Office of AIDS (OA) Update

- In the FY 2013-14 Enacted Budget, the OA programs which receive state General Fund include Local Assistance (LA) funds for the HIV/AIDS surveillance program and Support funds ($3.29 million) for multiple OA programs.
  - There were no changes in the $6.65 million General Fund Local Assistance for the HIV/AIDS Surveillance program.
  - In FY 2013-14, ADAP returned $16.9 million to the General Fund, made possible by the transition of eligible clients to the Low Income Health Program (LIHP) through December 31, 2013 and to Medi-Cal Expansion or Covered California effective January 1, 2014.

- The California Department of Public Health (CDPH) initiated discussions regarding the advantages to persons living with and at risk for HIV/AIDS, other STDs, and viral hepatitis in California to more completely integrate our STD program [the STD Control Branch which also includes CDPH’s small viral hepatitis program, all located within the Division of Communicable Disease Control (DCDC) in the Center for Infectious Diseases (CID) at CDPH] into our HIV/AIDS program [the OA, a Division located in CID at CDPH]. The goal of this proposed integration was to better serve our constituents with the limited funding that we all have by improving program coordination and optimizing staff resources. After completing extensive stakeholder engagement regarding this proposal, CDPH convened a stakeholder teleconference on May 2, 2013 to discuss the proposal and get stakeholder input, and similar discussions with local public health officials throughout California via the California Conference of Local Health Officers Communicable Diseases Committee, the California Conference of Local AIDS Directors, the California STD Controllers, and others were held. CDPH determined in the summer of 2013 that structural integration of the STD Control Branch and the Office of AIDS into one Division is not possible without legislative change, since current state statute defines OA as responsible for HIV-related activities and DCDC as responsible for STD control activities. As a result, this structural integration, if we chose to attempt it, could not happen for at least a few years and ultimately would require concurrence by the legislature. As a result, we adopted a partial integration model that involves project teams comprised of subject matter experts from both programs working together on joint projects. We are currently actively collaborating with our STD colleagues so as to best meet the needs of persons at risk for and living with HIV and other STDs in California.
• Governor Brown appointed Karen E. Mark, MD, PhD as Chief of the Office of AIDS in the Center for Infectious Diseases of the California Department of Public Health on June 21, 2013. Dr. Mark served as the Interim Chief of the Office of AIDS starting in September 2011.

• OA continued to collaborate with the California Department of Health Care Services (DHCS) LIHP Division in hosting biweekly OA/DHCS Ryan White Health Care Reform Stakeholder Advisory Committee calls, in which OA and DHCS worked together with county AIDS Directors, county Ryan White, ADAP, and LIHP Coordinators, HIV medical and non-medical providers, advocates, PLWHA, and other stakeholders throughout the state to create policies to enable a smooth transition for clients from Ryan White services into the LIHPs and other new payer sources related to the Affordable Care Act.

• The DHCS LIHP Division hired a new staff member, Debbie Wong-Kochi, who has been working closely with the Office of AIDS and outside HIV stakeholders on issues related to the transition of Ryan White clients into the LIHPs and from the LIHPs into Medi-Cal Expansion. Debbie has been closely involved in the OA/DHCS Health Care Reform Stakeholder Advisory Committee and other stakeholder meetings.

• OA worked closely with Covered California on issues related to serving PLWHA in Covered California, and gained commitment from Covered California to include information about Ryan White (Care and ADAP) into the next iteration of the Assisters training curriculum.

• OA co-sponsored the Affordable Care Act and HIV: Implementation Issues for California Ryan White Medical Directors and Administrators meeting on November 6, 2013 in Los Angeles. The meeting purpose was to provide a forum for clinic medical directors and administrators to share best practices and discuss challenges to care continuity in the new Affordable Care Act environment. Feedback from participants indicated that the meeting was successful in meeting its purpose.

• OA released two fact sheets on the status of California with regards to the National HIV/AIDS Strategy and the continuum of HIV care. These fact sheets provide baseline data on how California is doing relative to the national epidemic and sets specific targets to work toward.

  o The Continuum of HIV Care in California: [http://cdph.ca.gov/programs/aids/Documents/HIVCareContinuum-Dec2013.pdf](http://cdph.ca.gov/programs/aids/Documents/HIVCareContinuum-Dec2013.pdf)

Ryan White (RW) Part B HIV Care Program (HCP)

- OA transitioned its RW Part B HCP contracts from a state funding year to align with its federal funding year. To begin this transition, HCP and MAI contracts received a 9-month contract term starting July 1, 2013 through March 31, 2014. All subsequent contracts terms, beginning in funding year 2014, will be April 1st-March 31st.

- In July 2013, the revised RW HIV/AIDS Program Part B Manual was released by the Health Resources and Services Administration (HRSA). The manual was posted on the OA website at www.cdph.ca.gov/programs/aids/Pages/tOACareProviders.aspx and is also available on the HRSA website at http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf. OA began revising program and fiscal guidance for the HCP and MAI programs to align with updated HRSA policy to be released in 2014.

- In August 2013, OA received the final 2013-2014 Notice of Award (NOA) from HRSA, with reductions that were less than originally anticipated (7% as opposed to 12.7%). The reductions were a result of: 1) a reduced federal RW Part B allocation that was based on changes in how HRSA allocated RW funding among states; and 2) federal spending cuts called sequestration.

- OA collaborated with the DHCS to convene the Health Care Reform Communications Workgroup (HRCW), which was a workgroup of the RW Health Care Reform Stakeholder Advisory Committee. HRCW met monthly to develop a Communications Plan focused on systematic communications to educate RW providers and their clients about the impact of the Affordable Care Act on the RW system of care. The Communications Plan was released in April 2014.

- The HIV Care Branch hired three new staff who will contribute to the planning and implementation of the HCP: Jill Michel, HIV Care Operations Section Chief, Marjorie Katz, RW Policy Specialist, and Liz Hall, RW Program Specialist.

- On August 12, 2013, OA distributed a Management Memo to RW Part B HCP Contractors to clarify the roles and responsibilities between OA and RW Part B contractors regarding the annual site monitoring of sub grantees. The memo reiterated that RW Part B contractors have the responsibility of conducting annual monitoring site visits and follow-up for all of their sub-contractors. A teleconference call was held with RW Part B HCP Contractors to review the Management Memo and answer questions.

AIDS Drug Assistance Program (ADAP)

- On January 23, 2013, ADAP disseminated a management memo to ADAP Coordinators and Enrollment Workers (EWs) regarding a phased in
implementation plan for biannual ADAP eligibility recertification. The memo described the process and requirements for Phase I of informing new clients and clients that are returning for their annual recertification of the biannual ADAP recertification requirement. In January 2013, ADAP conducted three EW conference calls to provide technical assistance on the new biannual recertification requirements. OA, in collaboration with our ADAP Bi-Annual Recertification Work Group, composed of ADAP Coordinators and EWs, consumers, HIV advocates, and local AIDS Directors, developed processes and requirements for Phase II. This phase includes having ADAP’s Pharmacy Benefits Manager mail clients a Self-Verification Form to self attest ADAP eligibility. Due to administrative issues, Phase II was not implemented in 2013. OA plans to implement Phase II in 2014 and will conduct training for ADAP EWs prior to implementation.

- On February 5, 2013, the Insurance Assistance Section (IAS) released a management memo that provided updates on policies and procedures for the OA-Health Insurance Premium Payment (OA-HIPP) and OA-Pre-Existing Condition Insurance Plan (OA-PCIP) programs. The management memo is located on the OA website at www.cdph.ca.gov/programs/aids/Documents/IASMM201301.pdf.

- On February 19, 2013, OA notified OA-PCIP enrollment workers that the federal government suspended new PCIP enrollment after March 1, 2013. All currently enrolled PCIP clients would continue to receive services through 2013, and OA would continue to pay the monthly premiums for all OA-PCIP clients through 2013.

- On April 24, 2013, ADAP released Management Memo No. 2013-06, Ryan White Requirements and the Low Income Health Program (LIHP) – Frequently Asked Questions (FAQ) #6. The purpose of the memo was to inform ADAP Coordinators and local AIDS directors about Assembly Bill 1468, which permits OA to share RW HIV/AIDS Program client data, including ADAP client data, with county LIHPs and allows county LIHPs to share this data with the person to whom the information pertains, the person’s HIV care provider and OA. This new law also allows county LIHPs to share data relating to persons diagnosed with HIV/AIDS with OA. The memo also included a copy of FAQ #6, which addresses ADAP’s data sharing process. FAQ #6 was disseminated to county LIHP administrators by the DHCS and was posted on the OA website at www.cdph.ca.gov/programs/aids/Documents/LIHPFAQ6DataSharing.pdf.

- On May 14, 2013, OA was informed that the state PCIP will be transitioned to the federal PCIP effective July 1, 2013. Subsequently, OA developed a management memo that was posted online and sent to all enrollment workers that described the transition and its impact to clients. Furthermore, a new OA-PCIP application and a letter explaining the transition and the change in benefits were sent to each OA-PCIP client on May 29, 2013. Beginning June 19, 2013, each OA-PCIP client
was contacted to follow-up on the client’s application to transition to Federal PCIP as well as to obtain a new consent from that provides authorization for OA to communicate and exchange information with the Federal PCIP. As of July 11, 2013, 214 OA-PCIP clients had opted to stay in the program. On July 2, 2013, a check was sent to the National Finance Center to cover the July premiums on behalf of 212 OA-PCIP clients.

- In June 2013, ADAP completed a three-year site visit/compliance review cycle: OA-ADAP committed to performing technical assistance visits/compliance reviews for all of California’s ADAP enrollment sites within a three-year period. ADAP met this goal and is moving forward with visiting/reviewing all of California’s ADAP enrollment sites again, this time within a two-year period.

- On September 9, 2013, Dolutegravir (Tivicay) 50mg tablets was added to the ADAP formulary. Dolutegravir was approved by the FDA on August 12, 2013, and is the newest antiretroviral drug of the integrase-inhibitor class and is used for both treatment-naïve and treatment-experienced HIV infected individuals. With the addition of dolutegravir, ADAP has 185 drugs on the formulary.

- On November 27, 2013, ADAP released a letter to all ADAP clients providing information on Medi-Cal Expansion and Covered California. The letter informed ADAP clients that the two new health programs would be available to California residents beginning January 1, 2014. The letter provided eligibility information and instruction on how and where to apply for Medi-Cal Expansion and Covered California.

- On December 2, 2013, IAS sent a letter to all OA-PCIP clients to inform them that the PCIP program was ending on December 31, 2013. The letter included eligibility information and instructions on how and where to apply for Medi-Cal Expansion and Covered California health care coverage.

- On December 3, 2013, ADAP released Management Memo No. 2013-17 to all ADAP Coordinators and ADAP Enrollment Workers. The purpose of the memo was to educate ADAP Enrollment Workers about the eligibility criteria and enrollment process for Medi-Cal Expansion and Covered California, and to document OA’s policies and procedures regarding how to enroll clients who obtain health coverage through Covered California into the OA-HIPP program.

- On December 17, 2013, the IAS presented a training webinar to OA-HIPP Enrollment Workers. The focus of the training was Medi-Cal Expansion, Covered California and how to enroll clients into OA-HIPP after they acquire coverage through Covered California. The training was recorded and posted on the OA webpage at the following link: www.proprofs.com/quiz-school/story.php?title=NjI5ODAyEXD3. The password is “OA-HIPP.”
In December 2013, OA completed a comparison chart of ARV medications listed on each of the Covered California published formularies. The chart was made available to ADAP enrollment workers and posted on the OA website at www.cdph.ca.gov/programs/aids/Documents/ADAPCoveredCaliforniaFormularyARVComparisonChart.pdf.

HIV Prevention

The HIV Prevention Branch had several key successes in policy implementation in 2013 that will likely impact HIV prevention efforts statewide.

- OA developed emergency regulations to permit the new HIV testing algorithm to be used immediately by California licensed or approved public health laboratories. The new HIV testing algorithm can identify positive HIV test results much more rapidly than the existing HIV algorithm -- within 14 days of infection -- which is as many as 31 days earlier than the standard algorithm used in California laboratories. In a side-by-side comparison of the existing and new algorithm over an 18-month period, the San Diego Public Health Laboratory found 14 acute HIV infections that would not have been detected using the existing laboratory algorithm. The San Francisco Public Health Laboratory also ran a side-by-side comparison of the existing and new algorithm and found 19 acute HIV infections in 2012. The emergency regulations were approved by the Office of Administrative Law and are now in effect. Eight of California’s 38 Public Health Laboratories are using the new algorithm and it is expected that more will be using it by the end 2014. OA will be working with private labs to encourage use of this superior algorithm.

- OA developed regulations to implement the CDPH Syringe Exchange Program (SEP) Certification program, which allows qualified agencies to apply to OA for authorization to add syringe exchange to their services for injection drug users (IDUs). The regulations were approved and the program was launched in December 2013. Although this program does not impact existing SEPs, it will allow agencies in areas of the state that may not have Board of Supervisor or City Council support to pursue local approval to apply directly to OA for authorization.

- In collaboration with the California Department of Public Health’s STD Control Branch, OA issued a memo clarifying current California law that permits local health officers and their designees (i.e., partner services staff) to use locally-acquired HIV surveillance data to identify individuals infected with HIV and offer them partner services. This clarification of California law may help to expand surveillance-based partner services in local health jurisdictions, and OA will be providing technical assistance in 2014 to support these local efforts.
HIV Set-Aside Funds Initiative: The Substance Abuse and Mental Health Services Administration mandates that in the states most impacted by HIV/AIDS, five percent of the Substance Abuse Prevention and Treatment (SAPT) block grant to the states must be dedicated to HIV Early Intervention Services (EIS); these funds are commonly referred to as “HIV Set-Aside funds.” OA had previously identified several key challenges in the effective use of these funds as they have been allocated by the California Department of Drug and Alcohol Programs (now merged into the California DHCS), chiefly related to failure to target HIV testing to high risk populations such as gay men and other men who have sex with men, and failure to use funds to support HIV-positive individuals in drug treatment. DHCS’s federal funding for HIV EIS totals $12.5 million, making the program one of the largest public funders of HIV testing in the state. In 2013 OA worked with DHCS to inform their leadership about the National HIV/AIDS Strategy (NHAS) and help them to align their funding strategies more closely with the NHAS. DHCS’s new policy directs high-incident LHJs to target HIV testing within their drug treatment programs to MSM and IDUs, directs high and medium-incident LHJs to focus on providing medical services to HIV-positive individuals in drug treatment programs, and encourages low and medium-incident LHJs to use their funds for hepatitis C virus (HCV) and STD testing in these same settings instead of screening for HIV. This new guidance may be expected to expand efforts to reach out to gay men and other MSM who receive treatment for substance use disorders, and to expand access to HCV and STD testing in drug treatment programs.

Targeted HIV Testing: The OA Prevention Branch continues to prioritize targeted testing efforts, linkage to care (LTC) and partner services (PS). In Year 1 of OA’s implementation of the PS12-1201 High Impact Prevention grant from the Centers for Disease Control and Prevention (CDC), LHJs prepared to align testing priorities with the NHAS, and LHJs were asked to shift away from local venues that tested non-priority populations or that yielded low test numbers or low positivity rates. In 2013, OA issued new guidance that put new emphasis on achieving higher positivity yield through improved targeting of high-risk individuals for testing, rather than through increasing the number of tests. Success in the “treatment as prevention” paradigm means the focus on finding positives (yield) is more critical than ever. OA will develop additional technical assistance based on examination of populations with highest positivity yields – not all “high risk” populations are equal when it comes to yield. An analysis of positivity yield from Year 1 revealed that the vast majority of the newly-identified confirmed positives are captured within the top six risk categories (transgender, MSM, MSM/IDU, IDU, HIV-positive sex partner, and sex worker), with very few occurring in the remaining groups. As a result of this, OA has revised indicator reports to highlight these risk groups in a “high” risk category, reporting on the remaining groups in “moderate” and “low/no identified” risk categories. OA will also be providing technical assistance to help clarify the value of focusing on
those clients at highest risk for HIV by showing that more than seven times as many tests would need to be performed to find an equivalent number of positives in the “moderate” risk group.

- Expanded HIV Testing in Health Care Settings: The Expanded HIV Testing program has succeeded in integrating HIV testing elements into a variety of different Electronic Health Records (EHR). The EHR systems can now alert the medical assistant and/or the medical provider to order an HIV test. In some locations, an HIV test has simply been added to all standing lab orders. If the patient knows their HIV status or has had an HIV test in the past, the provider can remove the HIV test from the standing lab order. If the patient opts out of the HIV test, the EHR systems will set a reminder for the provider to test the patient at a future visit. These integrations have allowed health care resources to be utilized in other areas and have dramatically increased the total number of HIV tests. In 2013, Expanded HIV Testing in Health Care settings tested 71,931 people, almost 10,000 tests above the goal. An additional purpose of this program is to integrate these services into health care settings that serve communities disproportionately impacted by HIV. In 2013, 18% of newly-confirmed positives were African Americans and 42% of newly-confirmed positives were Latino. This data demonstrates our success in meeting the goals of this program and in addressing health disparities.

- Evaluation: OA developed LHJ-specific reports for testing indicators relevant to the goals outlined in the Comprehensive Program Plan (CPP) which were developed to set benchmarks for achieving the goals of the NHAS. These reports provided data on targeted testing services for each indicator by demographics, risk groups and risk levels, and were provided to all 19 funded LHJs. In conjunction with the reports, a customized evaluation worksheet was provided to each LHJ to use to determine their success at meeting specific objectives defined for them based on the HIV burden in their area. For example, because San Diego represents 22.4 percent of the burden of HIV in the California Project Area (CPA), their proportional Year 1 goal for identifying newly confirmed positives was 29 individuals, a goal which the San Diego LHJ exceeded. The worksheet functioned as a "report card" of sorts for the LHJs, clearly highlighting successes as well as showing areas for improvement on each of the important measures, such as HIV positivity yield, LTC, and provision of PS.

- Training: OA implemented HCV rapid test proficiency training for existing test counselors in 2013. Additionally, OA began the work to update the Basic Counselor Skill Training (BCST), in collaboration with OA training partners Alliance Health Project, San Francisco County Department of Public Health, Los Angeles County Division of HIV and STD Programs, and AIDS Health Foundation. The new BCST curriculum will include a comprehensive training on both rapid HIV and HCV test kits.
Comprehensive Prevention with Positives: The shift toward high-impact prevention with positives (PWP) activities continues. During 2013, OA worked with LHJs to increase the number of interventions focused on PWP while moving away from focusing on high-risk negative populations. OA guidance recommends maintaining an appropriate level of testing in alternative testing site settings and referring low risk clients to testing through their health care providers when possible, and shifting of focus to LTC, PS, retention and re-engagement and other PWP services.

Biomedical Interventions: OA continued to follow the development of PrEP protocols and best practices in order to identify and develop the most effective role for the State and its contractors in the provision of PrEP.

Condom Distribution Program: OA’s previous condom distribution had a regular set of venues (approximately 25-30 venues) ordering condoms, with a majority ordering for populations that were not part of our current priority populations. With OA’s new condom distribution program, the 19 Prevention-funded LHJs recruit and form working relationships with venues in both health care and non-health care settings that serve HIV-positive people and those at highest risk for acquiring HIV. This proactive approach has yielded 297 participating venues to date. This approach has created working partnerships that enable venues to refer their patrons to HIV/AIDS services offered by the LHJ. LHJs report increases in community interest in HIV information as well as an increase in referrals to health department services.

Funding: The HIV Prevention Branch examined several different ways to approach funding the California Project Area in light of a 6 percent cut in CDC HIV Prevention funding. OA consulted with the AIDS Directors of the Prevention-funded counties, and their input helped shape OA’s final decision on how best to allocate funds in order to meet NHAS goals. OA’s updated Prevention Program Guidance provides details on changes to OA’s HIV prevention plan, and is designed to provide information on all activities required and permitted under OA’s Prevention contracts with LHJs. The updated guidance includes additional resources to assist LHJs to develop and enhance local prevention portfolios, and incorporates lessons learned from the first two years of implementation of CDC’s PS12-1201 grant in the California Project Area.

California Planning Group (CPG)

OA convened the final CPG meeting for this membership term on April 3, 2013 in Sacramento, CA. The meeting focused on brainstorming ideas for structuring the next three-year round of CPG activity as well as discussed accomplishments during the previous three years such as the development of the OA Integrated Plan which included the Statewide Coordinated Statement of Need element.
• OA developed, with feedback from stakeholders, a CPG membership recruitment process for the 2014-2016 membership term. A change to this process compared to previous years is that the local HIV planning councils and groups were asked to nominate candidates in order to improve communication and coordination between local and state planning groups. In addition to the nominated candidates, OA also solicited for “at-large” applicants to represent the community and other stakeholders. The CPG application and review process was completed and the new CPG members were notified in February 2014.

• Information about the CPG can be found on the OA website at www.cdph.ca.gov/programs/aids/Pages/OACPG.aspx. For additional questions about CPG, please contact Liz Hall at liz.hall@cdph.ca.gov.

AIDS Regional Information and Evaluation System (ARIES)

• During 2013, OA worked with the Alameda County Office of AIDS Administration to transition their Ryan White Parts A, B, C and D-funded providers from using CAREWare to using ARIES for their data collection and reporting requirements. As of February 2014, the last data conversion was completed.

• OA continued discussions with the Los Angeles County Division of HIV and STD Programs to establish a data protocol for importing Ryan White Part B clients and services from its Casewatch data system into ARIES.

HIV Surveillance

• OA released an updated Adult Case Report Form in 2013 that is consistent with the most recent CDC adult case report form and integrates data collection for HIV incidence surveillance.