supportive services set up for aging in place; more connections between HIV and STD services, especially with regards to PrEP.

## Evaluation Results

At the end of the Town Halls, participants were asked to complete an on-line evaluation form using polling questions. This enabled us to gather immediate feedback on participants' experience. Results confirmed that virtual on-line, real-time Town Halls are a viable option for obtaining information and participation from a wide variety of representatives located throughout California.

Evaluation responses:

- "The format allowed me to voice my opinions in an open, nonjudgmental setting: 60/70 (86 percent) either agreed or strongly agreed.
- "I was able to participate as much as I wanted to:" 64/69 (93 percent) either agreed or strongly agreed.
- "The virtual Town Hall process was an efficient and effective way to capture a variety of perspectives throughout California:" 48/72 (67 percent) agreed or strongly agreed.

Other comments from the Evaluation Survey included the following:

- The process was very inclusive.
- This is a great way to conduct the California Needs Assessment process.
- I loved the format. It really helped to hear the perspectives and experiences.
- This virtual format was innovative and very useful.
- I appreciated being able to hear from folks from other regions in California and across a range of types of agencies
- Although not completely perfect, I think this was the best way to allow participants from multiple regions in a very short period of time. It was also very cost-effective for participants.

- I think additional Town Halls like this one as the Needs Assessment process continues may be helpful to ensure that the varying opinions and input are heard and incorporated into the Needs Assessment process.
- Good process.

## Other Beneficial Town Hall Results

The small-group, break-out sessions offered the opportunity for a wider and more focused dialogue than a large, group discussion, enabling participants to delve into one issue more in-depth, and to share lessons learned and resources. This was an unexpected positive outcome- the sharing of experiences and an exchange of information among participants. Examples of shared ideas included the following:

- Advice regarding clean syringe exchange services and ways to address legal barriers;
- Tips for reimbursement from a major behavioral health provider in the State;
- Grant funding to buy cell phones and cell phone service as an incentive for ongoing retention in care for women and young people;
- Information about the Transitions Clinic Network of medical homes for people with chronic diseases for recently released inmates from prison;
- Integrated clinic models that include same-day visits with a case manager and the clinician;
- Training all service provider staff on trauma informed care to better serve clients and prevent burn-out.

## Conclusion

The virtual Town Hall events were a cost-effective and efficient means to document a wide variety of perspectives and obtain geographic representation throughout California for the California Needs Assessment for HIV. While the process did not obtain specific quantitative data regarding needs and gaps, the qualitative results confirmed that OA is on the right track regarding the needs it has identified to- date. As the needs assessment process must be an ongoing activity to ensure that California continues to focus its HIV plans, services, and funding on the most critical needs, for the most vulnerable and at-risk populations, virtual Town Halls are a viable option for ongoing feedback, participation and representation.

# Appendix B: Cross-Walk Between the California Needs Assessment for HIV and the HRSA/CDC Integrated HIV Prevention and Care Plan Guidance, Including the Statewide Coordinated Statement of Need, CY 2017 – 2021

## Table 31. Cross-Walk Between the California Needs Assessment for HIV and the HRSA/CDC Integrated HIV Prevention and Care Plan Guidance Including the Statewide Coordinated Statement of Need, CY 2017 – 2021

| **HRSA/CDC *Plan Guidance*** | ***California Needs Assessment for HIV*** |
|---|---|
| Section I: Statewide Coordinated Statement of Need/Needs Assessment: Introduction | 2.0 Background and Overview |
| Section I.A.: Epidemiologic Overview | 4.0 Epidemiologic Overview and Continuum of HIV Care |
| 1.A.a. Description of geographical region of the jurisdiction | 4.0 Epidemiologic Overview and Continuum of HIV Care |
| 1.A.b. Socio-demographic characteristics of persons newly diagnosed and PLWH | 4.0 Epidemiologic Overview and Continuum of HIV Care |
| 1.A.b. Socio-demographic characteristics of persons at higher risk of HIV infection | 6.2 Pre-exposure Prophylaxis |
| 1.A.c. Burden of HIV in the service area | 4.0 Epidemiologic Overview and Continuum of HIV Care |
| 1.A.d. Indicators of risk for HIV infection | 6.2 Pre-exposure Prophylaxis<br><br>NOTE: Additional information on risk indications is forthcoming in supplemental briefs 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment |
| Section I.B: HIV Care Continuum | 4.0 Epidemiologic Overview and Continuum of HIV Care |
| 1.B.a. HIV Care Continuum of the Jurisdiction using the most current calendar year data | 4.0 Epidemiologic Overview and Continuum of HIV Care Figures 2 and 3 |
| 1.B.b. Description of disparities in engagement among key populations along the HIV care continuum | 4.0 Epidemiologic Overview and Continuum of HIV Care California Integrated Plan Figure 4 |
| 1.B.c. Description of how HIV care continuum is utilized in planning and improving outcomes | 4.0 Epidemiologic Overview and Continuum of HIV Care<br>California Integrated Plan |

*Table continued on next page.*

## Table 31. Cross-Walk Between the California Needs Assessment for HIV and the HRSA/CDC Integrated HIV Prevention and Care Plan Guidance Including the Statewide Coordinated Statement of Need, CY 2017 - 2021

| Section I.C. Financial and Human Resources Inventory | 5.0 California Financial and Human Resources Inventory |
|---|---|
| I.C.a. Jurisdictional HIV Resource Inventory | 5.0 California Financial and Human Resources Inventory Tables 18-21 |
| I.C.b. Narrative description of HIV Workforce Capacity | 5.0 California Financial and Human Resources Inventory – HIV Workforce Capacity |
| I.C.c. Narrative description of how different funding sources interact | 5.0 California Financial and Human Resources Inventory - Resource and Funding Interaction |
| I.C.d. Narrative description of needed resources and/or services which are not being provided, and steps taken to secure them | 6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on needed resources and services is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care |

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## Table 31. Cross-Walk Between the California Needs Assessment for HIV and the HRSA/CDC Integrated HIV Prevention and Care Plan Guidance Including the Statewide Coordinated Statement of Need, CY 2017 - 2021

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|---|---|
| Section I.D. Assessing Needs Gaps and Barriers | 6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on needs, gaps, and barriers is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care. |
| 1.D.a. Process used to identify HIV prevention and care service needs | 3.0 Methods |
| 1.D.b. Description of HIV prevention and care service needs of people at risk for HIV and PLWH | 6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on prevention and care service needs is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care. |
| 1.D.c. Description of Service Gaps | 6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on service gaps is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care. |
| 1.D.d. Description of Barriers | 6.1 HIV Opt-Out Testing<br>6.2 Pre-exposure Prophylaxis<br><br>NOTE: Additional information on barriers is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care |
| *Table continued on next page.* | |

## Table 31. Cross-Walk Between the California Needs Assessment for HIV and the HRSA/CDC Integrated HIV Prevention and Care Plan Guidance Including the Statewide Coordinated Statement of Need, CY 2017 - 2021

| Section I.E.: Data: Access, Sources, and Systems | 3.0 Methods |
|---|---|
| 1.E.a. Process used to identify HIV prevention and care service needs | 3.0 Methods<br>6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on process used to identify service needs is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care. |
| 1.E.b. Description of data policies | 6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on data gaps is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care. |
| 1.E.c. Description of data or information that was unavailable | 6.1 Routine Opt-Out HIV Testing<br>6.2 Pre-Exposure Prophylaxis<br>6.12 Additional Local Needs, Gaps, and Barriers<br><br>NOTE: Additional information on data gaps is forthcoming in supplemental briefs 6.3 Linkage to care, 6.4 Partner Services, 6.5 Case Management, 6.6 Housing, 6.7 Mental Health Care and Treatment, 6.8 Substance Abuse Care and Treatment, 6.9 Quality of HIV Medical Care, 6.10 Retention in Care, 6.11 Re-engagement in Care. |

# Appendix C: Glossary of Acronyms

| Acronym | Definition |
|---|---|
| AAHIVM | American Academy of HIV Medicine |
| ACS | American Community Survey |
| ADAP | AIDS Drug Assistance Program |
| AETC | AIDS Education and Training Centers |
| AHP | Alliance Health Project |
| APLA | AIDS Project Los Angeles |
| ARIES | AIDS Regional Information and Evaluation System |
| | |
| BRFSS | Behavioral Risk Factor Surveillance System |
| | |
| CA | California |
| Cares | CARES Community Health |
| CBO | Community-based organization |
| CDC | Centers for Disease Control and Prevention |
| CDPH | California Department of Public Health |
| CHIS | California Health Interview Survey |
| CI | 95% Confidence Interval |
| CMS | Centers for Medicare and Medicaid Services |
| CNA | California Needs Assessment for HIV—2016 |
| Con Plan | Consolidated Plan; a locally developed plan for housing assistance and urban development under the Community Development Block Grant and other CPD programs |
| CPA | California Project Area (All of California except for the Los Angeles and San Francisco Eligible Metropolitan Areas |
| CPD | Community Planning and Development (HUD Office of) |
| CPG | California Planning Group |
| CRUSH | Connecting Resources for Urban Sexual Health Demonstration Project |
| CY | Calendar year |
| | |
| DIS | Disease Intervention Specialists |
| | |
| ED | Emergency department |
| eHARS | Enhanced HIV/AIDS Reporting System |
| EHR | Electronic health records |
| EIIHA | Early Identification of Individuals with HIV/AIDS; a Ryan White HIV/AIDS Program |

| | |
|---|---|
| EMA | Emerging Metropolitan Area of the Ryan White HIV/AIDS Program |
| EMR | Electronic medical records |
| | |
| Family PACT | Family Planning, Access, Care, and Treatment program |
| FQHC | Federally Qualified Health Center |
| FY | Fiscal year |
| | |
| GTCV | Get Tested Coachella Valley campaign |
| GYT | Get Yourself Tested campaign |
| | |
| HARC | HIV/AIDS Resource Center |
| HET | MMP cycle applying to heterosexuals at increased risk for HIV infection |
| HIT | Health information technology |
| HIVMA | HIV Medicine Association |
| HOPWA | Housing Opportunities for People With AIDS |
| HRSA | Health Resources and Services Administration |
| HUD | U.S. Department of Housing and Urban Development |
| | |
| IDU | Injection Drug Use |
| INPUD | International Network of People Who Use Drugs |
| | |
| LEO | Local Evaluation Online |
| LHJ | Local Health Jurisdiction |
| | |
| MMP | Medical Monitoring Project |
| MSM | Men who have sex with men |
| | |
| NHANES | National Health and Nutrition Examination Survey |
| NHAS | National HIV/AIDS Strategy for the United States: Updated to 2020 |
| NHBS | National HIV Behavioral Surveillance |
| | |
| OA | California Department of Public Health, Center for Infectious Diseases, Office of AIDS |
| | |
| PACE Clinic | Partners in AIDS Care & Education Clinic |
| PAETC | Pacific AIDS Education and Training Center |
| PEP | Post-exposure prophylaxis |
| PLWH | Persons living and diagnosed with HIV; people living with HIV |
| PrEP | Pre-exposure prophylaxis |
| PS | Partner Services |
| | |

| | |
|---|---|
| SFAF | Sierra Foothills AIDS Foundation |
| SHAP | STD/HIV AIDS Program |
| STI | Sexually transmitted infection |
| | |
| TGA | Transitional Grant Area of the Ryan White HIV/AIDS Program |
| | |
| US | United States of America |
| USPSTF | United States Preventive Services Task Force |
| | |
| YRBSS | Youth Risk Behavioral Surveillance System |