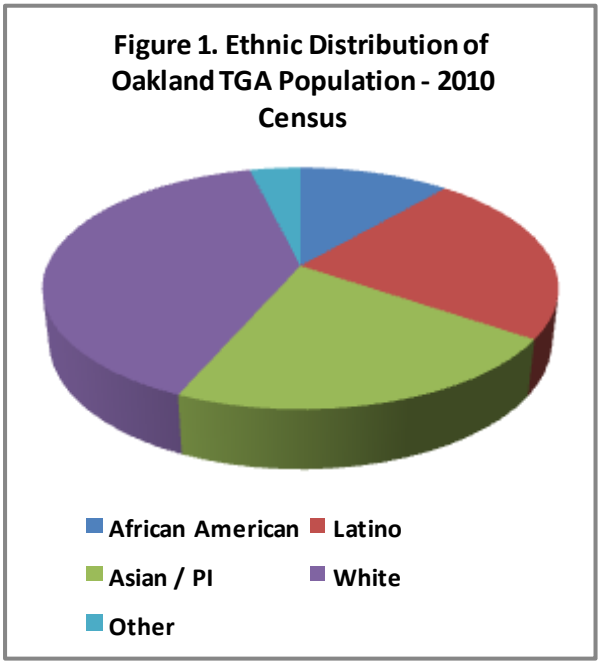
- **INTRODUCTION**

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high-quality, life-extending care, free from stigma and discrimination."[1]
- Vision for the National HIV/AIDS Strategy, July 2010

The Oakland Transition Grant Area (TGA) - a region hard-hit by the HIV/AIDS epidemic, particularly in regard to its impact on ethnic minority populations, respectfully requests a total of **$7,550,832** in FY 2015 Ryan White Part A Formula and Supplemental funding to support a comprehensive continuum of high-quality HIV care in our region. Requested funding will support a coordinated, comprehensive, and tailored plan for utilizing Part A funds to address the most critical underfunded needs in the local epidemic, with an emphasis on **core services** that provide fundamental support for maintaining health, stability, and quality of life. The funding plan simultaneously addresses a broad range of key HRSA priorities, including the need to: a) respond to identified service gaps and barriers in the TGA; b) address the needs of emerging populations; c) encourage PLWHA to remain engaged in primary care and adhere to medications; d) promote parity of services; and e) ensure that services are delivered in a manner that is culturally and linguistic appropriate to the regional service population. The funding plan also incorporates the most recent findings from a wide range of data, resource documents, studies, and publications that were used by the TGA Planning Council in making its decisions, and integrates an increasingly aggressive approach toward coordinated HIV care within the full spectrum of services along Continuum of HIV Care.



The Oakland TGA encompasses the hard-hit, ethnically diverse counties of **Alameda and Contra Costa -** the two easternmost counties of the San Francisco Bay Area. Together, the counties share a land area of **1,458** square miles encompassing major urban and suburban centers and extensive rural areas. The counties are large, and roughly equivalent in land mass (**733** square miles for Alameda and **725** for Contra Costa), which means that the underprivileged in both counties must often travel far distances to access needed services.

The combined Alameda / Contra Costa County region is one of the most ethnically diverse in the nation. According to the 2010 Census, the TGA is home to **2,559,296** residents, **59%** of whom reside in Alameda County and **41%** who live in Contra Costa County.[2] Persons of color make up fully **60.3%** of these residents, including a population that is **20.0%** Latino, **11.3%** African American, and **23.3%** Asian / Pacific Islander (see **Figure 1**). Non-Hispanic whites, by contrast, make up only **39.7%** of the overall TGA population. The city of **Oakland** in Alameda County - the nation's **47th** largest city - has a 2010 population of **390,724** and is even more diverse than the TGA as a whole, with whites making up **25.9%** of the total population and other ethnic groups comprising **74.1%** of local residents. The percentage of African Americans in Oakland (**28.0%**) is the **second** highest in California for places of 100,000 or more. More than **one third** of Oakland TGA residents (**37.2%**) speak a language other than English at home while more than **one-fourth** (**27.2%**) are foreign born. A total of at least **46** different languages and dialects are spoken here.

The local Ryan White Part A grantee is the Alameda County Board of Supervisors, which delegates this responsibility to the Public Health Department. The TGA operates as a tri-jurisdictional entity made up of the Alameda County Health Department, the Contra Costa Health Services Department, and the City of Berkeley Department of Health Services, which functions as an independent health jurisdiction within Alameda County.

- **NEEDS ASSESSMENT**

1) Jurisdictional Profile

1.A) HIV Incidence and Prevalence Table - Please see below

Reporting Categories	CY 2011	CY 2012	CY 2013
HIV Incidence: Number of new non-AIDS HIV cases reported during calendar year	**199**	**203**	**206**
AIDS Incidence: Number of new AIDS cases reported during calendar year	**40**	**38**	**25**
Total HIV/AIDS Incidence:	**239**	**241**	**231**
HIV Prevalence: Number of persons living with non-AIDS HIV at the end of calendar year	**2,371**	**2,438**	**2,547**
AIDS Prevalence: Number of persons living with AIDS at the end of calendar year	**5,213**	**5,271**	**5,255**
Total HIV/AIDS Prevalence:	**7,540**	**7,644**	**7,761**

1.B) PLWHA Characteristics Table - Please see **Attachment 3**

1.C) HIV/AIDS Epidemiology Narrative

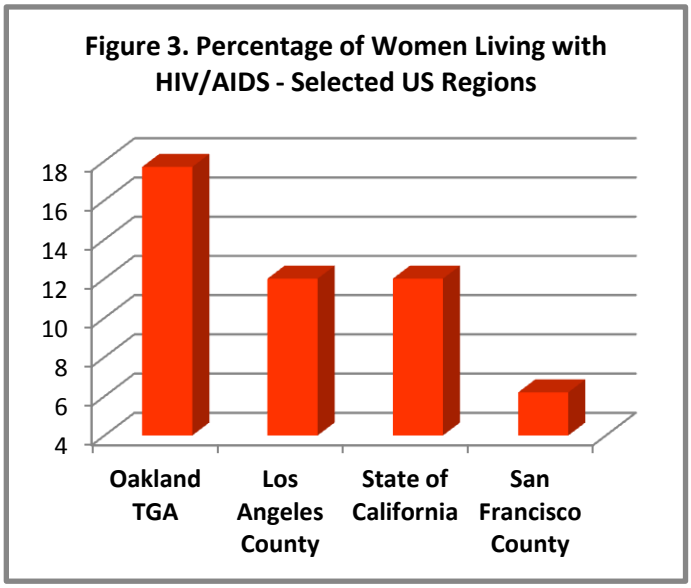
<u>Disproportionate Impact of Current HIV/AIDS Cases:</u> The epidemic of HIV/AIDS continues to constitute a severe and urgent health emergency for the Oakland TGA, one that takes a highly disproportionate toll on persons of color, women, and low-income individuals and families. With **11,799** cumulative AIDS cases diagnosed as of July 31, 2014, Alameda and Contra Costa Counties have the **17th largest** number of cumulative diagnosed AIDS cases of any US metropolitan area, and a cumulative AIDS caseload larger than that of **29** US states.[3] Alameda County alone had the **fourth highest** number of cumulative AIDS cases by county in California as of mid-2014, while Contra Costa ranks **tenth** in relation to other counties.[4]

As of December 31, 2103, a total of at least **7,661** persons were living with confirmed HIV/AIDS infection in our region, for an overall case incidence of **299.3** per 100,000 population.[5] The high local case incidence means that at least **1 in every 334** residents of the Oakland TGA is already living with HIV infection. Between 2003 and 2013, the total number of persons living with HIV in the TGA increased by **nearly 40%,** despite the fact that federal resources to address the epidemic have declined significantly over that period. The total caseload in our region includes **5,207** confirmed persons living with AIDS (PLWA) and **2,554** confirmed persons living with HIV (PLWH). The Oakland TGA also estimates that there are an additional **2,653** persons living with HIV in the TGA who are unaware of their HIV status, representing **34.2%** of the region's PLWHA population, based upon a projected HIV prevalence ratio of 1 PLWH to every 1 PLWA – an estimate developed through an epidemiological consensus process in July 2012 for the San Francisco EMA directly west of our TGA. Between 2011 and 2013 alone, a total of **711** new cases of HIV were diagnosed in Alameda and Contra Costa Counties. The majority of confirmed PLWHA in our TGA (**5,5,649** or **72.8%**) reside in Alameda County, while **27.2%,** or **2,112** cases, are Contra Costa residents.

<u>African Americans and Persons of Color:</u> The HIV/AIDS epidemic continues to have a devastating and highly disproportionate impact on African American populations in the Oakland TGA. As of December 31, 2013, African Americans make up **39.0%** of all persons living with HIV or AIDS in the region (n=**3,030**s) while making up only **11.3%** of the TGA's total population, a startling over-representation of nearly **400%**. African American PLWHA significantly outnumber white PLWHA in the TGA (**3,030** vs. **2,795**), and outnumber all other non-white ethnic groups **combined** by a factor of nearly two to one (**39.0%** to **24.9%**). While roughly **1 in every 334** residents of the TGA as a whole is infected with HIV, fully **1 in every 74** African American residents of the TGA is already infected with HIV. **The crisis of HIV among African Americans is so acute that in 1998 Alameda County took the unprecedented step of declaring a State of Emergency in relation to the African American HIV/AIDS epidemic, the first time that a local jurisdiction had taken such an action.** The rate of HIV/AIDS prevalence in African American populations (**1052.6** cases per 100,000 residents) is **four times higher** than the rate in non-Hispanic whites (**275.0** cases per 100,000 residents). By comparison, non-Hispanic whites comprise **39.7%** of the general population while accounting for **36.0%** of HIV/AIDS prevalence. HIV/AIDS prevalence rates in Latinos (**236.1** cases per 100,000) and Asian / Pacific Islanders (**58.1** cases per 100,000) are lower than rates among African Americans and non-Hispanic whites, although as indicated above, the epidemic is growing fastest within these populations (see **Figure 2**).

Figure 2. HIV/AIDS Prevalence by Ethnicity as of 12/31/13 - Oakland TGA						
Ethnicity	**2010 US Census Population**		**HIV/AIDS Prevalence**		**Population Variances**	**HIV Prevalence Per 100,000 Population**
	#	**%**	**#**	**%**		
African American	287,853	11.3%	3,030	39.0%	**+ 27.9%**	**1,052.6**
White	1,016,436	39.7%	2,795	36.0%	**- 3.7%**	**275.0**
Latino	585,773	23.2%	1,383	17.8%	**- 5.4%**	**236.1**
Asian / Pacific Islander	562,568	22.0%	327	4.3%	**- 17.7%**	**58.1**
Other / Unknown	106,666	3.8%	226	2.9%	**- 0.9%**	**211.9**
Total	**2,559,296**	**100%**	**7,761**	**100%**		**303.3**

<u>Women:</u> The Oakland TGA contains the highest percentage of diagnosed AIDS cases among women of any major metropolitan area in the western United States. As of December 31, 2012, fully **17.8%** of all people living with HIV and AIDS in our two-county region were women, as compared to percentages of **12.2%** for Los Angeles County, **12.0%** for the State of California, and **6.5.%** for San Francisco County (see **Figure 3**).[6] A total of **1,374** women were living with HIV or AIDS in the Oakland TGA as of December 31, 201, the **African American women**, who account for only **12.1%** of the adult female population yet account for **nearly two-thirds** (**62.7%**) of all women living with HIV/AIDS. By contrast, non-Hispanic white women account for **39.7%** of the TGA population but only **18.5%** of HIV/AIDS prevalence. Latina and Asian / Pacific Islander women account for **13.1%** and **3.5%** of HIV/AIDS prevalence respectively, while representing **23.2%** and **22.0%** of the adult female population.



As of December 31, 2013, an estimated **one out of every four** people living with HIV/AIDS in the Oakland TGA was a woman, infant, child, or young person (WICY) age 29 or younger. A total of at least **2,000** women, infants, children, and young people were living with HIV/AIDS in the region through December 31, 2013, representing **25.8%** of the **7,761 confirmed** PLWHA in the region. According to the most recent published CDC statistics through December 31, 2010 - the most recent date for which statistics could be obtained - the Oakland TGA WICY population was the **highest among all 14 western EMAs and TGAs,** with a WICY proportion nearly **three times higher** than that of our neighbor San Francisco EMA, at **7.96%** (see **Figure 4**).

Homelessness: According to a report by the National Low Income Housing Coalition, both Alameda and Contra Costa County rank among the **seven least affordable counties** in the United States in terms of costs of rental housing.[7] Because of the high costs of housing and low vacancy rates in the two counties, on any given night it is estimated that **15,000** individuals are homeless on the streets of the Oakland TGA, a rate of **586.1** per 100,000. Over the course of a given year, an estimated **42,000** men, women, and children will find themselves without an adequate place to find shelter.[8] The National Alliance to End Homelessness estimates that **3.4%** of homeless people are HIV-positive. Although this estimate varies widely by geographic region, the homeless population has a median HIV prevalence rate at least three times higher than the general population. [9]

Figure 4.
Women, Infants, Children & Youth as a Percentage of Total PLWHA Population for All EMAs / TGAs in the Western United States as of 12/31/2012

Oakland, CA	22.47%
Sacramento, CA	21.04%
Las Vegas, NV	20.06%
San Bernardino, CA	16.03%
Phoenix, AZ	15.86%
San Jose, CA	14.81%
Los Angeles, CA	14.64%
Portland, OR	13.29%
Seattle, WA	13.05%
Denver, CO	11.91%
San Diego, CA	11.85%
San Francisco, CA	7.96%

Formerly Incarcerated Populations*:* While absolute numbers of incarcerated persons with HIV are difficult to ascertain, a blinded HIV seroprevalence survey of inmates entering California Department of Corrections reception centers found that **2.5%** of entrants were HIV-positive.[10] Rates were highest in African American women (**2.8%**), followed by African American men (**2.3%**), white men (**1.3%**), and Hispanic men (**.06%**). Rates in white women and Hispanic women were each less than **.05%.** By applying this 2.5% to the **65,000** inmates released to Alameda and Contra Costa counties over the last 3 years,[11] we estimate that a minimum of **1,625** HIV-infected inmates were released to the two counties in TGA during this period. Given the fact that the CDC estimates that HIV seroprevalence in correctional facilities is **five times higher** than the general population,[12] formerly incarcerated persons are clearly a disproportionately impacted population.[13]

Populations Underrepresented in the Ryan White HIV/AIDS Program: **Figure 5** below provides a demographic and risk profile of the HIV/AIDS epidemic in the TGA compared to Alameda County Ryan White program clients for calendar year 2013. The chart indicates the success of the local Part A program in bringing higher percentages of marginalized, impoverished, and traditionally underserved clients into care. In terms of ethnicity, for example, the comparison indicates that **African Americans** (**+9.6%**) are overrepresented in the local Ryan White system of care, while non-Hispanic whites (**-12.8%**) are significantly underrepresented, a fact that reflects the lower rates of income and private insurance among African American communities in our region. By gender, **women** (**+9.4%**) and **transgender persons** (**+1.7%**) are overrepresented in the Part A system of care while **men** (**-11.1%**) are underrepresented. By age group, persons between the ages of **20 and 29** (**+4.5%**) and **30 and 39** (**+9.3%**) are overrepresented among Ryan White program clients because of the rising HIV case rates among younger MSM of color as well as increased testing outreach that has enabled us to successfully identify many new HIV-positive members of this population. The underrepresentation of members of primary transmission categories in Part A services is not due to a lack of service

access, but to Alameda County's new ARIES system launched earlier this year, which has created confusion with providers specifically in reporting primary HIV transmission categories. This issue is currently being addressed through system modifications and agency trainings and will result in a more accurate depiction in the near future.

Figure 5. Demographic Comparison of Ryan White Data with HIV/AIDS Surveillance Data

Demographic Group / Exposure Category	Total Unduplicated Clients Enrolled in Part A Services - 3/1/13 - 2/28/14		Combined Oakland TGA PLWHA Population as of 12/31/13		Population Variances
Race/Ethnicity					
African American	2817	48.7%	3030	39.0%	+ 9.6%
Latino / Hispanic	1196	20.7%	1383	17.8%	+ 2.9%
Asian / Pacific Islander	337	5.8%	327	4.2%	+ 1.6%
White (not Hispanic)	1341	23.2%	2795	36.0%	- 12.8%
Other / Multiethnic / Unknown	95	1.6%	226	2.9%	- 1.3%
	5786	**100%**	**7761**	**100%**	
Gender					
Female	1567	27.1%	1374	17.7%	+ 9.4%
Male	4057	70.1%	6300	81.2%	- 11.1%
Transgender	162	2.8%	87	1.1%	+ 1.7%
	5786	**100%**	**7761**	**100%**	
Age					
12 Years and Younger	11	0.2%	14	0.2%	0.0%
13 - 24 Years	144	2.5%	246	3.2%	- 0.7%
25 - 29 Years	561	9.7%	405	5.2%	+ 4.5%
30 - 39 Years	1370	23.7%	1115	14.4%	+ 9.3%
40 - 49 Years	1457	25.2%	2235	28.8%	- 3.6%
50 - 64 Years	1858	32.1%	3142	40.5%	- 8.4%
65 Years and Above	385	6.7%	504	6.5%	+ 0.2%
	5786	**100%**	**7661**	**99%**	
Transmission Categories					
MSM	2844	49.2%	4728	60.9%	- 11.8%
Injection Drug Users	626	10.8%	703	9.1%	+ 1.8%
MSM Who Inject Drugs	18	0.3%	450	5.8%	- 5.5%
Heterosexuals	135	2.3%	1258	16.2%	- 13.9%
Other	984	17.0%	73	0.9%	+ 16.1%
Unknown	1179	20.4%	549	7.1%	+ 13.3%
TOTAL	**5786**	**100%**	**7761**	**100%**	

Source: ARIES Statistical Analysis Report (STAR), 9/7/14.

New and Emerging Populations Not Reported in Previous Year's Application: While new or emerging populations not previously identified have been identified during the most

recent 12-month epidemiological reporting period, the growing infection rate among young people in Alameda County remains a cause for significant concern, particularly in terms of impacts on **young MSM of color.** Between 2010 and 2012 alone, fully **three-quarters (76.4%)** of all new HIV diagnosis in Alameda County occurred among young people ages 20 to 24. 44.3% of these cases were among African Americans while 27.4% were among Latinos. More startlingly, **MSM transmission** - including MSM / IDU transmission - accounts for **70.9%** of HIV cases among the youth PLWHA population, a fact which speaks to the extremely high incidence of youth HIV infection among young MSM of color. To address this issue, the Oakland Planning Council made the decision to devote a significant share of Minority AIDS Initiative funds to caring for young MSM of color beginning in FY 2013 (see MAI section below).

2) Demonstrated Need

2.A) Unmet Need

2.A.1) Unmet Need Table: Please see Unmet Need Framework in Attachment 4

2.A.2) Unmet Need Comparison Table: See **Figure 6** below.

Figure 6. Reported Percentages of Unmet Need in Oakland TGA – 2010 - 2013		
2010-2011	**2011-2012**	**2012-2013**
PLWH – 24.4%	**PLWH – 21.1%**	**PLWH – 24.2%**
PLWA – 24.8%	**PLWA - 21.7%**	**PLWA - 32.9%**
Total PLWHA – 24.6%	**Total PLWHA - 21.3%**	**Total PLWHA - 28.7%**

2.A.3) Use of Unmet Need Data in Planning Council Decision-Making: The Collaborative Community Planning Council utilizes the estimate of unmet need as a key component in its annual prioritization and allocation process, including a breakdown of unmet need by population characteristics. The 2010 Needs Assessment also included a heavy emphasis on specifically assessing unmet HIV service needs, producing critical information that was used by the Council in its prioritization and allocation process. This included information ranking Part A service categories in terms of those most utilized and most needed by PLWHA and recommendations addressing gaps in service delivery to ensure a more comprehensive system of care. The Planning Council utilizes Unmet Need data both to target the TGA's outreach and care linkage activities to persons who have fallen out of care and to anticipate future trends regarding the nature and composition of HIV care populations who may enter the system in the future.

Demographics and Location of Out of Care Populations: As described in **Figure 7** below, PLWA and PLWH with unmet need in the Oakland TGA are predominantly **male** (**74.9%**) and primarily **African American** (**41.8%**). **Women** living with non-AIDS HIV comprise a larger percentage of persons out of care than women living with HIV in the county (**22.5%** vs. **17.7%**). In relation to overall surveillance data, **men, persons 50 and older, Asian/Pacific Islanders,** and **whites** are **underrepresented** among those out of care while **women, young people,** and **African Americans** are **overrepresented** among persons in care,

Figure 7. Demographic Characteristics of Out of Care PLWA & PLWH in Oakland TGA as of June 30, 2013									
Categories	**Out of Care (Unmet Need)**			**In Care (Met Need)**			**Surveillance**		
	HIV-Aware PLWA	**HIV-Aware PLWH**	**Total HIV-Aware**	**HIV-Aware PLWA**	**HIV-Aware PLWH**	**Total HIV-Aware**	**HIV-Aware PLWA***	**HIV-Aware PLWH***	**Total HIV-Aware**
Total	**1,364**	**1,934**	**3,298**	**4,267**	**3,946**	**8213**	**4722**	**2099**	**6821**
Gender									
Female	17.4%	26.2%	22.5%	17.0%	19.8%	18.4%	17.40%	19.20%	18.00%
Male	81.7%	70.1%	74.9%	82.9%	79.9%	81.5%	81.30%	79.70%	80.80%
Transgender	--	--	--	--	--	--	1.30%	1.10%	1.20%
Unknown Gender	1.0%	3.7%	2.6%	0.1%	0.3%	0.2%	--	--	--
Age Group									
0 - 12 yrs	0.1%	8.6%	5.1%	0.0%	0.3%	0.2%	0.10%	0.60%	0.20%
13 - 24 yrs	1.0%	4.2%	2.9%	2.1%	4.7%	3.3%	2.00%	5.70%	3.20%
25 - 49 yrs	39.4%	52.6%	47.2%	46.0%	54.7%	50.2%	45.30%	60.20%	50.00%
50 & Over	59.2%	33.8%	44.3%	51.8%	40.2%	46.2%	52.60%	33.40%	46.50%
Unknown	0.3%	0.8%	0.6%	0.1%	0.0%	0.0%	--	--	--
Ethnicity									
Asian / Pac. Islander	3.4%	3.8%	3.6%	5.8%	5.6%	5.7%	3.40%	6.30%	4.30%
African American	40.0%	43.0%	41.8%	37.3%	41.0%	39.1%	43.20%	40.60%	42.40%
Latino / Hispanic	16.4%	22.2%	19.8%	19.2%	17.1%	18.2%	16.70%	17.50%	17.00%
White	38.1%	22.8%	29.1%	36.8%	34.8%	35.8%	33.00%	33.70%	33.20%
Other / Unknown	2.1%	8.3%	5.7%	0.9%	1.5%	1.2%	3.70%	2.00%	3.20%

*PLWH and PLWA Surveillance figures are as of Dec, 2012

attesting to the TGA's success in bringing the most highly disadvantaged populations in our region into care.

Trends Associated with Unmet Needs Over the Past Three Years: **Figure 6** above documents Oakland TGA unmet need percentages for the last three years. This year's unmet need estimate represents a significant reduction in the estimate of the total percentage of PLWHA who are currently not receiving HIV medical treatment in our region. Because of highly successful HIV testing outreach programs and the advent of the Affordable Care Act (ACA), it is extremely unlikely that fewer persons with HIV are engaged in care than in previous years. Instead, the increase is believed to be attributable to **two** distinct factors. First, with the transition to ACA coverage over the last 12 months, many providers have shifted the locations at which they access care, which in turn may have resulted in the State of California's like HIV care database showing a higher than normal percentage of patients appearing to exit care as they shifted providers. Second, Alameda County's recent transition to the ARIES database beginning in October 2013 has resulted in a client-level HIV data system which is not yet fully mature, and which may have reported lower numbers of persons in care because of underreporting at agencies who are still becoming accustomed to the system. The Alameda County HIV Epidemiology and Surveillance Unit is studying the issue in collaboration with the State of California to address this issue.

Assessment of Unmet Service Needs for Persons Not in Care: The Comprehensive 2010 Needs Assessment also a heavy emphasis on assessing unmet HIV service needs – including extensive interviews with out-of-care PLWH – which shed some important light on the disproportionate characteristics of unmet need populations and the reasons individuals with HIV may drop out of care. For example, the Needs Assessment revealed that fully **73.9%** of respondents reported having been out of care at some point during the preceding 12-month period. While the major reasons for leaving care included depression, homelessness, denial, financial issues, and the need to care for relatives, other participants reported that they were out of care because they had started using drugs (**32.0%**) and – more ominously – because their medical condition had improved (**30.2%**).

Since the Unmet Need dataset contains information on clients receiving services from ADAP, Kaiser, and organizations reported to ARIES, analysis is continually being done on the demographics of clients enrolled in these services. The information allows us to assess gaps in services by reviewing variances between clients being served by one system versus another. The Alameda County Office of AIDS has recently completed a transition from the CAREWare data system to **ARIES**, a system in use statewide which has already begun to facilitate more rapid data reporting and more comprehensive data access across our region. The system includes information on Part A, B, C, and D recipients in Alameda County and will eventually allow us to obtain a more complete picture of clients being served across the four Parts, including documenting service patterns for distinct populations and service gaps.

The Oakland TGA Planning Council also continually considers unmet need data to prioritize and fund effective mechanisms to expand the number of HIV-aware individuals who are involved in the system and receiving appropriate care and treatment. These efforts are closely linked to the TGA's EIIHA process, which includes assertive measures for linking and retaining HIV-positive populations in care. One of the most important recent Planning Council initiatives to address out of care populations has involved a new allocation of Part A Early Intervention Services funding to support enhanced linkage and re-linkage to care and treatment for persons with HIV who had formerly been part of the local Ryan White system but who had for whatever

reason dropped out of care. Key annual objectives of the project include re-linking to care a minimum of **50** newly diagnosed HIV-positive individuals who were previously lost to follow-up and linking to care a minimum of **30** previously diagnosed HIV-positive individuals who were indicated for HAART but were lost to follow-up before treatment could be initiated.

2. B) Early Identification of Individuals with HIV/AIDS (EIIHA)

2.B.1) EIIHA Data

Chart A.
Oakland TGA Newly Diagnosed HIV Test Events
January 1 - June 30, 2014

Data Elements	MSM of Color[1]	Women of Color[2]	Youth Ages 13 – 29[2]
▪ Number of test events	**439**	**2,863**	**5,510**
▪ Number of newly diagnosed positive test events	**10**	**2**	**12**
▪ Number of newly diagnosed positive test events with clients with reported linkage to medical care	**5**	**0**	**7**
▪ Number of newly diagnosed confirmed positive test events	**4**	**2**	**4**
▪ Number of newly diagnosed confirmed positive test events with client interviewed for Partner Services	**0**	**0**	**1**
▪ Number of newly diagnosed confirmed positive test events with clients referred to prevention services	**2**	**2**	**4**
▪ Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load testing[3]	**1.4**	**1.4**	**1.4**

[1] Includes all **state-funded** HIV test events with the exception of tests funded by PS12-1201 Category B (expanded testing) due to the lack of risk factor data for negatives
[2] Includes all **state-funded** HIV test events
[3] Estimated by multiplying the proportion of new diagnoses from January 1 to June 30, 2014 with both a CD4 and a VL **ever** reported and documented in HIV surveillance data (**69.9%**) by the number of newly diagnosed confirmed positive test events

Chart B. Oakland TGA Previously Diagnosed HIV Test Events January 1 - June 30, 2014			
Data Elements	**MSM of Color[1]**	**Women of Color[2]**	**Youth Ages 13 - 29[2]**
▪ Number of test events	**439**	**2,863**	**5,510**
▪ Number of previously diagnosed positive test events	**2**	**0**	**3**
▪ Number of previously diagnosed positive test events with clients with reported re-engagement in HIV medical care	**1**	**0**	**2**
▪ Number of previously diagnosed confirmed positive test events	**0**	**0**	**1**
▪ Number of previously diagnosed confirmed positive test events with client interviewed for Partner Services	**NA**	**NA**	**0**
▪ Number of previously diagnosed confirmed positive test events with clients referred to prevention services	**NA**	**NA**	**1**
▪ Number of previously diagnosed confirmed positive test events linked to and accessed CD4 cell count and viral load testing[3]	**NA**	**NA**	**0.70**

[1] Includes all **state-funded** HIV test events with the exception of tests funded by PS12-1201 Category B (expanded testing) due to the lack of risk factor data for negatives
[2] Includes all **state-funded** HIV test events
[3] Estimated by multiplying the proportion of new diagnoses from January 1 to June 30, 2014 with both a CD4 and a VL **ever** reported and documented in HIV surveillance data (**69.9%**) by the number of newly diagnosed confirmed positive test events

2.B.2) FY 2015 EIIHA Plan

2.B.2.a) Planned Activities of the Oakland TGA EIIHA Plan for Fiscal Year 2015

Estimate of HIV-Positive Individuals Who Are Unaware of Their Serostatus: The Oakland TGA estimates that a total of approximately **2,653** individuals were infected with HIV but unaware of their serostatus as of December 31, 2013, representing **25.5%** of all persons estimated to be currently infected with HIV in our region. This figure was derived by calculating a proportion of persons with AIDS to persons with HIV of **1:1** based on consensus estimated conducted by our sister EMA of San Francisco in 2012. This calculation results in an estimated total of **10,414** persons living with HIV and AIDS in the TGA as of December 31, 2013, including persons who were unaware of their serostatus. The estimate of **2,653** HIV unaware

individuals was arrived at by subtracting the total of **7,761** confirmed persons living with HIV and in the TGA as of 12/31/13 from the total estimated HIV/AIDS population..

Target Populations for FY 2015 EIIHA Plan: To better define and focus EIIHA activities in FY 2015, the following **three** populations have been selected as the target groups for the FY 2015 Oakland TGA EIIHA Plan:

1. Men of Color Who Have Sex with Men
2. Youth Ages 13 - 29
3. Women of Color

Primary Activities to be Undertaken: On a broad level, the FY 2015 EIIHA Plan will encompass **five** broad activity areas which mirror those of the FY 2013 and FY 2014 Plans. These are as follows:

1. Identifying individuals who are unaware of their HIV status and providing high-quality confidential and anonymous HIV antibody testing to them;
2. Successfully informing individuals of their post-test HIV status and ensuring provision of confirmatory test results for persons who preliminarily test positive for HIV;
3. Providing timely, accurate, and appropriate referrals to HIV-positive individuals to facilitate access to culturally competent health, medical, and social service programs;
4. Ensuring that HIV-positive individuals are successfully linked to essential medical and social services based on individual need; and
5. Providing support and navigation services that help secure long-term engagement in care while addressing immediate care engagement and retention barriers.

For purposes of the EIIHA Plan, persons have been defined as being unaware of their HIV status if they have not been tested for HIV within the **past 12 months** or if they have been tested for HIV but either did not receive a test result or, if HIV positive, did not return to receive a confirmatory test result.

The FY 2005 EIIHA Plan will place a further emphasis on improve the accuracy and timeliness of follow-up reporting related to linkage to care services, partner services, and prevention services for persons newly identified with HIV. Specific activities to be undertaken through the Plan will be tailored to meet the needs of the Plan's three identified target population groups, with a particular emphasis on overcoming barriers to testing for MSM of color, who continue to have disproportionately low levels of HIV testing engagement in our region. The Plan will also incorporate a new priority shift from the California Office of AIDS in which support for group-level HIV prevention interventions for high-risk negatives will be shifted into support for prevention for newly diagnosed positives using the ARTAS model.

Major Collaborations: The proposed FY 2015 EIIHA Plan will involve coordination and collaboration with the broadest possible range of public and private service providers and agencies throughout the Oakland TGA. This includes close collaboration with the Oakland TGA Collaborative Community Planning Council and its Prevention Committee and with the Contra Costa County HIV Consortium and ongoing coordination with both the Ryan White Part C HIV ACCESS network and the Part D-funded Family Care Network systems. Additionally, the Part A grantee will continue its efforts to broaden planning and information-sharing partnerships with private medical providers in the TGA, including major HIV care entities such as Kaiser

Permanente Northern California, with which the Office has enjoyed an increasingly close collaboration. Regional collaborative planning will have an additional focus on expanding the quality, speed, and accessibility of information technology systems through which agencies throughout the TGA can better and more rapidly access information on client-level data within the parameters of HIPPA regulations, with an emphasis on obtaining information on individuals who may have shifted care to another agency without notifying the primary care provider.

Because of its decades-long history of collaborative planning in response to HIV, the Oakland TGA is home to many close working partnerships incorporating virtually all public and private providers of HIV outreach, testing, care, treatment, and linkage in our region, all of whom have been active in implementing some or all of the components of the region's EIIHA strategy. All local HIV-specific care and prevention agencies are familiar with one another's services and approaches and work together through a number of planning structures to facilitate mutual planning and data sharing. Contra Costa County, for example, maintains its own local HIV Consortium (now also a formal subcommittee of the Oakland TGA Collaborative Community Planning Council) which provides countywide support in planning care and prevention responses and allocating funds to address areas of unmet need. Collaborative planning and information-sharing meetings also take place continually in the TGA involving County grantees and contracted prevention and care agencies, while numerous public / private planning bodies focus on specific aspects of HIV prevention and care across the region. As a merged prevention and care council, the Oakland TGA Collaborative Community Council also helps coordinate and integrate HIV care and prevention services in our region.

A significant milestone was achieved earlier last year with the formation of the **East Bay Linkage Advisory Group**, an important new countywide collaboration formed through the joint sponsorship of the East Bay AIDS Education and Training Center (AETC) and the Alameda County Public Health Department Office of AIDS Administration. Dr. Sophy Wong, who currently serves as Medical Director for the East Bay AETC, and Dr. Nicholas Moss, Director of the HIV/STD Section for the Alameda County Public Health Department, serve as co-chairs for this critical new planning and coordinating body. The East Bay Linkage Advisory Group meets **quarterly** and is currently comprised of nearly **60** HIV outreach and linkage specialists and planners based at more than **20** separate public and private agencies. Additional committees and ad hoc groups meet on a **monthly** basis to explore barriers and develop effective responses to specific linkage issues in the Oakland TGA. In 2014, for example, the group formed a task force to begin looking at ways to improve retention of the clients who have been recently re-linked to care. The Linkage Advisory Group is an active and committed group of individuals whose common purpose is to work together to improve the quality, impact, and efficiency of HIV outreach and linkage services in our region.

It is also important to note that the Alameda County Office of AIDS Administration continues to utilize Part B MAI funding to employ Georgia Schreiber, who serves as in the role of full-time countywide **HIV Linkage Coordinator**. The Linkage Coordinator serves as the County's lead point person in re-engaging clients with HIV who have been out of care for at least three months and who local HIV provider agencies have been unsuccessful in tracking re-linking to care. The Linkage Coordinator works in collaboration with all Ryan White funded agencies and providers to identify, track down, and re-engage out of care HIV-positive clients throughout our region. Although having only one individual in this position is not adequate to address the full range of regional HIV linkage needs, Ms. Schreiber has made a tremendous impact on the region's ability to re-engage in care a larger percentage of out-of-care HIV-

positive patients. Among other advances, Ms. Schreiber has achieve limited access to **DMV records** in order search for last known addresses of persons with HIV who have been lost to care and has negotiated a Memorandum of Understanding with the San Francisco Department of Public Health to share information on clients who cross the Bay for services. She has also led an effort on behalf of the State of California to release a letter highlighting the legal standing of the sharing of sensitive information from medical providers to local Health Departments in order to assist linking those with HIV to care.

Planned Outcomes of FY 2015 EIIHA Plan: As in past years, the two-part goal of the FY 2015 Oakland TGA EIIHA Plan is to a) increase the number of individuals in Alameda and Contra Costa Counties who are aware of their HIV status; and b) increase the number of HIV-positive individuals in our region who are in care. Specific objectives and activities through which progress toward these goals will be measured are described in detail below.

2.B.2.b) How the FY 2015 Plan Contributes to the Goals of the National HIV/AIDS Strategy: The goals and objectives of the proposed FY 2015 EIIHA Plan continue to be fully consistent with and contribute to the goals of the White House Office of AIDS Policy's National HIV/AIDS Strategy, including the Strategy's three primary goals of: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.[14] Our local EIIHA strategy is also fully consistent with HRSA's goal of making unaware individuals aware of their HIV status, particularly in terms of the strategy's aggressive approach to reaching and testing highly impacted HIV populations in the Oakland TGA.

2.B.2.c) Relationship to Unmet Need Estimate and Activities: The FY 2015 EIIHA Plan responds to the TGA's annual unmet need process both prospectively and retrospectively. In a prospective sense, the EIIHA Plan seeks to significantly decrease the number of persons living with HIV/AIDS in the region who are unaware of their HIV status. This is particularly critical at a time when health care reform promises to usher in new options for increasing the number of low-income persons with HIV who are able to access affordable, high-quality health care coverage. Retrospectively, the EIIHA Plan utilizes unmet needs data to prioritize specific target populations on which to focus regional outreach, testing, and care linkage and retention activities and resources.

2.B.2.a) How the FY 2014 EIIHA Plan Influenced the Current Plan: Because EIIHA Plan activities are closely coordinated with ongoing HIV prevention, outreach, and care linkage activities conducted by public and private agencies throughout the TGA, the Part A grantee relied on a wide range of data sources and reports to track progress toward FY 2014 EIIHA activities and objectives which in turn influenced the FY 2015 Plan. These include:

- Ongoing review of local HIV public and private testing data in the Oakland TGA as provided by the State of California, including demographic information on the total number of persons tested for HIV, the total number of new positives, and the percentage of new positives linked to medical care;
- Ongoing review of outreach, linkage, and retention support activities conducted by Part A-funded providers in regard to clients who have been lost to care or who are unstably engaged in care;

- Review of HIV outreach, testing, linkage, and retention activities conducted by agencies within the local Ryan White Part C and Part D care networks;
- Review of HIV prevention and outreach activities conducted by agencies funded under the CDC PS 10-1003 program in Alameda and Contra Costa County;
- Collaborative HIV testing and linkage planning conducted in collaboration with the Oakland TGA Collaborative Community Planning Council;
- Review of client satisfaction and needs assessment date in relation to EIIHA activities collected by both the local Planning Council and by local public and private HIV service organizations; and
- Ongoing collaborative planning meetings to review progress toward enhancing the local HIV testing and linkage system and to develop new approaches to expand the effectiveness of local EIIHA activities.

2.B.2.e) Planned Efforts to Remove Legal Barriers: California is fortunate to face few major legal obstacles to broadly-based HIV testing expansion and linkage services. The Oakland TGA Collaborative Community Planning Council also generates an **annual policy statement** endorsing specific policy initiatives or approaches that the Council believes have shown demonstrated success in improving access to HIV testing and care. The Council's current policy statement, entitled "Reducing Inequities in HIV", currently endorses a broad range of policy and legislative issues, including: a) endorsing needle exchange programs; b) endorsing condom distribution and HIV testing in jails and prisons; c) supporting routinized HIV testing in all medical settings; d) supporting full continued funding of the AIDS Drug Assistance Program (ADAP); e) supporting comprehensive reproductive and sexual health programs for team; and f) endorsing the Affordable Care Act (ACA) as an approach to expanding care access for low-income persons living with HIV.

2.B.2.f) FY Target Populations: As noted above, the three target populations selected for the 2015 EIIHA Plan are: **a) Men Who Have Sex with Men (MSM) of Color, with an emphasis on African American and Latino MSM; b) Youth Ages 13-29;** and **c) African American, Latino, and Asian Women.**

Why Target Populations Were Chosen: The three FY 2015 target populations were selected on the basis of **three** key factors. **First**, from an epidemiological standpoint, these three populations together encompass approximately **two-thirds** of all persons currently living with HIV/AIDS in the Oakland TGA. African American and Latino MSM alone make up over **40%** of all HIV/AIDS cases in the region as of December 31, 2013, while women make up another **18%** of all local PLWHA. **Second**, the populations represent the three groups most highly prioritized in the TGA's previous EIIHA plans by both the Oakland TGA Collaborative Community Planning Council and by key staff of the Alameda and Contra Costa County AIDS Programs. And **third**, the selected populations contain the highest rates of new HIV diagnoses as reported by the State of California for the previous January 1 - June 30, 2014 period (see testing tables above).

Challenges within Each Target Population: The three selected target populations face a broad range of barriers to accessing and utilizing HIV testing services in the region. As a result of poverty and a historical disenfranchisement from the health care system, many members of the target populations do not access or utilize routine or preventive medical care services which

in turn means that they do not access regular HIV testing or health counseling. Lack of access to transportation, a lack of knowledge of HIV and health care resources, and challenges in struggling with the necessities of day to day life also complicate the task of regularly testing many of the highest risk individuals in the TGA. The chart below details additional challenges facing each of the three FY 2015 target population groups.

Identified High-Risk Subpopulations	Additional Challenges Obstructing Awareness of HIV Status
▪ **MSM of Color**	▪ Fear that HIV risk behaviors or sexual orientation will be judged or stigmatized in culturally specific care and service settings ▪ Fear of discrimination based on ethnicity within traditional HIV service agencies ▪ Dual discrimination faced by MSM of color in terms of both sexual orientation and ethnic background ▪ Fear and mistrust regarding HIV drug treatment and the medical community among MSM of color, especially among African Americans ▪ Lack of education regarding HIV risk or the dangers of HIV related to unsafe sexual behavior, particularly in the context of drug and/or alcohol use
▪ **Youth Ages 13 - 29**	▪ Lack of youth-specific HIV testing information and outreach that is tailored to youth needs, language, and developmental levels ▪ Lack of youth-specific HIV testing outreach that is tailored to Latino and African American young people ▪ Lack of accessible, safe spaces in which young people can access non-judgmental HIV testing without fear of disclosure ▪ Inadequate long-term support to help young people effectively maintain themselves on treatment during the initial weeks following an HIV diagnosis ▪ Lack of understanding of the dangers and potential health implications of HIV infection ▪ Lack of support for youth to access HIV testing related to widespread sexual exploitation of youth, particularly involving youth employed as sex workers ▪ Shortage of drop-in and evening and weekend clinics
▪ **Women of Color**	▪ For heterosexual women in abusive relationships, a lack of knowledge regarding safe locations to seek HIV testing ▪ Fears and suspicions regarding conventional HIV medical care and drug treatments, particularly among African American and Native American populations ▪ A lack of education regarding potential HIV risk for female partners of incarcerated men ▪ High rates of intravenous drug use and unemployment ▪ Unstable access to medications/care and housing

Specific Activities to be Utilized With Each Target Population: The Oakland TGA will employ a broad range of strategies to expand awareness of, access to, and utilization of HIV testing and care services in the service region, both for persons who are currently unaware of their HIV status and for persons with HIV who have dropped out of or become lost to care. The table below outlines these activities in relation to the three FY 2015 target populations.

Identified High-Risk Subpopulations	Selected Activities to Increase Awareness and Utilization of HIV Testing and Care Services in Oakland TGA
▪ **MSM of Color**	▪ Increase and reinforce public awareness within the MSM community of the seriousness of HIV infection and the importance of testing and early intervention, particularly among young MSM ▪ Promote programs that address homophobia and HIV stigma, and provide support for positive self-awareness among MSM ▪ Expand public education and social marketing to overcome HIV stigma and the fear of HIV treatment ▪ Enhance the ability of HIV service agencies and programs to provide culturally and linguistically competent services to MSM of color with HIV ▪ Expand availability of culturally competent HIV testing venues that respond to issues related to MSM of color ▪ Expand HIV outreach and testing messages and campaigns tailored to African American and Latino MSM***** ▪ Expand opt-out testing within the Alameda County jail system and enhance linkages to community-based testing and care following release* ▪ Create expanded HIV testing opportunities in neighborhoods and venues frequented by MSM of color***** ▪ Recruit HIV testing participants through social and sexual networks of MSM of color living with HIV* ▪ Expand promotion of partner services to encourage greater disclosure and consider better linkages between syphilis and HIV partner services for this population ▪ Utilize internet-based outreach to publicize testing among MSM of color+ ▪ Ensure seamless system-wide linkages between MSM-specific testing and HIV care and treatment venues***** ▪ Utilize social networks to track and re-engage HIV-positive MSM of color who do not return for HIV test results***** ▪ Provide post-test education to overcome fears regarding HIV medications and treatment***** ▪ Ensure referrals to care and treatment agencies that specialize in health services for MSM of color or that have a demonstrated history of providing sensitive and appropriate MSM care***** ▪ Tailor referrals to meet the needs of African American and Latino MSM***** ▪ Include mental health and social support programs in MSM of color referral systems***** ▪ Ensure availability of African American and Latino MSM linkage specialists to facilitate transition to care***** ▪ Expand transportation opportunities to primary medical appointments and pharmacy visits+ ▪ Provide follow-up by specialists to ensure ongoing linkage to care for approx. 3 months following diagnosis+
▪ **Youth Ages 13 - 29**	▪ Increase the availability of accessible, youth-friendly HIV testing programs located directly within local communities and schools ▪ Expand the inclusion of routinized HIV testing in youth service programs and agencies ▪ Increase youth-specific HIV testing outreach that stresses the risks and negative consequences of HIV using youth language and terminology ▪ Utilize emerging communication technologies and tools to deliver messages

Identified High-Risk Subpopulations	Selected Activities to Increase Awareness and Utilization of HIV Testing and Care Services in Oakland TGA
	regarding HIV testing and HIV testing access sites ▪ Employ youth staff and volunteers to develop peer-to-peer programs to encourage access and utilization of expanded HIV testing services ▪ Develop outreach methods and campaigns that specifically speak to the needs and orientation of African American and Latino youth ▪ Work to overcome HIV stigma within local communities of color ▪ Conduct intensive, tailored outreach to young MSM, particularly young MSM of color***** ▪ Expand social marketing efforts to raise awareness of the risks of HIV and the importance of HIV testing among high-risk youth***** ▪ Expand the availability of HIV testing in school-based clinics* ▪ Expand the promotion and availability of HIV testing for all young people who test positive for a sexually transmitted infection ▪ Provide venue-based testing opportunities at sites frequented by high-risk young people***** ▪ Incorporate extensive partner notification programs aimed at youth social and sexual networks ***** ▪ Expand availability of HIV testing conducted by young people for young people***** ▪ Expand mobile testing opportunities at sites and events frequented by high-risk young people***** ▪ Ensure referrals to HIV health and social support programs that specialize in or have a demonstrated sensitivity to youth issues and needs ▪ Stratify referrals based on youth developmental level***** ▪ Ensure access to youth services in a range of appropriate languages***** ▪ Provide extensive peer-based referral follow-up to ensure linkage to care*****
▪ **Women of Color**	▪ Provide ongoing education to heterosexual communities regarding the risks of HIV infection and the importance of early intervention ▪ Increase access to safe testing spaces for heterosexual women in abusive relationships ▪ Expand the availability of routine HIV testing in general health settings serving women such as Planned Parenthood clinics ▪ Expand the availability of HIV testing services specific to women of color ▪ Target efforts to high-risk women of color subpopulations, including substance using women***** ▪ Expand culturally specific outreach to high-risk African American and Latina women***** ▪ Implement a program of standardized opt-out HIV testing within Planned Parenthood clinics throughout Alameda County* ▪ Target HIV testing approaches to female partners of incarcerated men***** ▪ Expand testing opportunities in traditional women's health and social service organizations+ ▪ Create safe testing and disclosure venues for high-risk heterosexual women who are in abusive or threatening relationships***** ▪ Ensure availability of testing programs in appropriate languages for non-English speaking women***** ▪ Incorporate expanded HIV testing in traditional women's service programs and health agencies+

Identified High-Risk Subpopulations	Selected Activities to Increase Awareness and Utilization of HIV Testing and Care Services in Oakland TGA
	▪ For heterosexual women in abusive or power-imbalanced relationships, ensure referrals to women's support agencies and appropriate partner disclosure support services***** ▪ For women who speak a primary language other than English, ensure referral to agencies that include indigenous speakers and interpreters***** ▪ Incorporate consideration of transportation and child care issues for heterosexual women with children***** ▪ Utilize female HIV-positive peers to support linkage to care***** ▪ Provide tailored HIV treatment access for women, such as designated women's clinic nights***** ▪ Include on-site child care wherever possible within primary HIV medical sites*****
*** = Able to be implemented immediately / + = To be implemented later**	

It is also important to note that the Alameda County Office of AIDS Administration has begun to take steps to build awareness of the problem of so-called "late testing" in Alameda County. Statistics reveal that across all ethnicities, roughly **40%** of all persons diagnosed with HIV in Alameda County meet the definition of **"late HIV testers",** defined by the Centers for Disease Control and Prevention as persons who receive a diagnosis of AIDS within one year of receiving a positive HIV test. Many of these individuals are persons who are admitted to hospital emergency rooms for HIV-related conditions and receive a diagnosis of both HIV and AIDS at the same time. High rates of late HIV testing in Alameda County suggests that too many individuals are still learning of their HIV infection or seek HIV treatment at a later stage of HIV disease progression. It also means that too many individuals with HIV are living with non-suppressed viral loads, significantly increasing their risk of passing the virus on to others. Improving access to regular and ongoing HIV testing, coupled with aggressive treatment linkage such as that already initiative by the County, will continue to significantly impact both the long-term health of persons with HIV and the overall rate of new HIV infections in Alameda County. Meanwhile, the County has begun efforts to draw attention to the issue through presentations at planning and collaborative meetings, newsletter and journal articles, web postings, and Part A grantee meetings.

SMART Objectives for Each Target Population:

MSM of Color:

1. Between March 1, 2015 and February 28, 2016, to provide a total of at least **1,233** documented HIV antibody tests for MSM of color in Alameda and Contra Costa County.
2. Between March 1, 2015 and February 28, 2016, to identify a total of at least **15** new HIV-positive individuals within this population.
3. Between March 1, 2015 and February 28, 2016, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
4. Between March 1, 2015 and February 28, 2016, ensure that at least **72%** of newly identified HIV-positive individuals have a confirmed linkage to care services.

5. Between March 1, 2015 and February 28, 2016, ensure that at least **91%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
6. Between March 1, 2015 and February 28, 2016, ensure that at least **37%** accept partner services.

Youth Ages 13-29:

7. Between March 1, 2015 and February 28, 2016, to provide a total of at least **2,158** documented HIV antibody tests for youth ages 13-29 in Alameda and Contra Costa County.
8. Between March 1, 2015 and February 28, 2016, to identify a total of at least **15** new HIV-positive individuals within this population.
9. Between March 1, 2015 and February 28, 2016, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
10. Between March 1, 2015 and February 28, 2016, ensure that at least **72%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
11. Between March 1, 2015 and February 28, 2016, ensure that at least **91%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
12. Between March 1, 2015 and February 28, 2016, ensure that at least **37%** accept partner services.

Women of Color:

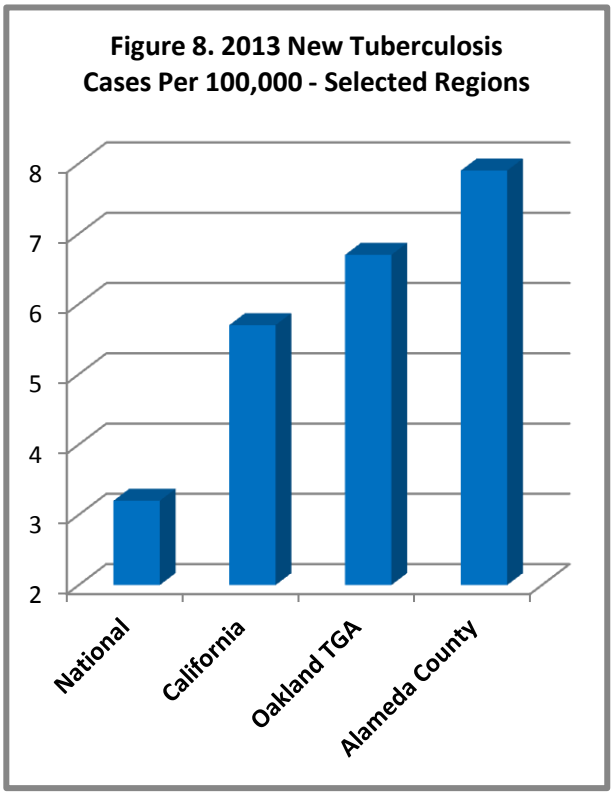
13. Between March 1, 2015 and February 28, 2016, to provide a total of at least **1,850** documented HIV antibody tests for women of color in Alameda and Contra Costa County.
14. Between March 1, 2015 and February 28, 2016, to identify a total of at least **5** new HIV-positive individuals within this population.
15. Between March 1, 2015 and February 28, 2016, to ensure that at least **90%** of newly identified HIV-positive individuals receive a confirmed HIV positive test result.
16. Between March 1, 2015 and February 28, 2016, ensure that at least **72%** of newly identified HIV-positive individuals have a confirmed linkage to care services.
17. Between March 1, 2015 and February 28, 2016, ensure that at least **91%** of newly identified HIV-positive individuals are referred to HIV prevention services; and
18. Between March 1, 2015 and February 28, 2016, ensure that at least **37%** accept partner services.

Responsible Parties and Collaborations: Implementation and evaluation of the FY 2015 EIIHA Plan will be the joint responsibility of the Alameda County Office of AIDS Administration and the Contra Costa County AIDS Program, with the close collaboration of the Prevention Committee of the Oakland TGA Collaborative Community Planning Council. Staff of the two county AIDS programs will continually collect data related to HIV testing, service linkage, and other follow-up activities for each of the target populations and will regularly report this information to the State of California and will summarize the data in regular reports to HRSA as required. Additionally, the two counties will collect information on specific enhancements and service activities brought about through the EIIHA Plan and will report these activities to HRSA as required. Modifications to the EIIHA Plan made during the 2015 Part A

fiscal year will be jointly approved by the two counties and discussed and approved by the Prevention Committee of the Collaborative Community Planning Council.

Planned Outcomes: The proposed FY 2015 EIIHA strategy will continue the work of the Oakland TGA to expand and enhance awareness and utilization of HIV testing throughout the region for the project's three key populations, while increasing utilization of care and prevention services and promoting greater adherence to HIV treatment services.

2.B.2.a) Plan to Disseminate EIIHA Plan and Outcomes: The FY 2015 EIIHA Plan will be shared with the Oakland TGA Collaborative Community Planning Council and discussed in detail with the Council's Prevention Committee, the standing committee which supports broad-based community participation in HIV prevention planning; identifies priority HIV prevention needs; and ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan. The EIIHA Plan will also be shared with the Contra Costa County HIV Consortium, the collaborative body responsible for planning and allocating public care and prevention funding in the county. A brief presentation on the EIIHA Plan will be made to the East Bay Linkage Advisory Group described above, with a specific focus on how countywide HIV outreach, testing, and linkage activities and initiatives relate to the specific objectives and activities contained in the EIIHA strategy. Ongoing progress related to EIIHA action steps will be extensively reported to the Planning Council and the Prevention Committee with the goal of refining and helping shape future EIIHA action plans and strategies. Model interventions and programs developed through the EIIHA program will be broadly disseminated and shared among public and private providers throughout the Oakland TGA, including through the unique forum of the East Bay Linkage Advisory Group. The Oakland TGA may also publish best practice documents or guidelines related to specific aspects of the outreach, testing, and linkage enhancement initiative, and/or develop and conduct trainings for local agencies and staff on demonstrated methods for enhanced EIIHA-related planning and program implementation.



2.C) Unique Service Delivery Challenges

A wide range of service delivery challenges complicate the provision of HIV care and treatment in the Oakland TGA and put individuals at increased risk for HIV transmission, particularly within ethnic minority communities. The following is a summary of some of the most critical factors influencing our ability to provide care for local PLWHA populations.

Tuberculosis: A total of **171** new cases of active tuberculosis were diagnosed in Oakland TGA in 2013, for a TGA-wide rate of **6.7** cases per 100,000. This rate is significantly higher than both the statewide rate of **5.7** cases and the national rate of **3.2** cases per 100,000 (see **Figure 8**).[15] In Alameda County the TB rate is

significantly higher, at **7.9** cases per 100,000, meaning that Alameda County has the **fifth highest tuberculosis rate among all of California's 58 counties.**

Cost and Complexity of Treating TB among PLWHA*:* Service data indicates that at least **27** Ryan White clients served in the last fiscal year were co-infected with TB and HIV. The treatment for TB is both costly and lengthy. HIV-positive patients with active TB need an initial chest x-ray, prophylactic treatment, and must be followed daily until the disease is controlled. Treatment for cases **of multidrug-resistant tuberculosis** are particularly expensive, with one nationwide study indicating that the cost of treating multidrug-resistant TB - including indirect costs to families - averaged **$89,594** per person for those who survived, and as much as **$717,555** for patients who died.[16] Once symptoms respond to medication, patients must be seen monthly for a year, with a chest x-ray. Officials of the health departments of Contra Costa and Alameda County estimate the cost of treatment at approximately **$5,000 per person**, including **$800** in drug charges, resulting in a total cost of at least **$135,000** to treat TB in co-infected Ryan White clients.

Diversity in Population: The Oakland TGA is a racially and ethnically diverse geographic area in which Ryan White service providers serve clients from a wide variety of racial and ethnic backgrounds who are living with HIV or AIDS and respond to being infected in different ways. Such diversity calls for culturally competent networks of service providers, although the TGA's newly developed 2012 - 2014 Comprehensive HIV Services Plan cites cultural competency and language barriers as challenges in delivering services. Delivering a comprehensive continuum of services for diverse and vulnerable clients is further complicated by staff turnover; funding restrictions that diminish the ability of agency administrators to conduct long-term planning; the difficulties in maintaining a system-wide structure that supports and enforces ongoing collaboration in the face of dramatic funding reductions; and the need for more coordination and collaboration across Ryan White and prevention services. These issues make a complex service delivery system even more challenging for ethnic/racial groups.

Rapidly Aging HIV Service Population: As in many jurisdictions hard-hit by HIV, **persons 50 and older with HIV** are rapidly becoming the majority population being treated by the local HIV service system. In the Oakland TGA, persons 50 and older make up **nearly half** of all persons estimated to be living with HIV and AIDS (**48.3%**) and the **majority** of persons living with AIDS as of 12/31/13 (**54.8%**). According to the most recent analysis of PLWHA 50 and older in the Oakland TGA, the vast majority of PLWHA 50 and older are **long term survivors**, with fully **71.1%** of PLWHA age 50 and above having lived with an HIV diagnosis for **more than 10 years** including nearly **one-quarter** (**21.7%**) who have lived with HIV for **more than 20 years.**

Because HIV medications are still relatively new, it is not yet known either what the long-term effects of HAART will be on older persons with HIV or how traditional health issues related to aging and geriatric health may interact with or complicate HIV treatment and care. There is some evidence that persons with HIV age 50 and older may be exhibiting traditional symptoms of aging at a point up to 10 years earlier than their non-HIV-infected counterparts. Aging populations will certainly present challenges to the health care system in terms of devising new strategies for providing integrated HIV and geriatric care, and for meeting the long-term needs of clients with increasingly complex needs. New models will need to be devised to provide effective services to aging populations that link and integrate HIV and geriatric specialty care and that ensure effective medical homes that effectively combine HIV and aging approaches and support services.

Impact of Intimate Partner Violence: Intimate partner violence (IPV), also referred to as domestic violence, is a major public health issue in the United States. According to the 2010 National Intimate Partner and Sexual Violence Survey (NIPSVS), approximately 1 in 3 women and 1 in 4 men in the United States have experienced physical violence, rape, and/or stalking by an intimate partner in their lifetime.[17] IPV is closely related to HIV infection, with one national study among 14,000 women finding that at least **12%** of HIV infections were attributed to intimate partner violence within this population.[18] Other studies have shown that HIV-positive MSM may be at least as likely to be survivors of IPV as HIV-positive women[19] and that HIV-positive MSM are more likely than HIV-negative MSM to report both physical and psychological abuse by a partner in the past 5 years.[20]

In 2013, the Oakland TGA Collaborative Community Planning Council commissioned a targeted, small-scale needs assessment designed to explore **four** key issues in HIV service delivery in the TGA, one of which was the impact of intimate partner violence on both HIV infection and on access to and utilization of HIV care in the region. The issue had come to the attention of the Planning Council during preparation of its most recent Comprehensive HIV Care Plan in 2012, and the Council made the decision to gain more information on the topic. As part of the focused Needs Assessment, Facente Consulting conducted **3** regional stakeholder meetings, **6** agency meetings, **6** consumer focus groups, **52** provider surveys, and **97** consumer surveys. Findings in regard to the IPV included the following:

- Of consumers who completed detailed surveys, fully **25%** reported having been survivors of intimate partner violence;
- Contrary to traditional views, **38%** of consumers who identified themselves as IPV survivors were **men** and **62%** were **women**;
- **Twenty percent** of whites, **27%** of African Americans, and **28%** of Latinos who responded to the survey reported being survivors of IPV
- Among persons who were IPV survivors and PLWHA, more than **half** said they thought their experience with IPV affected whether they became HIV-positive or had an impact on their health as a PLWHA; and
- Among agency providers who participated in the study, **72%** said that domestic violence is an important issue among their agency's clients.

2.D) Minority AIDS Initiative

2.D.1) Identified Targeted Minority Populations: Minority AIDS Initiative (MAI) funds play a major role in ensuring access to quality care for persons of color who are living with HIV/AIDS in the Oakland TGA. For several years, these funds had been used specifically to support high-quality ambulatory medical care services for **formerly incarcerated** low-income persons of color in our region. However, as a result of analysis of minority HIV infection and care data by the Oakland TGA Collaborative Community Planning Council in late 2012, MAI funds were re-directed beginning in the 2014 Part A fiscal year to support HIV outreach, testing, care linkage, and support and retention services specifically **young African American MSM age 24 and younger** and **women of color**, both with an emphasis on **African Americans.** This funding change responded directly to the growing incidence of new cases of HIV infection within both populations, coupled with increases in co-morbid STIs within the two groups. The funding shift also seeks to address two subpopulations within the epidemic that have confronted

our TGA for over two decades, and which the Collaborative Community Planning Council believes requires a more aggressive approach.

2.D.2) How MAI Funding Was Considered During the Planning Process: The Oakland TGA Collaborative Community Planning Council continually reviews trends in HIV testing and incidence data to identify emerging populations of color that may be facing special or expanded needs within the region. By 2012, the expanding HIV epidemic among young MSM of color and women of color in the Oakland TGA could not be ignored. As with many other populations in our region, **African Americans** make up the majority of young PLWHA, comprising **51.2%** of this population, as compared **40.1%** among PLWHA in the TGA as a whole. **Latino and Asian / Pacific Islander** youth are also over-represented in comparison to general PLWHA populations, with Latinos making up **26.0%** of youth PLWHA but only **17.9%** of PLWHA overall and Asian / Pacific Islanders making up **6.8%** of youth PLWHA but only **4.4%** of PLWHA. More startlingly, **MSM transmission** - including MSM / IDU transmission - account for **70.9%** of HIV cases among the youth PLWHA population, a fact which speaks to the extremely high incidence of youth HIV infection among young MSM of color. Young MSM color - already stigmatized as a result of race - are frequently reluctant to seek care in a timely manner because of the fear of stigma. Additionally, **26%** of youth respondents to the Needs Assessment reported being diagnosed and treated for substance abuse within the 12-month period preceding the survey. A large percentage reported using a variety of substances including alcohol, meth, and ecstasy.

At the same time, at **18.2%,** the Oakland TGA contains what is by far the largest proportion of **women** living with HIV and AIDS of any EMA or TGA in the western United States. This disproportionate representation is largely attributable to the devastating impact the HIV epidemic has had among **African American women**. African American women make up **62.7%** of all female PLWHA in the TGA as of 12/31/12. By contrast, Latina women account for **13.1%** of PLWHA; Asian / Pacific Islander women account for **3.5%** of PLWHA; and white women represent **18.5%** of female PLWHA (see **Figure 14**). The dominant mode of HIV transmission is through **heterosexual contact,** which accounts for **60.8%** of all female PLWHA cases as of December 31, 2012. **Injection drug use** also plays a critical role, underlying **21.1%** of all female HIV/AIDS cases through 12/31/12. Many providers also report that a large percentage of their female clients are **domestic violence victims**. Due to the threat of violence and out of a general fear of the stigma associated with HIV or an AIDS diagnosis, many women avoid treatment, and their HIV infection may in part be due to an inability to suggest or enforce safer sexual behaviors by their male partners. Women also often fail to prioritize their HIV care because of competing survival needs, including the need to care for one or more children. Heading up single-parent households also means that many HIV-infected women struggle with barriers related to **childcare** and **transportation** in accessing regular HIV medical care and services.

In response to this growing problem, and in response to a special presentation on Youth HIV to the Oakland TGA Collaborative Community Planning Council in September 2012, the Council made the decision to devote **all** of the region's Part A MAI resources specifically to increasing outreach, testing, care linkage, treatment, and treatment adherence support to young MSM of color ages 13 to 24 and to women of color, both with a focus on African American populations.

2.D.3) Description of MAI Funded Activities: The FY 2014 Minority AIDS Initiative subcontract was awarded to **East Bay AIDS Center (EBAC)**, a large and highly respected hospital-based HIV specialty clinic that operates the **Downtown Youth Clinic (DYC),** our region's innovative hub of care for HIV-infected young people. The DYC provides youth-centered HIV care to over **100** HIV-positive young people ages 18 to 24, over **80%** of whom are young MSM of color. The Downtown Youth Clinic is currently in the process of implementing **Project CRUSH** (Connecting Resources for Urban Sexual Health), an innovative and highly aggressive new program that will recruit and bring into medical care at least **400** of the very highest risk HIV-negative young MSM of color between the ages of 13 and 29 living in Oakland and Alameda County, California. Project CRUSH will provide these clients with comprehensive medical, behavioral, psychosocial, and risk reduction services designed to track their health status, support safer behaviors, and promote youth empowerment and self-protective outlook. Through a generous five-year funding commitment from Gilead Sciences, Inc., Project CRUSH will also provide **free daily pre-exposure prophylaxis (PreP) treatment** using Truvada to all high-risk HIV-negative young MSM of color who wish to receive it. The project will provide important new data on the impact of PreP utilization on high-risk young MSM of color. EBAC is also the largest single provider of care to **women of color** in the Oakland TGA, and is a key partner in our region's Part C-funded **Family Care Network.**

Through its first year MAI contract - which is expected to be continued in the 2015-2016 Ryan White Part A fiscal year - EBAC has been contracted to provide a comprehensive range of high-quality and culturally competent medical, psychosocial, and supportive services to HIV-positive young MSM of color and women of color. This includes the following:

- Providing high-quality, HIV specialist **ambulatory care** to a minimum of **25** YMSM of color living with HIV and **30** women of color living with HIV;
- Providing high quality **mental health** services, including mental health assessment and individual and group counseling, to a minimum of **50** YMSM of color living with HIV and **75** women of color living with HIV;
- Providing high quality **medical case management** services to a minimum of **30** YMSM of color living with HIV and **50** women of color living with HIV;
- Providing high quality **substance abuse treatment** services, including group substance abuse counseling and client advocacy to a minimum of **20** YMSM of color and **30** women of color living with HIV;
- Delivering high quality **food and congregate meals** to a minimum of **50** YMSM of color living with HIV and **75** women of color living with HIV;
- Providing **emergency financial assistance** in the form of food and utilities support to **125** YMSM of color and **175** women of color living with HIV; and
- Providing high quality **psychosocial support services** in the form of Wellness Navigator services to a minimum of **10** YMSM of color living with HIV and **15** women of color living with HIV.

In addition to the above targets, the program also provides a smaller level of supportive services to **women of color living with HIV,** with an emphasis on **young women of color**. Additionally, the program supports **ambulatory care services** to serve **25** Latino residents of Contra Costa County.

3) Impact of Funding

3.A) Impact of the Affordable Care Act

3.A.1) Uninsured and Poverty - Please see **Figure 9** below

Figure 9: FY 2015 Oakland TGA Uninsured and Poverty Data Table
Reporting Period: March 1, 2013 - February 28, 2014

(Note: The chart below provides data only for clients in the Ryan White system of care as contained in the regional ARIES database)

Client Characteristics	Number	Percentage of Total Ryan White Population
▪ Total persons with HIV who are enrolled in Medicaid, Medicare, and marketplace exchanges[1]	**3,092**	**53.4%**
▪ Total persons with HIV without insurance coverage, including those without Medicaid or Medicare[2]	**818**	**14.1%**
▪ Total persons with HIV living at or below 138% of 2014 Federal Poverty Level (FPL)	**3,807**	**65.8%**
▪ Total persons with HIV living at or below 400% of 2014 FPL	**5,786**	**100.0%**
▪ Percentage of FPL used to determine Ryan White eligibility in the Oakland TGA: **400% of FPL**		

Source: ARIES Statistical Analysis Report (STAR), 9/7/14.
[1]Does not include persons whose insurance status is listed as "unknown" at any time within the reporting period.
[2]Includes persons covered under Ryan White (without insurance coverage) at any time within the reporting period.

3.A.2) Impact of Insurance Expansion: The advent of health care reform through the Affordable Care Act (ACA) has resulted in significant, positive change in regard to the number and proportion of low-income persons with HIV in our region who benefit from affordable and more accessible health insurance coverage. California, which has eagerly embraced the ACA since its inception, began the process of implementing the ACA over three years ago through its "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver program which created the State's **Low Income Health Insurance Program (LIHP).** Eligibility and benefits available through LIHP, which was launched on July 1, 2011, mirrored to the fullest extent possible the expanded income eligibility levels and care packages of the expanded Medicaid coverage that

became available on January 1, 2014. LIHP enrollees were split into two income-based categories: Medicaid Coverage Expansion (MCE) enrollees with family incomes up to 133% (later 138%) of Federal Poverty Level (FPL) and Health Care Coverage Initiative (HCCI) enrollees with incomes above 133% (138%) and up to 200% of FPL. During the period in which the program was operating, **19** different LIHPs operated to service Medicaid Coverage Expansion enrollees in a total of **53** of California's 58 counties. At the same time, however, while all LIHP programs enrolled clients at 133% of FPL or less in expanded Medicaid lookalike programs, only **four** counties in California chose to provide direct insurance services who qualified for care through the Health Care Coverage Initiative portion of LIHP. **Two of these counties are the two counties that make up the Oakland TGA - Alameda and Contra Costa.** (The other two counties were Ventura and Orange).

Particular attention was given to ensuring that the needs of persons with HIV would be effectively met through the California LIHP program. New laws and regulations were enacted to facilitate data sharing between the LIHP program and the California AIDS Drug Assistance Program (ADAP) operated by the California Office of AIDS. Frequent policy briefs were developed and circulated beginning in 2011 to provide guidance on overlapping benefits or benefits conflict involving LIHP and other public and private insurance programs. Most importantly, activists throughout the state worked to ensure that persons with HIV who qualified for expanded Medicaid coverage would continue to receive the same high level of care they are able to receive through services funded wholly or in part by the Ryan White program. Among other outcomes, this resulted in specific policy directives regarding which HIV benefits would be coverable under expanded Medicaid and the new insurance exchange and which would remain eligible for reimbursements solely through Ryan White care.

The LIHP Program proved to be a tremendous and unprecedented success. When LIHP coverage ended at midnight on December 31, 2013, more than **630,000** Californians automatically became beneficiaries of expanded Medicaid service available through the Affordable Care Act.[21] An additional **24,000** individuals who did not qualify for expanded Medicaid began the process of obtaining coverage through the State's health insurance exchange, **Covered California** (see Marketplace Options section below). The outreach activities begun through the LIHP program have continued in 2014, resulting in stunning decreases in uninsured populations in our state. According to the Los Angeles Times, over the nine-month period between September 2013 and June 2014 alone, the percentage of Californians without health insurance was **reduced by half** as a result of ACA coverage, with the proportion of uninsured persons in the state dropping from **22%** in late September 2013 to **11%** by early June 2014.[22]

Unfortunately, because of HIV case reporting restrictions that still exist in California, many of which stemmed from the early years of the epidemic when the fear of HIV status disclosure was a very real possibility, it is impossible to currently ascertain the exact number of persons with HIV who have successfully transitioned to expanded Medicaid coverage through LIHP and the ACA. Local providers have reported percentages ranging anywhere from 5% to 12% of client populations transitioning to expanded Medical coverage as a result of the ACA, but these figures are wholly anecdotal. We do know that because of the extremely low incomes on which most persons with HIV served by Part A agencies already live, the percentage of clients eligible for benefits either through expanded Medicaid or Covered California does not represent a dramatic percentage of each agency's client base. Providers in California has recently made a formal request to the State ADAP Program for data on how many individuals previously enrolled in

ADAP transitioned to drug coverage through expanded Medicaid and other marketplace options, since that information is tracked at the ADAP level, and a response is expected soon.

3.A.3) Outreach and Enrollment: The State of California Department of Health Care Services worked in close contact with LIHP programs throughout the state - including those serving the two counties of the Oakland TGA - to educate health care providers and agencies regarding LIHP program eligibility and benefits and to train benefits program recruiters and assistants. HIV service agencies in the Oakland TGA were active participants in this process, and virtually every Part A-funded provider incorporated staff who had been fully trained in LIHP regulations and eligibility screening enrollment procedures. Both the Alameda County Office of AIDS Administration and the Contra Costa County AIDS Program participated in collaborative efforts to provide early outreach and education regarding the LIHP program beginning in 2011, and worked with the Oakland TGA Collaborative Community Planning Council to develop guidelines and informational options for Part A-funded agencies on LIHP program options. This included supporting the formation of **achealthcare.org,** a collaborative online resource for low-income persons exploring health care insurance options. The Alameda County Medical Center, the Alameda County Health Care Services Agency, and the Alameda County Health Consortium, which receives and distributes Ryan White Part C funding in the county, were all participants in this initiative.

These and other efforts were magnified in 2013 when Covered California began training thousands of **Certified Enrollment Counselors** to provide in-person counseling and assistance to consumers in need of help with applying for Covered California programs. Many HIV agency staff became certified as Enrollment Counselors, and were reimbursed on a per-enrollment basis for their assistance in linking new low-income individuals and families to Covered California services. Counselors were particularly valuable in providing assistance in a culturally and linguistic appropriate manner to distinct consumer sub-groups throughout California, many of whom had been disenfranchised from health care services on a multi-generational basis.

3.A.4) Marketplace Options: The most important complementary funding stream to support HIV care for populations with low incomes is the **Medicaid** system, or **Medi-Cal**, as the system is known in California. Medi-Cal is an indispensable link in the chain of support for persons with low-incomes and HIV in the San Francisco EMA, and it has become an even more fundamental component with the advent of expanded ACA coverage. Based on a report from the California Medi-Cal Office, Medi-Cal reimbursements in Alameda and Contra Costa County for persons with HIV totaled approximately **$54,518,260** in HIV Medi-Cal reimbursements for calendar year 2012, the last date for which statistics are available. About **one-third** (**35.8%**) of these expenditures supported the cost of HIV-related medications (**$19,518,468**) while another **36.5%** support intensive and skilled nursing care (**$19,898,646**) and **11.2%** (**$6,085,722**) supported inpatient care**.**[23] The remaining **16.5%** of Medi-Cal expenditures are dispersed among additional categories. A total of **6,286** unduplicated HIV-positive individuals were listed as Medi-Cal recipients in the TGA for the six-month period January 1 – July 31, 2012, a number that will undoubtedly be shows to have increased once conclusive client-level data is available. The Oakland Planning Council examines changes in Medi-Cal data each year and takes this information into consideration in making its annual allocation of Part A primary medical care funding.

In addition to expanding Medicaid enrollment through LIHP, California was one of the very first states to develop a **state-based health insurance exchange** authorized by the ACA, which was conditionally approved to operate by the U.S. Department of Health and Human Services in 2011. The exchange, named **Covered California,** is essentially a **virtual marketplace** that allows citizens and legally recognized immigrants who do not have access to affordable employment-based coverage and are not eligible for Medicaid or other public coverage to purchase subsidized health insurance if they earn up to 400% of FPL. Covered California health plans are also available to small employers through the Small Business Health Options Program (SHOP). In early 2013, the California Simulation of Insurance Markets (CalSIM) model predicted that at least 840,000 individuals with family incomes below 400% FPL would purchase insurance offered through Covered California and receive income-based premium tax credits to subsidize the out-of-pocket cost of coverage in 2014.[24] The vast majority of these individual are eligible for premium tax credits expected to range from 36 to 54% of enrollees in 2014.[25] However, during the historic first open-enrollment period from November 15, 2013 through April 15, 2014, more than **1.3 million** Californians chose health insurance through Covered California for coverage in 2014, while millions of additional Californians learned that they qualified for free or low-cost health coverage through Medicaid. Covered California today provides a critical bridge to affordable care for many persons with HIV in the Oakland TGA whose incomes do not qualify them for expanded Medicaid coverage.

Residents of Alameda County earning less than 200% of FPL have the option of applying for insurance coverage through **HealthPAC**, Alameda County's low income public health insurance program. HealthPAC was launched on July 1, 2011, replacing and expanding up the previous County Medical Service Program (CMSP) and initially drawing down federal funding made available through the Medicaid 1115 Waiver. The program is available to all Alameda County residents whose income is under 200% of the Federal Poverty Level and who are ineligible for other forms of insurance. HealthPAC provides a program of limited benefits for an extremely low cost, including annual exams, chronic disease care, dental care, HIV treatment, STD testing and treatment, vaccines, and vision testing.

An additional Alameda County insurance option is the **Alameda Alliance for Health,** a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents and features access to over **1,700** doctors, **29** community health centers, and over **200** pharmacies for modest, sliding scale-based monthly premiums. Contra Costa County has also operated its own public health insurance program since the early 1990s, called the **Contra Costa Health Plans** which serves over **100,000** residents, providing them with access a comprehensive array of providers and benefits, including services through the highly regarded **Contra Costa Regional Medical Center.**

Additionally, Contra Costa County's **Basic Health Care System (BHC) –** a longstanding healthcare reform model - provides universal access to health care for individuals at or below 300% of federal poverty levels. BHC provides a local health safety net for individuals who do not have other health insurance resources, ensuring access to ambulatory outpatient medical care, inpatient care, lab work, x-rays, and other medical procedures as well as access to medications, emergency dental care, nutrition consultations, and specialist care. Before receiving services through BHC, all applicants must submit an application for State Medi-Cal Assistance, demonstrate proof of residency in Contra Costa, and may receive services only through Contra

Costa Regional Medical Center and its referral partners. The BHC system provides multiple points of entry into care for HIV-positive individuals by serving clients at the Contra Costa Regional Medical Center (CCRMC) and at **13 clinics** throughout the county. Infectious disease / HIV specialty clinics operate in three regions and augment Contra Costa's Regional Medical Center's Family Practice healthcare model. Social workers staff the family practice and infectious disease clinics, and HIV specialists provide ambulatory care services. Because of a 2000 HRSA directive stating that Part A funds could not be used to augment services provided by the BHC, Contra Costa allocates only a small amount of Ryan White funding to primary care as a safety net for individuals who do not qualify for BHC due to their failure to complete the BHC registration process. **This accounts for the fact that nearly two-thirds of Ryan White Part A funds allocated in Contra Costa County go to support medical case management services.**

3.A.5) Successes / Outcomes: Because of the relatively recent enactment of ACA and the lack of extensive data on impacts of Medicaid expansion on persons with HIV, it is still not possible to document specific or detailed successes related to the expansion process in regard to low-income persons with HIV. However, as noted above, California has been extremely successful in enrolling low-income individuals in both expanded Medicaid and Covered California exchange services, with the percentage of Californians without health insurance dropping by **100%** due to expanded ACA coverage, from **22%** in late September 2013 to **11%** by early June 2014.

3.B) Impact of Decline in Ryan White Formula Funding

The Oakland TGA was grateful to receive a Part A formula funding increase for the 2014 Fiscal Year, with formula funds growing from **$3,989,731** in FY 2013 to **$4,190,965** for the current year**.** However, over the ten-year period between FY 2003 and FY 2013, Part A formula funding for the Oakland TGA was reduced by a devastating **43%,** falling from just over **$7.0 million** in FY 2003 to **$3.9 million** in FY 2013. Yet over that same time period, the number of persons living with HIV and AIDS in the region **increased** by precisely the same 43%, rising from 4,944 confirmed PLWHA in 2003 to 7,093 confirmed PLWHA by the end of 2012. This means that as the Oakland TGA's burden of HIV care has **nearly doubled,** its share of federal Part A to support these populations has been cut **nearly in half.** Between FY 2012 and FY 2013 alone, the Part A formula allocation for the Oakland TGA decreased by **13.4%**, from **$4,609,367** last year to **$3,989,731** this year.

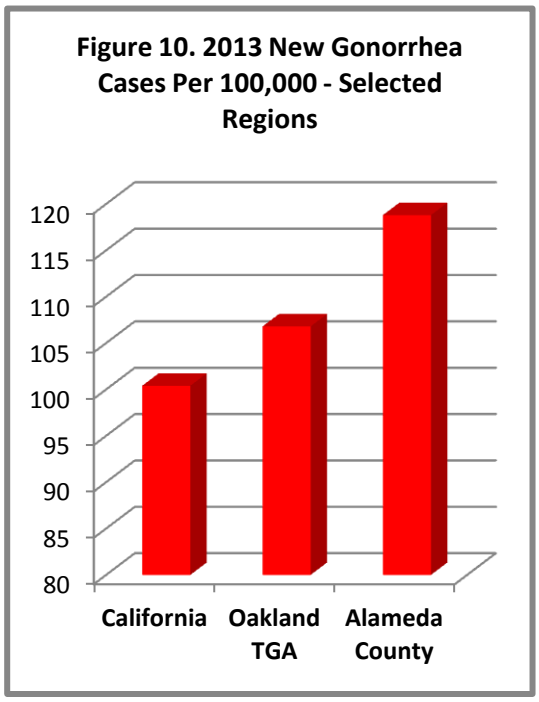
Progressively declining Part A funding has a powerfully detrimental impact on the ability of the Oakland TGA to comprehensively identify, link to care, and serve persons living with HIV infection in our region. The TGA has had to consistently struggle to maintain a high quality of care and to develop advanced systems in the face of ongoing budget cuts that often thwart the region's ability to develop new care mechanisms and to update existing systems. This has been particularly disheartening in light of the high proportion of low-income persons of color living with HIV in our region, the vast majority of whom are coping with co-occurring disorders that complicate their ability to access care and consistently remain adherence to HIV treatments and medications. While the TGA has been highly successful in developing a high-quality, multi-leveled system of HIV care linkage and access, the task has been greatly complicated by ongoing Part A formula reductions.

3.C) Impact of Co-morbidities on the Cost and Complexity of Providing Care

3.C.1) Co-Morbidities Table - Please see **Attachment 5.**

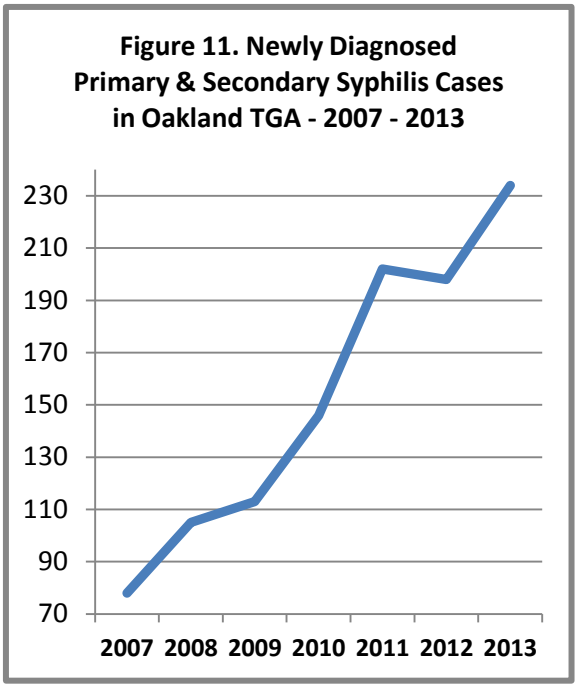
3.C.2) Co-Morbidities Narrative

Both on a national basis and throughout the Oakland Transitional Grant area, HIV care costs continue to increase due to a combination of rising co-morbid conditions, rising healthcare costs overall, a severely depressed economy accompanied by reduced employer contributions to health care, and increased survival rates of PLWHA associated with the success of Highly Active Antiretroviral Therapy (HAART). The number of PLWHA in the Oakland TGA has increased by over **33%** over the last six years, with some of the highest increases in populations already challenged by socioeconomic disparities and other medical conditions. The summary below outlines the impact of a range of HIV-related co-morbidities including sexually transmitted infections, homelessness, underinsurance, poverty, and state and federal budget issues.



Sexually Transmitted Infections: The Oakland TGA continues to experience a severe epidemic of sexually transmitted infections (STIs) which complicate the provision of care to persons with HIV and serve as ominous markers for the future of the HIV epidemic in our region. In terms of **gonorrhea,** for example, a total of **2,734** new cases were identified in the Oakland TGA in calendar year 2013 for a TGA-wide incidence rate of **106.8** cases per 100,000. This rate is higher than the 2012 California rate of **100.4** cases per 100,000 (see **Figure 10**).[26] Alameda County's 2013 gonorrhea incidence of **118.8** cases per 100,000 is **the 10th highest incidence rate** of any of California's 58 counties. Many of the TGA's new gonorrhea cases are occurring among **young women aged 15 – 24,** who accounted for **645** cases in 2013 or nearly **one-fourth** (**23.6%**) of all gonorrhea cases diagnosed in the TGA. The gonorrhea rate of **366.6** per 100,000 among 15-24-year-old women in Alameda County is the **6th highest** in California and is nearly **50% higher** than the statewide rate of **260.9** per 100,000.[27]

The Oakland TGA is also facing a serious epidemic of **Chlamydia,** with a total of **10,483** new Chlamydia cases reported during calendar year 2013 for a TGA-wide incidence rate of **409.6** per 100,000, slightly lower than the statewide incidence of **439.5** per 100,000.[28] The 10,483 chlamydia cases diagnosed in 2013 represent a **14.6% increase** from the **9,148** cases diagnosed in 2006, and represent a significant threat to our region particularly in terms of their indication of sexual risk for young women. **Nearly half** of new Chlamydia cases diagnosed in the Oakland TGA in 2013 occurred among **young women between the ages of 14 and 24** (**45.1% /** n=**4,728**), including **2,803** cases in Alameda County for a stunning countywide rate of **2,763.5** per 100,000.



Syphilis also remains a serious problem in the Oakland TGA. In calendar year 2013, a total of **234** new primary and secondary syphilis cases were diagnosed in the TGA, for an overall region-wide incidence of **9.4** cases per 100,000, roughly equivalent to the California incidence of **9.3** per 100,000 but significantly higher than the 2011 national incidence rate of **4.5** per 100,000. Alameda County has the **7th highest** syphilis rate out of all California counties (**10.0** per 100,000).[29] The 2013 syphilis caseload represents a **12.1% increase** over the 198 new syphilis cases diagnosed in the Oakland TGA in 2012 still represent a **154% increase** over the **78** cases diagnosed in 2007 (see **Figure 11**). The local growth of syphilis cases has become a significant concern for both county health departments, which have launched intensive public education and prevention campaigns relating to the epidemic.

Cost and Complexity of Treating STIs for co-infected PLWHA*:* Chlamydia requires a lab and physician visit for initial diagnosis, antibiotic treatment and follow-up visits to determine the success of treatment, as well as gynecological specialty care, all of which increase the cost and complexity of care. Treatment for gonorrhea requires an initial diagnostic visit involving urine testing followed by antibiotic treatment for those who test positive, and follow-up visits to determine the effectiveness of the treatment and six-month follow-up visits including lab tests. Syphilis is an extremely costly and complex STI to treat. Initial diagnosis requires a blood test, rather than urine test, and after initial prophylaxis treatment, monthly visits with accompanying lab tests are required for up to six months. The conservatively estimated rate for STIs other than Syphilis among PLWHA in the Oakland TGA is **3%,** or about **293** PLWHA in calendar year 2012. Although the exact cost of treating STIs for patients co-infected with HIV in the TGA can vary dramatically, we have estimated the cost of treatment in **Figure 12** by assuming a **3%** co-infection rate and applying it to available estimates of treatment costs for each STI. The number of syphilis cases is based on Contra Costa County Ryan White Part C and Alameda County Ryan White Program data indicating a **1.8%** co-infection rate. **These estimates, however, do not include the costs related to complications from STI infection nor the increased frequency of new HIV infections resulting from unprotected behaviors among PLWHA with STIs.**

Figure 12. Estimated Annual Cost of Treating STDs in Oakland TGA Among PLWHA

STI	Per Person Cost	# of Clients	Total Cost
Chlamydia	$244	293	$71,492
Gonorrhea	$160	293	$46,880
Syphilis	$444	176	$78,144
TOTAL		762	$196,516

Homelessness and Poverty Rates: The high rates of homelessness and poverty experienced by our clients in comparison to poverty and homelessness in the general population clearly place our clients at a much greater risk for negative health outcomes than within the

general public as a whole. As noted in **Attachment 5**, utilization databases indicate that **18.9%** of Ryan White clients in the TGA had a period of homelessness or unstable housing during the most recent 12-month reporting period, while **13.9%** of all 2010 Needs Assessment respondents reported that they had been homeless in the last five years and **14.3%** stated that they had lived in a homeless shelter at some point during that time. Oakland TGA Ryan White clients are far less likely to attend to basic healthcare needs, and often present at emergency rooms with advanced ailments such as abscesses, blood poisoning, and AIDS diagnosis in late stages of HIV infection. The average cost per client for short term and emergency housing assistance for each homelessness incident was at least **$1,485**. However, based on a conservative estimate of **7%** of PLWHA in care experiencing some period of homelessness each year (n=**683**) at an average annual cost of **$17,500** per person, the total cost of care may be as high as **$11,952,500**.

Formerly Incarcerated Individuals: While absolute numbers of incarcerated persons with HIV are difficult to ascertain, a blinded HIV seroprevalence survey of inmates entering California Department of Corrections reception centers found that **2.5%** of entrants were HIV positive.[30] Rates were highest in African American women (**2.8%**), followed by African American men (**2.3%**), white men (**1.3%**), and Hispanic men (**.06%**). Rates among white women and Hispanic women were each less than **.05%**. By applying this **2.5%** to the total of **65,000** inmates released to Alameda and Contra Costa counties over the last 3 years,[31] we estimate that a minimum of **1,625** HIV infected inmates were released to the two counties in TGA during this period. Most of these prisoners return to the low income neighborhoods in either Oakland in Alameda County or Richmond and San Pablo in Contra Costa County. Most state prisoners returning to the TGA have been incarcerated in San Quentin State Prison, a large, medium security prison near San Francisco in Marin County, California.

As is the case with the TGA's Ryan White client population generally, HIV positive prisoners reentering the TGA from state, federal and local jails deal with a wide variety of health problems in addition to HIV. A California Department of Health Services study reveals that the prevalence of hepatitis C in California prisons is **34%** and hepatitis B is **28%.** Estimates of prisoners with serious mental illness are as high as **20%**. Alcohol and other drug abuse rates are estimated to be as high as **85%.** California's **70%** recidivism rate is also nearly twice the national average. A high rate of recidivism means that many parolees reenter prison several times, which can subject HIV-positive individuals to treatment delays or interruption if the individual refuses medication in prison to avoid revealing that he is HIV positive. At the same time, in July 2010, Governor Schwarzenegger of California eliminated a total of **$9 million** in funding to pay for ADAP medications for all of the state's city and county jail inmates – a shortfall that will need to be filled by local jurisdictions if it is to be met at all. The TGA estimates the annual cost of care for Ryan White clients at approximately **$15,000** including a minimum of two medical visits, diagnostic and laboratory costs, pharmaceutical costs, and other costs of core services. Given the complexity of services to the recently incarcerated – including the costs of outreach, mental health services, substance use services, and the effects of late entry to care and intermittent care - the TGA estimates that these costs are increased by at least **25%** for an annual cost per client of approximately **$18,750**. Assuming an in care rate of **50%**, we calculate the cost of serving this population may be as high as **$30,468,750** per year.

Mental Illness: About **one third** of all Oakland TGA Ryan White clients served in the last fiscal year presented with mental health issues. The most commonly reported mental health problem in the 2010 Needs Assessment was **depression**, with a near-majority of respondents (**47.8%**) reporting having been diagnosed with depression, and another **42.2%** having been

diagnosed with anxiety disorder. Another **16.5%** had been diagnosed with post-traumatic stress syndrome while **12.7%** suffered from bipolar disorders. Transgender women and women of color reported being diagnosed and treated more frequently than other groups with **66%** of transgender women and **48%** of women of color reporting diagnosis and treatment for depression. An additional **8.5%** of Needs Assessment respondents reported being diagnosed with bipolar disease, with women of color (**16%**) and IDU (**9.5%**) diagnosed more than other groups.

Cost and Complexity of Treating Mental Illness: The average cost per client for mental health services per client in the Oakland TGA last fiscal year was **$1,800**. However, the need is undoubtedly greater, and per client expenditures would undoubtedly rise if more services were available. In 2004, Californians passed Proposition 63, now known as the Mental Health Services Act, which provided the first opportunity in many years to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act imposes a 1% income tax on personal income in excess of $1 million and generated $683 million in fiscal year 2009 - 2010. The Act has helped increase funding for county mental health programs to fund programs consistent with their local plans.

Substance Use: Approximately **20%** of the TGA's Ryan White clients presented with substance abuse issues in the last Ryan White fiscal year, and nearly **17%** of these were injection drug users. Tri City Health Center, a community based medical care provider in south Alameda County, has reported that **57%** of clients who identified as MSM stated that they engage in substance use and/or experience depression, anxiety or mental illness while **41%** of Latino clients reported these same problems. There were an estimated **1,323** IDU PLWHA cases in the Oakland TGA as of December 31, 2012, including MSM who inject drugs. A collaborative study involving the University of California AIDS Research Program, the Grantee, and Tri-City Health Center found a notable diversity in the ethnic background of methamphetamine using HIV positive MSM in Alameda County. Investigators conducted ethnographic mapping, field observations and qualitative interviews, and found that after learning about their positive status many MSM engaged in a period of accelerated meth use and suffered deteriorating health.[32]

Cost and Complexity of Treating Substance Use: Outpatient methadone maintenance treatment costs approximately **$12.00 per day** on a sliding scale basis while Residential Treatment for men ranges from **$52 to $85 a day** and for women from **$49 to $55 a day**. Detoxification treatment typically lasts between 21 days and six months, although methadone maintenance can last for many years. Perinatal treatment costs between **$66 and $122 per day** and lasts an average of 90 days for those who test negative for drugs upon admission or show low signs of withdrawal. Local health officials estimate that the additional detoxification, residential treatment, methadone maintenance, specialty oral health services, clinic visits, and mental health services associated with treating this population also significantly increase the costs of treating this population. At an estimated cost of **$17,500** per year per client, the costs of HIV care costs for IDUs with HIV in the TGA may be as high as **$20,650,000** per year.

3.D) Coordination of Services and Funding Streams

3.D.1) Report on the Availability of Other Public Funding - Please see **Attachment 6**

3.D.2) Appling Part A Funds to Meet Service Gaps: The Oakland TGA Collaborative Community Planning Council (CCPC) works in close collaboration with both the Alameda and Contra Costa County Health Department to ensure that all potential Ryan White funding streams

in our region are fully maximized and that funds are never used to support duplicative and overlapping services. During its FY 2015 prioritization and allocation process, the Planning Council reviewed income and utilization data related to all Ryan White sources of income, and carefully considered service gaps and client needs data to ensure that Part A funds were used to support only the most critical and underfunded services for low-income persons living with HIV/AIDS in our region. The Planning Council continually incorporated consideration of Part B funding while taking into account the dramatic cuts in funding through the State of California which devastated the State beginning in July 2009.

The Planning Council receives annual service category summaries that include a detailed listing of all non-Ryan White funding streams for each category, including sources such as ADAP, Medicaid and Medicare support, public entitlement programs, private insurance and HMO support, Veterans Administration programs, city and county funds, CDC, HOPWA and SAMHSA grants, and state mental health funds. The Grantee also works to ensure that services are coordinated to maximize the number and accessibility of services, while seeking every possible alternate source of funding apart from Part A to support HIV care.

- **METHODOLOGY**

1) Planning and Resource Allocation

1.A) Letter of Assurance from Planning Council Chairs - Please see **Attachment 7**

1.B) Description of Priority Setting and Resource Allocation Process

1.B.1) Description of Overall Structure of the Priority and Allocations Process: The Oakland TGA Community Collaborative Planning Council has responsibility for setting priorities and allocations for the Oakland TGA. The Planning Council currently includes representatives from Contra Costa County and the City of Berkeley Public Health Departments as well as other stakeholders from across the TGA. The Contra Costa County Consortium - the regional HIV planning body for Contra Costa County - also became a formal standing committee of the Planning Council this year. The Consortium actively fulfills Ryan White responsibilities for assessing local HIV service needs; prioritizing high-need services and population; allocating Part A funding based on identified needs; and monitoring the expenditure and utilization of Part A funds across the TGA.

As in previous years, the Oakland TGA Planning Council employed a multi-part process for FY 2015 priority-setting and allocations. This process began in **May 2014** with an overview on the impact of **poverty** on health disparities; a review of **current service utilization data**, including information on the number of unduplicated persons served by service category; and a **gap analysis** of target and actual units of services provided and unduplicated clients served. This was followed in **June 2014** by a Planning Council meeting which doubled as a **Town Hall forum** in which consumers, agency representatives, and other interested parties provided input into the local HIV service system, and in which the Council reviewed needs assessment and utilization data related to food and housing programs. In **July 2014**, the Council reviewed **current epidemiological data** presented by the HIV Epidemiology Section; voted on allocations by the Contra Costa County Consortium; reviewed patient satisfaction, oral health, and MAI data; and conducted service category priority ranking. In **August 2014** the Council heard a

presentation on fiscal expenditures and then discussed and voted on its final core and support services ranking and allocation percentages based on these priorities. The Council also created a **contingency plan** for the expenditure of resources under or over current Part A funding levels.

1.B.2) Description of the Community Input Process

Consideration of Needs of Persons Not in Care, Persons Unaware of their HIV Infection, and Historically Underserved Populations: The Oakland TGA Community Collaborative Planning Council utilized a range of approaches to incorporate the needs of out of care PLWHA throughout its prioritization and allocation process. The Council utilized the **Unmet Needs Framework** as a tool to quantify the number of individuals living in the TGA who are aware of their HIV status but are not currently in care. The Council heard recommendations from its People Living with HIV/AIDS Committee regarding the needs of out-of-care populations while reviewing service utilization data related to specific Ryan White service categories. The Council also continued to be informed by the findings of its **2010 Comprehensive Needs Assessment** and its **2013 Mini-Needs Assessment Updates** which included significant qualitative input from out of care populations and has influenced decisions on how best to tailor services to overcome barriers to care for PLWH.

The Planning Council relied on a combination of quantitative and qualitative data to assess the needs of **unaware populations** into its current prioritization and allocation cycle. From a quantitative standpoint, an important document the Council considers is the **TGA-Wide Epidemiological Chart** developed each year for the Ryan White Part A application which utilizes epidemiological consensus to provide a reliable estimate of the size and scope of the population of persons living with HIV in the region, including persons with HIV who are unaware of their status. From a qualitative standpoint, the Council relies on the fact that it serves as the **joint prevention and care planning council** for the Oakland TGA in order to keep informed of key developments and data related to HIV prevention activities in the region, including data related to HIV testing and care linkage and to late testers who receive their HIV positive test result in close conjunction with an AIDS diagnosis. This helps inform the Planning Council of emerging populations in the epidemic as well as future trends which will need to be incorporated into care allocation decisions.

The Oakland Planning Council has always placed a high priority on meeting the needs of **underserved populations**, and on developing care systems which facilitate entry and retention in care for these groups. This approach is consistent with the overall purpose of Ryan White funding, which is in part to develop systems that allow highly underserved individuals to access high-quality HIV care, treatment, and support services regardless of income status. Services in the Oakland are designed to ensure access to care for underserved populations and to provide culturally competent services relevant to its priority populations. As part of the FY 2015 allocations process, the Council reviewed data on persons underrepresented and overrepresented in the local Ryan White system of care based on ARIES presented by the Alameda County Office of AIDS Administration. The Council also heard recommendations regarding under-addressed needs through direct presentations by local agencies**.**

Involvement of Persons Living with HIV/AIDS: Persons living with HIV/AIDS (PLWHA) participated directly and on many levels in the formulation of the FY 2015 Ryan White Part A funding plan for the Oakland TGA. PLWHA consumers form the majority of the membership of the local Planning Council and play an active role in reviewing service and

funding data and in developing and advocating for specific recommendations regarding local priorities and allocations. In addition, the **People Living with HIV/AIDS (PLWHA) Committee** of the Planning Council meets on a **monthly** basis to discuss key Council issues related to persons living with HIV/AIDS; to review policy decisions made by the Planning Council; and to produce ongoing recommendations for Planning Council consideration. The overarching, three-part mission of the PLWHA Committee is to: a) help decide how Ryan White CARE Act funding is spent for treatment, services, education, and prevention; b) identify the needs of an advocate for people living with HIV/AIDS; and c) help ensure that agencies deliver the quality services they are funded to deliver. Additionally, throughout the prioritization and allocation process, the Council hears input from members of the public as well from as its PLWHA members, and the Council places a special focus on ensuring that PLWHA community members participate in the priority setting and allocation processes on an active basis. The overall membership of the Oakland TGA Planning Council represents the ethnic and racial diversity of the region. All ethnic groups and affected exposure categories - especially those affected disproportionately - are represented on the Council, including transgender persons, youth, and women.

An additional key strategy for ensuring input by consumers and community members involves the **needs assessment process** in which the Council engages to solicit and obtain direct input on specific needs, barriers, and issues faced by persons living with HIV/AIDS throughout the TGA. In 2010, Harder+Company Community Research conducted an extensive survey process that gathered both quantitative and qualitative data from a total of **259** PLWHA from throughout the Oakland TGA. The survey consisted mainly of closed-ended questions addressing demographics, health status, health and supportive services, and challenges to access faced by people with HIV in the region. The survey was made available in both English and Spanish, and survey participants were recruited in both counties through flyers, advertisements, agency outreach, and by posting flyers in alternative locations such as Single Room Occupancy (SRO) locations, clinics, and other alternative locations. In addition, Harder+Company staff distributed flyers at community events, meetings, drop-in groups, and other client gathering points. The results of the 2010 Needs Assessment process helped shape a series of service recommendations that will greatly enhance the quality and scope of HIV care in our region.

An additional focused needs assessment was also conducted in 2013 which concentrated on four priority planning areas in the TGA: 1) **Proximity** of persons living with HIV/AIDS to medical and support services, including an analysis of the distance clients must travel to access medical appointments; 2) Knowledge and awareness of the **Affordable Care Act (ACA)** and its provisions, including its current transitional incarnation as the Low-Income Health Program (LIHP); 3) The needs of **heterosexual HIV-positive men** in the Oakland TGA; and 4) Prevalence, awareness, and impact of **intimate partner violence** as an issue impacting both HIV infection rates and adherence to medical treatments and regimens. The findings played an additional major role in shaping priorities and allocations for the FY 2014 planning process.

Use of Data to Increase Access to Core Medical Services: In setting priorities and making allocations, the Planning Council reviewed a wide range of Office of AIDS Administration **fiscal and service utilization data** which showed high utilization of ambulatory care and case management services. Use in both categories surpassed the predicted units of service for the current Part A fiscal year by a significant degree. The Council also noted the number of individuals reporting substance use and mental health problems in both the Needs Assessment and in service utilization databases for the two counties. The Council closely reviewed updated

epidemiological data for the TGA with a focus on MSM of color, women of color, monolingual Spanish-speaking persons, injection drug users with a special focus on monolingual Spanish-speaking people, youth 13-24 years of age with a focus on young men, and transgender persons, also with a special focus on monolingual Spanish speakers.

Meanwhile, to prepare for the prioritization and allocation process, the Planning Council's **Quality, Data, and Services Planning Committee** held preliminary discussions on epidemiological trends, reviewed utilization data before it was brought to the full Council, and coordinated data presentations to the Council. In Priority Setting meetings the Council listened to public comment, discussed epidemiologic trends, reviewed several service delivery issues, reviewed information on out of care populations, established service categories and allocations, and chose Priority Populations. The Council also heard a presentation on the Consumer Needs Assessment and reviewed principles, goals, objectives, and action steps contained in the TGA's 2012 - 2014 Comprehensive HIV Services Plan.

Incorporation of Changes in Epidemiological Data: Changes and trends in the epidemic led the Planning Council to prioritize ambulatory care, medical case management, and range of important access and support services aimed at the newly emerging PLWHA demographic. As noted above, the HIV/AIDS epidemic in the Oakland TGA has increasingly affected African Americans, IDUs, young people, and women, especially women of color. PLWHA in the Oakland TGA are typically poor individuals living in some of the most economically depressed neighborhoods in the cities of Oakland and western Contra Costa along the I-80 corridor. Many clients are homeless at intake. Data for youth and transgender women indicate the possibility of high rates of untreated infection. Additionally, the growing population of HIV-infected persons over 50 has led the Planning Council to recognize and increasingly prioritize the needs of this group.

Use of Cost Data: Cost data is a central component of the Planning Council's allocation process each fiscal year. The most critical source for such data is the annual presentation by the Office of AIDS Administration of **Service and Fiscal Utilization Data** for the current Ryan White fiscal year to date and for the previous completed fiscal year. The OAA data report includes components on: a) fiscal and service utilization data by service category with the number of unduplicated clients served and number of units of service provided; b) a "gap analysis" of targeted and actual unduplicated clients and units of service by service category; and c) a HARS data report on total clients served through Ryan White Part A funding. Among other findings, the gap analysis identified a difference of **10.0%** between the number of clients stating that they needed **prepared meals** versus the clients who did not receive them (**34.0%** need vs**. 32.4%** received); a difference of **9.9%** in regard to clients needing **child care** (**22%** need vs. **12.1%** received); and a difference of **9.2%** in regard to placement and care of minor children whose parents are deceased and/or unable to care for them (**23.4%** need vs. **14.2%** received). Additional key service gaps were noted in regard to **emergency housing vouchers, respite for care providers, legal assistance,** and **peer advocacy.** While not all of these funding streams were either directly funded or increased in funding as a result of the gap analysis, the analysis as a whole emphasized the importance that clients place in services that help them obtain the basic necessities of life and that help them overcome stress and barriers to care – key elements in ensuring a robust and extensive system of client case management in ensuring access to and retention in HIV care.

Addressing Prospective Funding Changes: In order to simplify the process of dealing with either increases or reductions in potential anticipated funding levels – particularly given the

volatile nature of the current economic system - the Oakland TGA Planning Council allocates across service categories on a **flat percentage basis**. In general, this means that if Part A funding is increased, **all** services are increased proportionately to maintain the same established funding percentage for each category. Similarly, if funding is reduced, the amount allocated across each service category is reduced so that the same percentage allocations for each category remain the same. This system allows the Council to rapidly respond to potentially precipitous funding changes without the need to revisit its allocations process. However, it does not hold the TGA harmless against possible eliminations in entire service categories as a result of funding allocations becoming too low to be supported in a given category, nor does it preclude the possibility of needing to revisit the contract allocation process to accommodate severe funding changes across the entire system.

Consideration of MAI Funding: From FY 2010 - FY 2012, the Oakland TGA utilized Minority AIDS Initiative funding to support a tailored network of services directed toward recently incarcerated HIV-positive men of color. As noted above however, a review of recent epidemiological trends in the TGA, accompanied by consumer and agency input, resulted in the re-allocation of MAI funds beginning in FY 2013 to specifically address the growing needs of **young MSM of color and women of color, with an emphasis on African Americans.** This new MAI initiative is intended to make a significant contribution toward both involving young MSM and women of color in care at an earlier stage of their HIV infection while stabilizing them on treatment in order to reduce the risk of passing the virus on to others. This year, the Planning Council reviewed preliminary service data related to the FY 2014 MAI contract with East Bay AIDS Center and considered the impact of contract activities in light of available funds.

Incorporation of Data on Other Federally Funded HIV/AIDS Programs: The FY 2015 prioritization and allocation process incorporated ongoing consideration of both financial and programmatic data related to all federal sources of HIV/AIDS funding in the Oakland TGA. In addition to Ryan White funding, this includes funding sources such as Medicaid and Medicare, the US Centers for Disease Control and Prevention (CDC), HOPWA, and funds provided through the US Substance Abuse and Mental Health Services Administration (SAMHSA).

Potential Changes through the Affordable Care Act (ACA): The Collaborative Community Council is strongly aware of current changes taking place through implementation of the Affordable Care Act (ACA) and took these potential changes into account while prioritizing and allocating FY 2015 resources. While the precise scope of changes to be realized through the ACA are not yet known, California and the Oakland TGA have already begun to feel the impact of shifting resources through implementation of ACA-eligible low-income persons in the California Low Income Health Program (LIHP), California's bridge to ACA care.

Efforts to Integrate Prevention and Care: As a merged HIV prevention and care planning body for nearly a decade, the Oakland TGA Collaborative Community Planning Council incorporates consideration of both prevention and care issues at all levels of planning and allocation. Prevention issues and approaches are continually developed and vetted by the Council's freestanding Prevention Committee, which brings ideas and concepts for better integrating prevention and care forward to the Council on an ongoing basis. All Prevention Committee members also sit on at least one care-related Council committee to ensure cross-fertilization of prevention and care enhancement approaches. The Prevention Committee finalized a new Comprehensive HIV Prevention Plan earlier this year which includes approaches for enhancing the continuum of care, described in the section immediately below.

- **WORK PLAN**

A) HIV Care Continuum for FY 2015

A.1) Care Continuum Graph - See Attachment 9

A.2) Care Continuum Narrative

How the Continuum Could be Incorporated in Planning: The continuum of care graph introduced in the FY 2015 Part A Request for Applications embodies a new approach to comprehensive care which has not yet been applied to HIV prevention and service planning at the level of the Oakland Planning Council. While the chart has the potential to prompt discussion and to move planning forward in regard to the continuum of care, issues related to the chart itself will need to be addressed before it can become a practical tool for the Oakland TGA. The tool, for example, appears to assume the ability to generate a valid estimate of the total number of HIV-infected, HIV-unaware persons in our region - an ability which is not yet available to us given current limited resources. As is the case with most jurisdictions, we are also note yet able to comprehensively track HIV testing other than that provided through publicly funded test sites, which make up only a portion of the total testing being conducted in our jurisdiction. This means that our true overall HIV positivity rate in unknown, as is the extent to which we are being successful in targeting the highest-risk populations in our region across all venues. While we are working on enhancing our client-level data system, we also still the capacity to link HIV pharmacy and prescription data to clients in the ARIES system, and have deficiencies in terms of reliably reporting care engagement and viral load suppression because of reporting issues at our hard-pressed and overworked local clinics. Even when these issues are resolved over the next two years, the data available will still only apply to clients enrolled in Ryan White services, and not to other persons with HIV living in the region. There are also concerns that in the drive to move forward rapidly towards an integrated system, an assumption may be made that data collection and reporting and advanced outreach and engagement strategies and resources in Part A jurisdictions should somehow **already be in place** to adequately integrate and track data throughout the continuum, when in fact a significant new investment of resources at the federal level will be needed to make full continuum implementation a reality. The responsibility for implementing such a continuum will lie well beyond the capacity of the Part A system alone to implement or oversee, even when it is working in tandem with the local HIV prevention system.

That said, however, the Continuum of Care graph does send a clear signal regarding the future, merged direction of HIV prevention and care, one that the Oakland TGA has already embraced for more than a decade through its merged prevention and care planning council model. The graph also sends an important message to the two counties of the **TGA** and to local providers that the ability to better manage, enter, track, and coordinate data will be a critical function that will need to be significantly enhanced in the coming months and years. The Alameda County AIDS Office plans to make a presentation on the Continuum of Care graph at an upcoming Planning Council meeting, and may ask a representative of HRSA to be available by speaker phone to respond to questions regarding the Continuum model. The Part A Grantee will also incorporate discussions and considerations of the Continuum of Care chart in upcoming planning meetings to consider ways in which the Oakland TGA can better improve systems and infrastructure to better engage, support, and retain clients as they move through the continuum.

Current Successes or Possible Improvements in Supporting Client Movement Along the Continuum: The Oakland TGA continues to push forward in its effort to better support and track client movement along the HIV continuum of care. In addition to EIIHA strategies described above, including the addition of a critical, State-funded HIV Linkage Coordinator two years ago, the Alameda County Office of AIDS Administration has also received State funding and is in the process of hiring **two** additional staff whose work will be focused on HIV linkage and integration activities and whose work will enhance the impact of the proposed program. One of these individuals is a **new full-time STD/HIV Integration Epidemiologist** who will use surveillance data to support enhanced HIV and STD public health outreach and follow-up activities as well as monitor linkage and retention outcomes. The second new position is a **full-time HIV Partner Services Public Health Investigator** who will provide partner services and linkage-to-care support for individuals newly diagnosed with HIV. Both staff positions will be hired and in place prior to July 1, 2015.

Additionally, Alameda County recently received one of only **four** statewide grants from the State of California Sexually Transmitted Disease Control Branch to support a new **Expanded HIV / STD Integration Initiative** that includes the following components and outcomes:

1. **HIV Testing in STD Patients:** Increase routine HIV testing in MSM and other clients diagnosed with STDs, especially gonorrhea and syphilis, through direct case follow-up and referral;
2. **STD Testing in HIV Patients:** Increase routine STD testing among MSM and others with known HIV infection by primary clinical providers according to current guidelines;
3. **HIV Linkage and Partner Service Coordination:** Ensure that persons with new or known HIV infection are connected to the County's HIV linkage and partner service outreach staff;
4. **HIV STD Surveillance and Epidemiology:** 1) Use public health data to assess the need for HIV testing in STD cases, particularly gonorrhea and syphilis, and to track rates of STD cases in HIV-infected persons, and 2) Track testing, linkage and partner services outcomes using a quality improvement approach; and
5. **STD/HIV MSM Service Coordination:** Work with community clinicians and other service providers to coordinate responses to the STD/HIV syndemics in MSM and identify training or service gaps.

The key grant-funded intervention involves the hiring of a **new full-time STD/HIV Integration Coordinator** who will oversee and implement a series of critical new initiatives and interventions to coordinate HIV and STD testing and treatment in Alameda County with a specific focus on men who have sex with men. Among other tasks, the STD/HIV Integration Coordinator will:

- Ensure HIV status checks for all men who test positive for syphilis and/or for rectal or pharyngeal gonorrhea in the county;
- Ensure follow-up and care linkage for HIV-infected individuals identified through this process, including previously diagnosed HIV cases who are out of care;
- Conduct community outreach to determine awareness of and adherence to STD testing guidelines in public and private clinics serving HIV-infected MSM;
- Conduct training and capacity-building throughout the county to ensure strong STD testing standards and quality measures in local HIV care facilities;
- Implement innovative methods to expand ongoing STD and HIV testing among high-risk MSM in Alameda County, including through text and e-mail follow-up, online partner notification services, and potential distribution of home test kits; and

- Optimize utilization of CalREDIE and electronic lab reporting to support STD/HIV integration activities in Alameda County.

Through the proposed program, Alameda County will: **a)** increase the number of high-risk MSM who are regularly tested for both STDs and HIV; **b)** increase HIV case detection **c)** improve timely engagement in care for HIV infected persons; **d)** monitor and improve the quality of direct STD/HIV public health services in the county; **f)** enhance the impact and quality of the local MSM prevention and treatment network; and **g)** reduce new cases of HIV infection in Alameda County.

Gaps, Barriers, and Challenges in Developing and Implementing the Care Continuum Model Into the Part A Program: A key challenge that will confront the Oakland TGA as it moves forward to better integrate the care continuum into the Part A program involves the **relatively small pool of resources** available in our region to develop and implement comprehensive outreach and care engagement programs and to more comprehensively utilize data to track and manage patients along the full spectrum of engagement in HIV care, including at the level of monitoring and tracking regular and ongoing HIV testing for at-risk negative persons. Our neighbor San Francisco EMA to the west utilizes the resources of a large-scale, direct CDC grant to develop and implement uniquely complex and sophisticated approaches to HIV outreach, testing, care engagement, and tracking, such as the region's model of community viral load mapping developed in 2011. While these approaches provide invaluable models for other jurisdictions to adopt and emulate, the Oakland TGA is in desperate need of additional resources to implement a fully comprehensive continuum to seamlessly track and shepherd clients throughout all stages of movement through the continuum.

Serious challenges also exist in relation to determining calculation methods across the continuum in a manner that is both consistent and relevant. As the HIV treatment cascade is currently portrayed, all percentages along the cascade from HIV status awareness to viral load suppression are based on the same estimated population of persons who are infected with HIV but not aware of their serostatus. However, within our own system of Ryan White care, success at the level of treatment engagement, ART prescription , and viral load suppression is measured not in relation to the total HIV-unaware population but to the extent to which these measures are achieved for individuals **already engaged in care**. This creates a dissonance in terms of the specific denominators used to measure success at different stages of the continuum.

At the same time, the treatment cascade at times appears to assume a **static** population of HIV-infected persons who are unaware of their status which can be gradually but inexorably whittled down through ongoing, consistent testing. In fact, however, the population of HIV-infected, sero-unaware persons is a moving target about which too little is still known, and which varies from region to region depending on specific risk and behavioral factors at work in a given region. Better identifying and targeting the HIV-unaware population in the Oakland TGA will require much more extensive resources than we currently have at our disposal. Moreover, the HIV-infected but unaware population continually expands even as it is reduced, making it difficult to measure success without better strategies for estimating and pinpointing the unaware population. These and other issues will need to be addressed at the Ryan White level before a truly comprehensive continuum of care strategy can be implemented in most jurisdictions.

Using the FY 2015 Award to Address Continuum Gaps & Barriers: Several components of the FY 2015 Part A Plan address the continuum of HIV care and will work to reduce barriers to its full implementation in the Oakland TGA. The Part A Plan, for example, seeks a total of **$262,639** to support **HIV Outreach Services** that will specifically work to

identify and link to testing and care members of the highest risk populations in the region, including young MSM of color, women of color, and transgender persons. Several other service categories, such as **Medical Case Management, Mental Health Services, Substance Abuse Services**, and **Psychosocial Support Services** address critical barriers to persons with HIV remaining in care by stabilizing lives and addressing underlying adherence issues, including issues related to reimbursement and appointment scheduling, health issues, and drug and alcohol abuse. Other services such as **Food, Medical Transportation, Housing,** and **Legal Services** address direct barriers to consistent service access by low-income people with HIV which in turn increase the percentage of low-income PLWHA who are able to consistently remain in care and stay adherence to anti-retroviral therapies.

Significant Health Disparities Revealed Through the Continuum: While the process of completing the initial Consortium of Care chart did not reveal any specific new disparities, the process clarified issues in our own countywide reporting systems and capacity which our TGA will continue to address in order to strengthen our capacity to track the progress of persons with and at risk for HIV as they move through the treatment cascade. This includes utilizing data to effectively track service access and utilization in regard to key demographic factors such as race, gender, sexual orientation, and age.

B) Implementation Plan

B.1) FY 2015 Implementation Plan Table - See Attachment 9

B.2) FY 2014 HIV Care Continuum Table - See Attachment 9

C) FY 2015 Implementation Plan Narrative

The FY 2015 Ryan White Part A funding plan for the Oakland Transitional Grant Area (TGA) represents a coordinated, comprehensive, and tailored plan for utilizing Part A funds to address the most critical underfunded needs in the local epidemic, with an emphasis on **core services** that provide fundamental support for maintaining health, stability, and quality of life. The funding plan simultaneously addresses a broad range of key HRSA priorities, including the need to: a) respond to identified service gaps and barriers in the TGA; b) address the needs of emerging populations; c) encourage PLWHA to remain engaged in primary care and adhere to medications; d) promote parity of services; and e) ensure that services are delivered in a manner that is culturally and linguistic appropriate to the regional service population. The funding plan also incorporates the most recent findings from a wide range of data, resource documents, studies, and publications that were used by the TGA Planning Council in making its decisions, including the findings of the 2010 Oakland TGA HIV/AIDS Services Needs Assessment.

The FY 2015 Ryan White Plan seeks a total of **$6,439,804** in direct Part A support for key Ryan White services in our region, along with an additional **$697,490** in support for administrative costs and **$348,746** for quality management activities, for a total FY 2015 Part A request of **$7,550,832**. **77.8%** of the TGA's direct Part A funding request (**$4,990,441**) supports **core medical services** in the region, including ambulatory / outpatient medical care, while the remaining **22.2% ($1,427,767**) funds key supportive services essential for retaining clients in care and stabilizing the circumstances of their lives. Overall, the funding plan seeks a total of **$2,401,075** for ambulatory / outpatient medical care and an additional **$457,790** for oral health

care services. The Plan also seeks a total of **$246,645** for direct home and community-based health services. T**he Oakland TGA's FY 2015 funding request seeks a return to the most recent highest level of combined Part A and MAI funding which the region received in FY 2003-2004, coupled with a 10% increase in funding related to inflation and rising costs of health care.** While even this request is inadequate to meet local HIV/AIDS care and support needs, it would provide a significant augmentation to the TGA's desperately underfunded service capacity at a time when our region is striving to continue provide the highest quality care possible to an increasingly impoverished and complex service population.

Prioritization of Core Services: The FY 2015 Plan prioritizes **eight** core services to receive funding in the Oakland TGA: 1) ambulatory / outpatient medical care; 2) medical case management; 3) oral health care; 4) home and community-based health services; 5) mental health services; 6) outpatient substance abuse services; 7) early intervention services; and 8) medical nutrition therapy. The TGA does **not** allocate funds in the remaining core categories. Brief explanations for this are included below:

- **AIDS Drug Assistance Program (ADAP) and Local AIDS Pharmaceutical Assistance:** The State of California has traditionally augmented federal ADAP funds at a level needed to meet statewide demands with a relatively full formulary that includes pain medications. For this reason, the TGA Planning Council was once again not able to use Part A funds specifically to support the costs of medications. Meanwhile, the conversion to expanded Medicaid coverage and to a range of low-cost health insurance options through Covered California and a range of County plans will support medication costs for hundreds of persons whose medications had formerly been paid through ADAP. The shifting of HIV pharmaceutical support should further strengthen ADAP's position and allow it to continue absorbing new low-income persons with HIV over the coming years.
- **Health Insurance Premium and Cost Sharing Assistance:** Through the CARE Health Insurance Premium Payment (CARE/HIPP) program, persons who are unable to work because of disability due to HIV/AIDS can often qualify for premiums payment assistance for up to **29 months**, provided they meet specific criteria. CARE/HIPP helps offset the need for Part A funds to support health premium payment assistance.
- **Home and Community-Based Health Services and Hospice Services:** The California **Medi-Cal Waiver Program** operated by the California Department of Health Services Office of AIDS allows many local providers to bill Medi-Cal for a range of HIV-specific services including attendant care; homemaker services; in-home skilled nursing care; nutritional counseling; nutritional supplements; and specialized medical equipment and supplies. Use of the Waiver by two Alameda County community providers helps offset the need to request Part A funding for the three services above.

Promoting Parity of Services: The Oakland TGA is committed to ensuring parity of Part A-funded HIV services across a spectrum of elements including geographic location, quality, comprehensiveness of services, and cultural appropriateness. Each year, the Oakland TGA Planning Council incorporates a discussion of these issues in its prioritization and allocation deliberations, and bases its decisions in part on the extent to which Part A services can help address identified barriers and needs. The Ryan White-funded system is in large part designed to address issues of disparity by supporting a system in which a diverse range of providers are scattered across the region and in which specific population groups have the option of receiving care and psychosocial support at agencies best able to meet their needs.

The 2010 Needs Assessment was invaluable in helping the TGA identify key areas in which additional Part A support could help promote parity of services across the entire two-county region. The needs assessment found, for example, that while **70%** of respondents stated that they needed medical case management services, only **two-thirds** were actually able to receive those services. The assessment also found that gay and bisexual-identified males were **significantly less likely** to receive medical case management services (**62%**) as compared to heterosexual respondents (**83%**). These and other findings led directly to the recommendation to expand support for medical case management services in the FY 2014 Part A funding plan. As a direct result of client feedback received by the Planning Council this year, Alameda County is also incorporating questions regarding **evening and weekend hours** in its just-issued Medical Case Management RFP to encourage providers to expand availability of care for an HIV population that is increasingly returning to the workforce.

Both Alameda and Contra Costa County have adopted **Standards of Care** for Ryan White funded services which all contracted service providers are required to follow, and which are designed to ensure a level playing field in terms of overall service quality and consistency throughout the region. **Beginning in FY 2015, the County will begin a 2-year process of completely updating Standards of Care for all Ryan White Part A-funded service categories.** Additionally, the TGA has taken measures to ensure **geographic parity** of services, particularly by allocating resources to ensure services are available in high impact regions of the TGA, especially along the I-80 corridor that stretches through some of the poorest and most heavily impacted parts of the TGA. Contra Costa County alone operates **13** public health clinics located throughout the county and provides van service to take clients to and from medical and laboratory appointments.

Culturally and Linguistically Specific Services: The Oakland TGA is focused on creating specialized and targeted community service options that incorporate culturally competent care approaches coupled with increased accessibility to community-based services. Oakland TGA service providers are **contractually obligated** to achieve and exercise cultural competence by demonstrating attainment of a **practice model** which: a) incorporates culture in the delivery of services; b) includes procedures for staff recruitment, hiring and retention that achieves the goal of a diverse and culturally competent workforce; and c) provides resources to support the professional development of awareness, knowledge and skills in the area of cultural and linguistic competence. The TGA's own organizational principles also state that persons with HIV **must** have access to a "high quality, evidence-based system of care" that measures health outcomes and incorporates continual assessment and planning.

On a broad systemic level, the Part A-funded system in the Oakland TGA includes a range of population-specific providers who are directly based in ethnic minority neighborhoods and who specialize in providing culturally competent care to specific cultural groups including African Americans, Latinos, Asians / Pacific Islanders, and Native Americans. All Part A-funded care providers in both of our TGA's counties also employ culturally diverse staff and take part in ongoing cultural competency training and support programs. Medical and non-medical providers are outstationed throughout the TGA, often directly within hard-hit ethnic minority communities, in order to encourage and facilitate service utilization. The TGA also employs **mobile services** that are able to meet clients directly where they live, such as in the case of mobile HIV early intervention services.

On an agency capacity level, **all** Part A-funded providers in both counties are required to have standards and systems in place to ensure that staff are reflective of the cultural diversity of

the communities they serve, and that they receive continual training in the delivery of culturally competent services and outreach. Agencies must also ensure that access to **translation and interpretation** services that ensure that persons who speak a language other than English are able to access care. In many cases, the TGA mandates that cultural competence training be delivered directly by Clinical Quality Management staff and consultants, particularly in the case of medical case management services. Ensuring the availability of effective and culturally competent case management in both counties has been and will continue to be the primary means of reducing access barriers to care for minority communities.

Relationship of FY 2015 to the Comprehensive HIV Services Plan: The FY 2015 Plan directly reflects and advances the goals and objectives contained in the TGA's 2012 - 2014 Comprehensive HIV Services Plan. Published in May 2012, the Plan offers a wide-ranging blueprint to guide the next three years of unprecedented change in the Ryan White service system, including detailed and aggressive responses to the implications of health care reform and the impending implementation of the Affordable Care Act (ACA) in January 2014. **Progress toward the goals and objectives of the Comprehensive Plan are continually monitored and reported out on a quarterly basis at Planning Council meetings.** Key goals of the 2012 - 2014 Plan directly addressed in the proposed Part A Plan include:

- **Goal # 1:** Ensure access to a comprehensive continuum of high-quality, community-based care for low-income individuals and families with HIV, including addressing the needs of priority populations;
- **Goal # 2:** Continually identify, link, and retain in care low-income persons with HIV who are not yet aware of their HIV status;
- **Goal # 3:** Support retention in care for low-income persons with HIV, including identifying, linking, and retaining in care HIV-aware persons who are not currently involved in the HIV care system;
- **Goal # 4:** Support and expand collaboration and coordination with relevant funding streams and service systems in the Oakland TGA; and
- **Goal # 5:** Anticipate, respond to, and play an active role in influencing changes in the health care and Ryan White systems through the Affordable Care Act (ACA) with the goal of ensuring quality of care and retaining in care all low-income persons with HIV who are currently involved in the Ryan White system.

Ensuring Proportional Funding for Women, Infants, Children, and Youth: Resource allocations for women, infants, children, and youth (WICY) in FY 2015 are proportionate to the high percentage of local HIV/AIDS cases represented by these populations. The Planning Council considers Part A funding in light of the proportion of women, infants, children, and youth affected by HIV/AIDS, as well as in light of additional funding streams available to meet the needs of these populations. All Ryan White Part A-funded services specified in the FY 2015 funding plan are open and available to women and young people, and many programs include specialized services to meet their needs. In addition, the Part D-funded **Family Care Network** based at Children's Hospital Oakland supports a well-developed, integrated system of care for meeting the needs of this population, including an aggressive countywide program that has virtually eliminated the incidence of HIV infection among infants in our region. The TGA also considers funding sources such as the State Child Health Insurance Program (CHIP); the Services for Women, Infants, and Children (WIC) program; and the Substance Abuse Treatment Program for Pregnant Women program. Part A funding also directly supports a model program of HIV care for HIV-infected young people through the **Downtown Youth Clinic at East Bay**

AIDS Center (EBAC). The Clinic serves over **100** HIV-positive young people age 24 and below, the vast majority of them African American, with culturally competent clinic services that are provided at **separate times** from HIV services provided to other clinic populations.

Linkage of Needs Assessments and Updates to Part A Planning and Allocation: Each year the Oakland Planning Council reviews a summary estimate of **unmet need** among PLWA and PLWHA in the TGA utilizing HRSA's unmet needs framework, including a detailed breakdown of unmet need by population, and an analysis of populations in which unmet need is most prevalent. The 2010 Needs Assessment also included a heavy emphasis on assessing unmet HIV service needs specifically, yielding critical information that was used by the Council in its prioritization and allocation process. This included information ranking Part A service categories in terms of those most utilized and most needed by PLWHA, along with recommendations for addressing gaps in service delivery to ensure a more comprehensive system of care. Key unmet needs findings contained in the 2010 assessment, for example, included recommendations to: a) increase the availability of substance use services for PLWHA; b) enhance transportation services for severe need clients; and c) address housing disparities in regard to race and ethnicity. The condensed Needs Assessment completed in 2013 also included several findings that influenced Planning Council prioritization and allocation in relation to the continuum of care, including the need to better address transportation barriers throughout the county and to incorporate expanded training regarding the prevalence and impacts of intimate partner violence on issues of care access and retention in the TGA.

- **RESOLUTION OF CHALLENGES**

Because of its extensive experience in supervising, managing, and coordinating Part A resource planning, prioritization, and allocation in the Oakland TGA, both the project Grantee and the local Planning Council believe there will be few challenges or barriers to full and successful implementation of FY 2015 Part A activities proposed in this application. Both the Alameda County Office of AIDS Administration and the Contra Costa County AIDS Program have the capacity and experience to allocate and manage proposed grant funding and to supervise and track project contracts to ensure that they are providing high-quality care while utilizing Part A resources strictly as the funding source of last resort. Both counties also have the existing data capacity to effectively track program expenditures and activities and to intervene where needed to ensure effective care using proposed grant dollars. At the same time, the merged Oakland TGA Collaborative Community Planning Council, including the Contra Costa HIV Consortium functioning as a full Council Committee, have the expertise, diversity, and knowledge of the community to effectively assess local needs, prioritize services, and allocate Part A resources in a manner that most effectively supports the ongoing health and wellness of persons living with HIV in our region while continuing to address critical health disparities throughout the continuum of HIV care. The key challenge for all Ryan White jurisdictions moving forward involves the need to continue to implement a fully **integrated** care and prevention system that fully addresses each stage along the care continuum while creating new approaches to better tracking client status and providing continually more effective case finding, outreach, and support strategies to ensure the identification and long-term care engagement of the most highly disenfranchised and highest-risk PLWHA still not identified in the Oakland TGA.

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

1. CLINICAL QUALITY MANAGEMENT

1.A) Description of Clinical Quality Management (CQM) Infrastructure

Number of FTEs Assigned to QM: The Office of AIDS Administration employs **two** designated quality management staff through Part A funding: 1) a **1.0 FTE Quality Assurance Coordinator** and 2) a **.33 FTE Public Health Epidemiologist**

CQM Program Staff Roles and Responsibilities: As the grantee agency for the Oakland TGA, the Alameda County Office of AIDS Administration (OAA) oversees the TGA's Clinical Quality Management Program. Overall responsibility for coordination and management of the QM program lies with its **full-time Quality Assurance Coordinator (Pamela Casey)** who is responsible for tracking and reporting QM data and for providing QM-related training and assistance to OAA contractors and partners and the Planning Council. Since early 2013, the OAA has, been organized under the Alameda County HIV/STD Section within the division of Division of Communicable Disease Control and Prevention within the Public Health Department. We share the expertise of the HIV Epidemiological Surveillance Team led by Dr. Neena Murgai, who provides epidemiology data for the CCPC during the PSRA process. The Grantee also supports **33% time** for a **Public Health Epidemiologist (Richard Lechtenberg)** who provides support in linking QM data to local client services utilization data. The Alameda County Public Health Department also recently hired Dr. Nicholas Moss to serve as the Director of the HIV/STD Section which is over the Office of AIDS Administration. Dr. Moss previously served as Director of Clinical Prevention in the HIV Prevention Section of the San Francisco Department of Public Health, managing clinical HIV prevention programs and performing prevention research on behalf of the department. Dr. Moss successfully implemented SFDPH's HIV linkage-to-care program in partnership with the SFDPH STD and HIV Surveillance units. Dr. Moss's current research emphasis is on the implementation of effective HIV prevention programs based on testing and linkage to care models, with a special focus on detection and early treatment of acute HIV infection.

The Quality Assurance Coordinator works in close collaboration with the **Quality, Data and Services Planning Committee (QDASC)** of the Oakland TGA Collaborative Community Planning Council, the local Ryan White Part A planning body. The eight-member multi-disciplinary committee - which includes several persons living with HIV - meets **monthly** in meetings in which the Quality Assurance Coordinator plays a key role. The committee is responsible for oversight of all CCPC data collection processes and for the coordination of all CCPC needs assessments and gap analyses. The committee also assists with the annual priority setting and allocation process; supports epidemiological planning; and develops and monitors the TGA-wide Comprehensive Plan. In collaboration with the Office of AIDS Administration, the QDASC also: a) develops and reviews Part A Standards of Care and Service Category Definitions; b) develops procedures for client chart reviews; c) helps develop the annual TGA-wide patient satisfaction survey d) continually reviews QM-related data reports and findings and incorporates these findings into ongoing service planning and allocation; and e) updates the Service Category Definitions document, which defines funded services within the Oakland TGA.

Entities Contracted to Support or Perform QM Activities: The Alameda County OAA utilizes a limited amount of subcontracted individuals and organizations to carry out local QM activities. These include the following:

- A HRSA-approved **Data Contractor** assists in the accurate accounting of funding sources between separate Ryan White Parts, providing data input training and is assisting with the current transition from CAREWare to ARIES, the statewide HIV database to which the TGA is converting.
- An average of **three nurses per year** are hired on a short-term basis to conduct the TGA's annual chart review process.
- An **Information Technology Contractor** helps build and maintain a small-scale database to store annual chart review data.
- A dentist employed through the Alameda Health Consortium will serve as a **Dental Health Consultant** to help revise the evaluation tool used for the annual chart review and to assist with the piloting of a system-wide dental referral form.
- The East Bay AIDS Education and Training Center (AETC) operating out of CARDEA Services assists with provider training throughout the TGA and the OAA contracts with the EBAETC and **Dr. Sophy Wong** to assist in the development of a TGA-wide linkage to care protocols.
- A local **community conflict resolution agency** provides mediation and facilitation services for clients and agencies with unresolved grievance issues.

Beginning in October 2014, Alameda County will also contract with **Barbara Rosa**, a highly respected National Quality Center consultant, to conduct a full review of the TGA's quality management program and to help develop enhancements and improvements across the system.

Efforts to Coordinate CQM Activities with Other Ryan White Grantees in the Jurisdiction: Over the past three years, the Oakland TGA QM program has sought to significantly expand its collaborative partnerships with care and service programs throughout our region in order to improve the quality of region-wide data and achieve expanded QM coordination and integration. An informal, ad hoc quality work group made up of these partners meets frequently to explore common TGA quality activities and develop coordinated efforts. Jointly collaborated activities realized through this effort include: a) measuring client satisfaction through joint surveys; b) coordinating QM trainings for grantee staff and contracted service providers; c) conducting assessments of service provider QM activities; d) conducting chart reviews; e) updating and finalizing standards of care f) establishing appropriate and measurable health indicators; g) developing a peer program (MAI) to help connect and/or retain clients in care; h) providing mutual support in analyzing and displaying data; and i) presenting QM findings and utilization data to the Collaborative Community Planning Council as part of the priority setting and allocation processes. The Quality Assurance Coordinator also participates in **quarterly** meetings of the Quality Management Working Group established by the Alameda County Low Income Health Program (LIHP), formerly known as the Medically Indigent Program. This group includes representatives of several Part A funded primary care agencies including La Clinica de La Raza, Native American Health Center, Alameda County Medical Center, and LifeLong Medical Care. The focus of the group this year has been on establishing the medical home model within the TGA while finalizing Panel Management Standards of Care.

1.B) Description of CQM Program Performance Measures

Service Categories for Which the Applicant Has Performance Measures: The Grantee has established performance measures in place covering the service categories of **Ambulatory / Outpatient Medical Care** and **Medical Case Management.**

Specific Performance Measures for the Upcoming Year for Medical Care and Medical Case Management, including Frequency of Performance Measure Data Collection from Sub-Grantees: Oakland TGA **continually** monitors the following indicators for outpatient and ambulatory health services and medical case management. These indicators are monitored through a combination of approaches that include the review of ongoing contractor progress reports and electronic data in regard to key client outcomes and indicators and an annual chart review process that analyzes a representative cross-sampling of patient records at each site to monitor both client health outcomes and patient assessment and management procedures.

- **Ambulatory/Outpatient Medical Care Indicators:**
  - % of clients with HIV infection who have a medical visit with an HIV specialist at least every 6 months
  - % of clients on ART
  - % of clients screened for alcohol, tobacco, and other substance
  - % of clients with at least two CD4
  - % of clients with viral load suppression
  - % of clients with screening for Hepatitis B & C status (baseline)
  - % of clients with TB screening
  - % of clients with lipid screening
  - % of clients with STD screening (based on risk factor) for syphilis, chlamydia, gonorrhea
  - % of clients with Pap smear (female); male if indicated
  - % of clients with flu vaccines
  - % of clients who receive oral health screens

- **Medical Case Management Indicators**:
  - % of clients with HIV infection who have a medical visit with an HIV specialist at least every 6 months
  - % of clients with HIV infection who have a case management care plan documented (with evidence of self-management goals) and updated at least every 6 months
  - Increase in % of clients with HIV infection who receive Prevention with Positives messages, including risk reduction and education/referral for PCRS
  - Increase in % of clients with HIV infection who are screened and referred (if appropriate) to mental health and/or substance abuse services

Outpatient / Ambulatory Medical Care and Medical Case Management Data: The following table reflects aggregate data from chart reviews from agencies providing core services funded within all Part A-funded agencies in the Oakland TGA, and a partial list of data collected from consumer input surveys. The data include trending data for the last **two** funding periods, FY 2012-2013 (March 1, 2012 - February 28, 2013) and FY 2013-2014 (March 1, 2013 - February 28, 2014).

Oakland TGA Primary Care Indicators	FY 2012-13	FY 2013-14
% clients seen at least twice in the last 12 months	**99.2%**	**94.9%**
% clients on ART regimen	**92.7%**	**92.3%**
% clients receiving adherence counseling	**86.2%**	**91.9%**
% clients who received oral health screens	**63.4%**	**54.7%**
% clients receiving flu vaccine	**62.6%**	**81.2%**
% of clients with syphilis screening	**81.3%**	**79.5%**
% of clients with a lipid screening	**86.2%**	**87.2%**
% of clients with at least one suppressed / undetectable viral load result	**88.6%**	**74.4%**

The chart shows highly positive trends and/or consistent achievement in performance in regard to **four** key indicators: a) percentage of clients on ART (**92.7%** in FY 2012-13 vs**. 92.3%** in FY 2013-14); b) percentage of clients receiving adherence counseling (**86.2%** vs. **91.9%**); c) percentage of clients receiving a flu vaccine (**62.6%** vs. **81.2%**); and d) percentage of clients with a lipid screening (**86.2%** vs. **87.2%**). Meanwhile, other categories experience a drop between FY 2013 and FY 2014, including downward shifts in the percentage of clients seen at least twice in the last 12 months and percentage of clients on ART regimens. There are two key reasons underlying what is seen as a one-time drop. First, the **TGA**'s recent transition to the ARIES base is still not fully complete, and many agencies are either still experiencing reporting gaps or have not yet fully incorporated all reporting fields into the own EHR systems. Second, in the transition to a wide range of new coverages under ACA transition, some clients have been mis-categorized or misreported within individual agencies, a situation that is being corrected as client coverage issues stabilize.

How Performance Measure Data are Analyzed to Evaluate for Disparities in Care and Actions Taken to Eliminate Disparities: Local analysis of collected data seeks to measure whether core services are in compliance with HRSA HAB/HIV performance measures and local service category Standards of Care. The grantee staff, contractors, and the QDASP committee - which includes consumers - continually review results collected through the QM program. QM staff annually presents the results of chart reviews, focus group findings, and consumer input surveys to the Planning Council. **These data consistently confirm that collaboratively prioritizing core services is essential to the health and well being of Part A clients in the Oakland TGA.** The data has also validated the fact that regular testing and screening for certain bio-markers including TB, STIs, and gynecological screenings for female clients provide clinicians with critical information necessary to prescribe appropriate treatment and improve the health outcomes for HIV-positive women. In response to these and other findings, the Planning Council maintains or increases its prioritization and allocation of primary care services on an annual basis.

How Stakeholders Contribute to QM Activities: All local QM data is first shared with the Planning Council's Quality, Data, and Services Planning Committee. The Committee works with the Coordinator to identify any information that is contradictory or might difficult to interpret before it is presented to the full Council. Once the report is refined / revised, it is then presented to the Planning Council during the monthly grantee report and/or annual retreat. The QA coordinator also provides a quarterly grievance report to the PLWHA committee. This report details the nature and status of any grievance or complaint filed

1.C) Description of CQM Program Quality Improvement

Process to Determine Priorities for QM Projects and QM Monitoring, including Specific Quality Improvement Projects: The Oakland TGA Quality Assurance Coordinator has overall administrative responsibility for planning, implementing, and monitoring quality improvement activities. Meanwhile, the OAA Director, the Oakland TGA Planning Council, and other stakeholders are responsible for **annually evaluating** the Oakland TGA's **Quality Management Plan**. This annual evaluation process includes: a) assessing the effectiveness of the infrastructure and quality improvement activities in achieving quality management goals; b) determining whether work plan goals have been achieved; and c) determining whether performance measures were appropriate and helpful in the priority setting and resource allocation process. Grantee quality management staff reviews annual evaluation documents and submits recommendations, which are then amended and approved by the Planning Council and other stakeholders in time for the following year's QM plan. Once finalized, the QM Plan is submitted to the HRSA Project Officer who in turn monitors program activities using the Plan as a quality management road map.

Key activities to assess service quality in the Oakland TGA include: a) regular site visits to Part A-funded agencies to review quality activities and processes and provide technical support and training for QM activities; b) a periodic review of each Part A-contracted agency's internal Quality Management Plan; c) review of provider progress reports and computer-reported data, including comparison of outcome data to established benchmarks; d) distribution, collection, and analysis of consumer input surveys; d) an annual system-wide chart review; e) client satisfaction surveys to assess quality needs and identify issues and problems in regard to quality; and f) ongoing tracking of client grievances and resolution measures.

If it is determined by the Quality, Data, and Services Planning Committee that a specific performance measure does not meet specific HRSA benchmarks, does not represent an improvement over the previous year's measure, or if there is a large discrepancy between an agency's performance and the aggregate data, further investigation is instigated and conducted by the Quality Assurance Coordinator and the Committee. If the issue is found to be significant, a quality improvement plan is developed and established using standard Plan, Do, Study, Act (PDSA) enhancement cycles. The Quality Assurance Coordinator and other staff and subcontractors provide training and support as needed to inform subcontractors of new quality initiatives and to assist them in implementing enhanced QI efforts and programs.
Alameda County Public Health Department (PHD), which includes the OAA, is currently undergoing a national accreditation process. Part of that process involves coming up with a way to determine how effective PHD programs are in improving health outcomes for the residents of Alameda County. Results Based Accountability (RBA) was selected as this process. Ultimately, it is similar to the CQI in that indicators will be selected and tracked. The goal is to choose

indicators that easy to track and already have systems in place to track them, and that may have relevance to multiple PHD programs. The OAA is in the process of deciding which 3-5 indicators (performance measures) to use to track the effectiveness of the OAA's contract monitoring, as well as to track the quality of service delivery for each of the funded service categories and how they influence health outcomes for the clients they serve. Although these indicators were developed in the past for each of the service categories, the RBA process will allow the OAA to update and refine this list of indicators.

The Oakland TGA is continually engaged in a wide range of both formal and informal quality improvement projects designed to continually enhance the quality of HIV care services in the TGA. Current projects that are a major focus of the QM program include the following:

- Increasing cultural sensitivity for non-English speaking clients;
- Tracking HIV care in correctional facilities in Alameda County;
- Using Risk Behavior Assessment (RBA) to develop performance measures;
- Linking newly diagnosed and those out of care to care; and
- Improving agency grievance processes.

Last year, the Office of AIDS Administration released a Request for Applications (RFA) to agencies already receiving Ryan White Program dollars to serve low income clients living with HIV/AIDS. **The purpose was to support QI activities related to transferring clients into the Low Income Health Plan (LIHP) in preparation for health care reform and the transition to Medicaid and health exchange services.** The agreement was for a **six-month period** from January 2013 through June 2013. The OAA received Measure A funding to support these quality improvement activities that were mainly used to assist agencies and the clients they serve make the transition to health care reform. In 2004, Measure A was approved by voters to "provide for additional financial support for emergency medical, hospital inpatient, outpatient, public health, mental health, and substance abuse services to indigent, low-income and uninsured adults, children, families, and seniors and other residents of Alameda County." A total of **six** community-based contractors were identified in conjunction with this project which together served a diverse range of highly impacted PLWHA in our region. Samples of quality improvement activities related to the ACA were defined as, but not limited to:

- Production and/or translation of materials for mono-lingual clients;
- Retention of consultant services for quality improvement related work;
- Ensuring that client data collection is accurate, complete and up-to-date;
- Development of "standing orders" for efficient delivery of health care for clients across the patient spectrum;
- Development of performance measures to track outcomes of client care;
- Evaluating and responding to client satisfaction feedback;
- Tracking linkage to care, client referrals or client no-show rates; and
- Developing protocols for seamlessly transferring clients from your agency to others.

Efforts Aimed at Improving HIV Viral Suppression Within the Jurisdiction: The entire Oakland TGA QM system is designed to enhance the quality of care and follow-up at each care-related stage of the continuum in order to ensure the goals of long-term retention in care and long-term viral load suppression resulting from consistent ART utilization. The region continually promulgates and enhances QM measures that require agencies to focus their efforts on these key outcomes, while providing other related health services that help ensure long-term client health and wellness. At the same time, the QM system requires agencies to develop continually enhanced data management, data entry, and data tracking systems both to measure

the impact of care on their own populations and to build more integrated data sharing capacity among Ryan White providers.

How QM Data is Used to Improve and Change Service Delivery in the TGA, including Strategic Long-Range Service Delivery Planning: Oakland TGA staff measure core services delivery data in regard to primary care, case management, oral health, home health care, substance abuse, and mental health services along with service provider compliance with quality goals such as HRSA HAB/HIV performance measures, local TGA indicators, and local Standards of Care and contractual requirements. These data are collected using chart reviews and progress reports to obtain a sample of the entire Ryan White Part A population. For primary care, data collection seeks to measure whether clients are adequately screened for co-morbidities such as mental illness, substance use, STIs, and hepatitis. These data are then used to improve and/or change service delivery within the TGA.

The Oakland TGA will continue to oversee a range of activities designed to enhance the utilization of quality improvement findings as a way to improve the quality of patient care. These include:

- Collaborative efforts to improve coordination and understanding of TGA quality efforts through Planning Council member orientation and staff and service provider training at contracted agencies;
- Inclusion in service contracts and contract RFPs of information on how increased utilization of data is critical for determining how best to deliver services in the TGA;
- Training and technical assistance to providers to allow them to use quality data to make informed decisions to improve and enhance client care; and
- Collaborative regional meetings designed to create a multidisciplinary approach to quality improvement throughout the TGA.

Additional QI activities that are and/or will be used to improve and enhance service delivery in the TGA include the following:

- Information on grievances or complaints will continue to be reviewed by the Planning Council and the Quality Assurance Coordinator as an approach to tracking quality of care, and interventions will be developed as needed to resolve issues, including the use of community mediation centers.
- Results of grantee consumer input surveys will continue to be compared with those of internal agency surveys results to prioritize areas for improvement.
- Regular client focus groups will be used to identify areas for quality improvement in the TGA's system of care, such as the need for more culturally competent staff or the need for expanded support for child care and transportation services.
- Chart review evaluation tools will continue to be updated not only to capture data related to performance measures but to develop measures to determine whether clients are better off as a result of the agencies meeting their performance measures.

Participation of Stakeholders: HIV-infected consumers play a critical role at all levels of the Oakland TGA CQM planning and implementation process. The Oakland Collaborative Community Planning Council and its quality committee - a majority of whom are persons living with HIV - review, revise, and participate in producing CQM standards, systems, and support. At the agency level, subcontractors rely on ongoing client satisfaction surveys to assess the qualitative impact and effectiveness of agency services, while working directly with consumers to collect required data and ease the burden of data collection and reporting on clients. The results of consumer needs assessment processes also directly influence the design and

implementation of CQM projects, as do findings related to changing client utilization of Ryan White Part A services.

1.D) Data for Program Reporting

Description of the TGA's Management Information System: Both counties of the Oakland TGA utilize shared data systems that allow contracted agencies to directly enter client and service-level data at their facilities - data that can in turn be uploaded to a unified TGA-wide database. This process greatly facilitates data collection while allowing the counties to reduce duplication in client reporting. Both Alameda and Contra Costa County now utilize the ARIES system to track client level data, and the ARIES system is directly linked to both the State of California AIDS database and to the existing electronic health record (EHR) systems in place at all Ryan White Part A agencies.

Current Client-Level Data Capabilities: Both Alameda County and Contra Costa County collect and maintain a variety of client level data through use of the ARIES database. Data collected through the TGA are used to:

- Identify disparities in outcome related to race, gender and language;
- Eliminate or significantly reduce duplication of intake activities so that clients are not forced to complete the same forms at each provider agency;
- Efficiently gather service delivery data from the provider agencies;
- Assist providers in unduplicating client numbers for reporting and planning purposes; and
- Automate the production of the Ryan White Program Services Report (RSR).

According to the RSR Completeness Report, **100%** of Oakland TGA providers are now able to report client level data. Only **one** agency had missing data for more than 10% of clients for at least one clinical data element for the last Ryan White fiscal year.

▪ ORGANIZATIONAL INFORMATION

1) GRANTEE ADMINISTRATION

1.A) Program Organization

1) Overview of Part A System: The Alameda County Public Health Department administers all parts of the HIV Emergency Relief Grant Program for the Oakland TGA as the Grantee and Fiscal Agent. Dr. Muntu Davis is the Director of the Department and the County's Health Officer. Keith Carson, President of the Board of Supervisor is the Elected Official for the Part A/MAI award. The Ryan White Part A program in the Oakland TGA is administered by the Alameda County Public Health Department's Office of AIDS Administration (OAA), which does not provide direct services itself but instead contracts with over 25 local prevention and treatment providers. The Director of the Office of AIDS Administration is Keith C. Waltrip, MSHS, who has extensive experience in managing and coordinating HIV care and prevention programs. The Director has primary responsibility for oversight and coordination of the Part A program and manages a staff of six Care and Prevention Contract Monitors who oversee implementation of treatment and prevention service contracts with community based care and prevention service providers and assure compliance with fiscal and program monitoring

standards. The Director also supervises a Quality Management Program Manager, an Information Systems Specialist, and a Linkage to Care Coordinator.

The Contra Costa County Part A program is coordinated by Christine Leivermann, who serves as Director of the Contra Costa Health Services AIDS Program. Coordination of the Contra Costa HIV/AIDS Consortium – which plans HIV/AIDS services in the county and produces an annual set of Allocation Recommendations that is considered and approved by the Oakland TGA Planning Council – is provided by Carla Goad, who serves as Education and Services Supervisor for the AIDS Program.

2) Process and Mechanisms to Distinguish Funding Streams: The Oakland TGA ensures that Ryan White Part A funds are used as the funding source of last resort and that Part A expenses are distinguished from other Ryan White sources, including differentiating between MAI and Part A funding. All local contractors are required to utilize Part A funds as the financial source of last resort as a stipulation of contract award and are provided with direct training and technical assistance by OAA staff in regard to billing and accounting procedures to ensure that this takes place. Contractors must also distinguish between the various Ryan White streams used to support specific client populations.

Alameda County also utilizes a financial system called **ALCOLINK** in which each grant is assigned a specific project / grant number in order to distinguish the expenses, revenue, and funding streams for each grant. When the notice of a new grant is received, a request to set up a project / grant number is sent to the Auditor's Office. All expenses and revenue are then coded properly and respectively according to assigned project / grant number and its respective funding streams. Distinguishing support for MAI populations in the TGA is simplified by the fact that local Part A MAI contracts fund specific activities and/or populations that are generally distinct from general Part A activities. The unique level of collaboration and information sharing that existing among Ryan White grantees in our region - including collaboration and the utilization of common information systems by the local Part A / B, Part C, and Part D programs - further facilitates the process of distinguishing funding streams.

1.B) Grantee Accountability

1.B.1) Program Oversight

Steps to Implement National Monitoring Standards: The new HRSA / HAB National Monitoring Standards for Part A and Part B provide a comprehensive blueprint designed to ensure that Part A and B grantees meet federal requirements for program and fiscal management, monitoring, and reporting to improve program efficiency and responsiveness. The Standards consolidate existing HRSA/HAB requirements for program and fiscal management and oversight based on Federal law, regulations, policies, and guidance documents. The Oakland TGA has taken and will take the following steps to effectively implement these complex new standards:

- In 2011, Alameda County Office of AIDS Administration (OAA) completed a general review of the new HRSA / HAB National Monitoring Standards for Part A and B programs in order to identify any immediate required action steps.
- In 2012, the Office created and approved a new set of Fiscal Monitoring Standards consistent with the National Monitoring Standards and developed and conducted a series of agency trainings in the use of the new standards. The Office is currently in the process of scheduling

initial site visits with at least four major local subcontractor agencies to verify compliance with the new fiscal standards.

- In 2013, the Office drafted and implemented a new set of Program Monitoring Standards that reflect and comply with the National Monitoring Standards, and provided training and support to ensure that these Standards were in place prior to the conclusion of the 2013 Part A fiscal year.
- In 2014, the Office completely revamped its site visit monitoring tool in order to provide enhance oversight and a clear distinction for agencies that are in compliance both programmatically and fiscally (100 - 85 compliance; 85 – 70 conditional compliance; below 70 not compliance).

Process Used to Conduct Program Monitoring: The TGA's system of fiscal and program monitoring is designed to assure and document ongoing contractor compliance with all applicable fiscal and programmatic standards while providing training, TA, and support where needed to ensure adherence and support collaboration and coordination of services. Each service provider must submit to the Office of AIDS Administration an **annual composite budget** detailing all HIV/AIDS and non-HIV/AIDS specific funding by the agency, including information to distinguish utilization of multiple Ryan White funding streams. Each agency must also submit a **midyear and final progress report** that describes progress toward meeting each agency's outcome objectives as well as achievement of units of service and unduplicated client count. The report also requires providers to document success or challenges, needs for technical assistance, and action plans as they pertain to each of the following areas: a) reducing barriers to care; b) strategies for bringing PLWHA who know their status into care; c) increasing client access to care; d) maintaining clients in care; e) reducing barriers/disparities to care; f) improving quality of care; and g) ensuring fiscal accountability. A **feedback report** responding to the mid-year report is then prepared and forwarded to each agency by the OAA affirming compliance and identifying areas for correction or action. Agencies must also submit **detailed monthly invoices** which indicate the number of unduplicated clients served and units of service provided. Starting in 2014, for those agencies in which UDC and UOS did not match with data entered in ARIES, invoices were held until data was entered. At the end of the fiscal year, each agency must submit an **actual expenditures report** per General Ledger to ensure that all invoiced expenditures are per agency's accounting record.

Through Fiscal Year 2013, to enhance the quality and intensity of its fiscal and programmatic monitoring process, the Grantee took the step of hiring **two HRSA-approved fiscal and program consultants** who completed site visits at **all** Ryan White funded agencies. The consultants were hired at the recommendation of HRSA to ensure a more detailed level of agency review than had previously been utilized at the agency. The contracted auditors comprehensively reviewed fiscal, programmatic, and, service delivery factors at each subcontracting agency. Each agency was then provided with a final report and the OAA implemented Correct Action Plans if appropriate. In order to institutionalize this highly successful process, the OAA is in the process of hiring a staff-based **Financial Services Specialist** who have ability to conduct fiscal site visits with the same level of detail and oversight as that provided by the HRSA consultants. This will help improve overall oversight and while additional support to Part A-funded agencies.

It is important to note that a **HRSA site visit** was conducted at the Grantee agency in October 2012. The site visit occurred during a period of intense change within the Alameda County Office of AIDS. The OAA has been focusing on the following four areas since the site

visit: 1) timely completion and submission of required progress reports; 2) fiscal monitoring of sub-grantees; 3) MAI data collection, reporting and monitoring; and 4) CCPC and OAA collaboration. In relation to program reporting, the Grantee has achieved significant success in beginning to clear its reporting backlog and in creating a more reliable reporting framework moving forward. **All** reports in FY 2013 and so far in FY 2014 have been submitted either early or on time. In regard to fiscal monitoring, the OAA has reviewed all contracts and made corrections as needed while hiring an outside fiscal consultant to review all Part A funded agencies, of which 10 agencies have been audited thus far, with five additional audits currently scheduled. For the third area of focus - the MAI grant - a new MAI provider was awarded these funds in FY 2014 and there has been strict oversight of grant fund expenditure by the OAA. Finally, in regard to collaboration and interaction between the CCPC and OAA, the CCPC Co-Chair and the OAA Acting Director have developed a strong working relationship and communicate on a continual basis to ensure clear understanding of issues and mutually agreed upon next steps of action. The issues in Grantee reporting in relation to Part A services have in no way affected the quality, impact, or effectiveness of Part A care, treatment and support services to low-income persons with HIV in our region.

In FY 2014, the main focus for the OAA continues to be on providing monthly invoice submission to HRSA and on continuing to ensure appropriate MAI reporting and expenditures. Also in FY 2014, the OAA restructured both its **Emergency Financial Assistance (EFA)** and **Housing Services** programs in order to ensure appropriate use and oversight of the funds. All funds are now under one agency that provides no other RW services in order to ensure appropriate use of funds and remove any perceived perception of favoritism.

Total Number of Contractors Funded in FY 2014; Frequency of Programmatic and Fiscal Monitoring Site Visits and the Generation of Reports During a Program Year; Number and Percentage of Contractors That Have Received a Fiscal and/or Programmatic Monitoring Site Visit to Date; and Total Number of Monitoring Visits Planned for FY 2015: A total of **26** separate agencies are contracted to provide Part A-funded services in FY 2014. The Office of AIDS Administration utilizes an extensive programmatic site visit process to ensure compliance with contract terms and fiscal and programmatic standards. As noted above, a new site visit tool was created this year and agencies that reach a score of compliance based on this tool will receive only **one** site visit per year. Those agencies that obtain a score of **conditional compliance** will received a **second** site visit by the end of the fiscal year to review those areas that were found to be deficient. Those agencies that received a score of **non-compliance** will received a site visit **within 3 months** along with a prescriptive **Corrective Action Plan**. Among other factors, the new site visit tool reviews personnel to ensure appropriate staffing, training and evaluation. Client files are now also reviewed to ensure eligibility, ACA enrollment, grievance policy, client rights and responsibilities, and client involvement in treatment plans. The site visit also reviews and scores timely and correct invoice submission, date entry, and reporting, with OAA Staff reviewing data entry to date in conjunction with the agency's management and staff , as well as compliance with contract requirements, submitted reports, expenditure reports, client satisfaction reports, adherence to established timelines, and quality assurance reports. OAA staff provides each agency with an assessment of the agency's progress and whether the agency is meeting identified objectives and achieving HRSA goals. As of the time of this writing, a total of **5** site visits have been conducted with Part A providers using the new tool (finalized in July) since the beginning of the FY 2014

Ryan White fiscal year on March 1, 2014. An estimated total of approximately **40** site visits are anticipated for the upcoming 2015 Part A fiscal year.

Process and Timeline for Corrective Action; Improper Charges or Findings in FY 2014 to Date; and Summary of Corrective Actions Planned to Address These Improper Charges or Findings: When grantee staff members identify irregularities or programmatic-related concerns, the responsible Program Manager raises the issue immediately with agency staff and with the OAA Director . The nature and extent of the concern is documented and shared with the agency administration. The Program Manager requires the agency to develop a **Corrective Action Plan** detailing precise steps to remedy the matter and the Program Manager supports the agency as needed in developing the Plan. Agencies that fail to respond with an adequate plan may be placed on probation. The CAP may consist of monthly visits, submission of monthly reports by the agency, participation in specified trainings and or technical assistance activities. If at the end of the probationary period efforts to resolve the problem have failed, the contract may be terminated.

The Corrective Action for improper Part A charges in the Oakland TGA is as follows:

- **Questioned Costs** are costs that are not properly supported by accounting records, are related to a violation of law, regulation or contract, or appear unreasonable. The contractor must provide supporting documentation or an explanation within 30 days. If the contractor fails to comply with this requirement, the costs are disallowed and are not reimbursable to the Department.
- **Disallowed costs** are costs that are clearly unallowable or reimbursements in excess of allowed costs. To resolve disallowed costs, the contractor repays the disallowed amount in full within 30 days of notification of disallowance. The County may enforce repayment by deducting the amount owed from any outstanding balance due to the contractor, or by other legal means.
- **Improved delivery of services to clients in the form of cultural competent care and staff.**

Number of Contractors That Have Received Technical Assistance for FY 2014 to Date: Technical assistance is provided during the annual site visits and upon request on an **ongoing basis**. This means that all Part A contracted agencies receive TA **each year.** Technical assistance typically involves budget preparation and assistance with accounting and reporting. QM staff provides QM technical assistance on standards and other measures of quality management. In May of 2014 the OAA held **a mandatory** Contractors Meetings which covered the following topics: updates to Ryan White funding; draw down status; invoicing; HCR; transition to ARIES; client eligibility requirements; UOS/UDC; and ACA enrollment. Evaluations were completed and the meetings received very favorable reviews. A second contractors meeting is scheduled for October 2014.

1.B.2.) Fiscal Oversight

Process Used by Program and Fiscal Staff to Coordinate Activities, Ensuring Adequate Reporting, Tracking, and Reconciliation of Program Expenditures: The Fiscal and Contract Unit is responsible for all financial and contracts related aspects of Office of AIDS Administration and works closely with program staff to ensure adequate reporting, reconciliation, and tracking of program expenditures, and to ensure financial and programmatic compliance with Federal and County policies and regulations. The **Fiscal and Contract Officer** monitors the Office's contracts with service providers and reports to the Deputy Director of the

Division of Communicable Disease Control & Prevention. The Fiscal and Contract Officer meets with the HIV/STD Section Chief, Office of AIDS Director and Deputy Director of the Division **once every two weeks** to discuss the status of the overarching Part A program on a grant by grant basis. The Fiscal and Contract Unit also produces a **monthly status report** for each program, in which the Program Monitor reports the total amount billed to date by service category, along with the date and amount of the last invoice submitted by each contractor. This report helps the Program Manager know if there is any slow spending taking place and whether resources may need to be reallocated to other contractors within the same service category or to another service category. The Fiscal and Contract Unit also provides and presents a report to the Executive Committee and the Oakland TGA Planning Council **every quarter** reporting on the status of the expenditures and justifying any funds that have been overspent or under spent compared to projections to date. Additionally, both the Fiscal and Program units must approve the budget of each contractor before a contract is processed and prior to invoices being submitted to ensure that programmatic and fiscal requirements are being met by the contractor. **Each contractor is now required to provide the number of Unduplicated Clients (UDC), Unit of Service (UOS), and Program Income per service category on their monthly invoice.** The monthly and cumulative total of UDC and UOS is also provided to the Program Manager, which in turn helps the Program Manager know if the contractor is meeting the target UDC and UOS.

Process to Separately Track Formula, Supplemental, MAI, and Carry Over Funds, Including Data Systems Utilized: Upon receipt of the Notice of Grant Award, the Fiscal & Contract Unit calculates a ratio/percentage of formula and supplemental funds to the total grant award. This ratio is applied in calculating formula and supplemental expenditures. The same ratio is applied to any unobligated funds at the end of the grant period. Carryover funds are tracked separately from formula and supplemental funds based on budgets that Office of AIDS submitted with the requests to carry over funds. Distinguishing support for MAI populations in the TGA is simplified by the fact that local Part A MAI contracts fund specific activities and/or target populations that are generally distinct from general Part A activities. The unique level of collaboration and information sharing that existing among Ryan White grantees in our region - including collaboration and the utilization of common information systems by the local Part A / B, Part C, and Part D programs - further facilitates the process of distinguishing funding streams.

Process to Ensure Timely Monitoring and Redistribution of Unexpended Funds: The grantee makes every effort to avoid the need for substantial reallocation of funds by monitoring the previous year's funding distribution and expenditures. For the FY 2013 fiscal year the grantee needed to redistribute only **$64,481**of the total FY 2013 award. All of these funds were related to a one-time interruption in the expenditure of MAI funding which the TGA is seeking to utilize during the current fiscal year.

If needed, redistribution occurs in September at the halfway point of the Ryan White fiscal year. At that time, OAA staff determines which agencies have and have not expended 50% of their funds. Staff also reviews spending patterns, service utilization data including numbers of clients served to date, and other factors that impact expenditures, including the seasonal nature of some HIV-related expenditures such as the need for expanded housing and utilities support during the winter. For agencies with low service utilization and/or low client numbers, funds are reallocated immediately within the same service categories to other agencies. Agencies that have over-expended for good cause may receive strong consideration for supplemental funding during this process. The grantee seeks Planning Council approval prior to reallocating funding to a

different core or support service category. The grantee also provides quarterly fiscal reports to the Planning Council with recommendations on reallocation.

Compliance with OMB Circular A-133: All **26** local Part A funded agencies are compliant with OMB Circular A-133. Fiscal monitoring consists of a fiscal interview and completion of the fiscal questionnaire during a site visit. Once completed, the questionnaire is forwarded to the Fiscal and Contracts Director for review. If the Director identifies problems, she conducts a phone interview with the agency to gather more information. If this process proves unsatisfactory, the Fiscal Director conducts a Technical Assistance visit. All agencies are required to submit an annual audit report six months after the end of the agency's fiscal or calendar year. County Auditors review the Audit Report and recommend acceptance or rejection of the report. If it is rejected, the agency is required to submit a corrected report within 30 days of notice.

Improper Findings and Actions: There were no improper findings in subcontractors' A-133 audit reports during the FY 2013 fiscal year.

Receipt and Payment of Vouchers / Invoices from Subcontractors: Upon receipt, invoices are entered on the invoice spreadsheet which is used to verify their mathematical accuracy in terms of elements such as total monthly bill, total billed to date, difference between cumulative amount paid and projected to date, and unexpended balance. If these are not accurate, they are sent back to the Contractor for correction. If accurate, they are reviewed and authorized by the Program Manager and the Fiscal & Contracts Director. Upon approval by both, one copy is placed in files and the other copy is submitted to Public Health Administration, a process that normally takes **2 to 5** working days. In September 2013, notice was provided to all agencies that the OAA will begin to review UOS/UDC provided on invoices against what is entered in CareWare/ARIES. The OAA is aware that the transition in data collection systems will cause some issues and will work with agencies as needed. Invoices that have a discrepancy will be paid after UOS/UDCs have been corrected.

Signed invoices are submitted to the Public Health Administration liaison for further verification, including ensuring that the monthly invoices do not exceed the maximum allowable amount and that the proper account is used for billing. The Public Health Administration liaison then forwards the invoices to Public Health Finance to enter the invoices in the Accounting (ALCOLINK) system to create a voucher. This process normally takes **2 to 4** working days. After the Public Health Finance creates a voucher and approves it in the ALCOLINK system, Public Health Finance will send the invoices to the Auditor-Controller's office for final approval. Following final approval, the Auditor's office will issue the warrant on the **next business day**. Payments are usually mailed out to the Contractor the same day that the warrants are issued. This process normally takes **5 to 7** working days.

1.C) Third Party Reimbursement

Ensuring Monitoring of Third Party Reimbursement: All service providers are contractually required either to conduct an assessment of each client's eligibility for public entitlements and insurance benefits or to refer the client to an Entitlements Advocate for this assessment. This assessment and/or referral must be done during the initial intake at the beginning of each fiscal / contract year. Pending approval for public or private benefits, clients may be provided with services covered solely by Ryan White funds. Service providers that are third party certified (e.g., able to bill Medi-Cal or Medicare) are obliged by contract to bill the

relevant third parties. Additionally, clients are required to provide a verification of income, verification of residency, verification of HIV status, and verification of insurance coverage to determine eligibility for Ryan White funded services. Training in benefits / reimbursement streams and client eligibility is provided for any interested Part A agency staff by the East Bay Community Law Center.

Documenting Client Screening for Eligibility: The grantee conducts fiscal and programmatic monitoring throughout the fiscal year to ensure that expenditures are accurate and that CARE Act funds are used as the payer of last resort. During the contract negotiations process and in contracts language, contractors are informed of their obligation to access CARE Act funds only when other resources are not available. Subcontractors for services that are third party reimbursable are also required to submit a comprehensive budget to the grantee reflecting all third party funds available for billing. The OAA provided all funded agencies an update in September 2013 regarding proof of eligibility for all clients receiving RW services, including HIV status, income, insurance, and residency and again at each contractors' meeting. The OAA provided a form for funded agencies to use to assist in the documentation of eligibility and a second form for the State OA for Covered California.

Tracking Program Income and Rebates: The Oakland TGA requires or directs that all programs track their income and rebates and ensure that this income is used to offset Part A expenditures as opposed to supplanting funds. Most Part A-funded agencies in the TGA do not receive significant program income or rebates to offset the costs of HIV care; however, all agencies must document such income and maintain ongoing cost analysis to demonstrate that Part A funding remains the funding source of last resort.

1.D) Administrative Assessment

- **Assessment of Grantee Activities**
- **Addressing Identified Deficiencies**

Assessing the Grantee is completed through a survey process that is generally completed by the Oakland TGA Collaborative Community Planning Council **every three years.** However, during the last three cycles the Planning Council has opted **not** to conduct a formal assessment, in part because the Council's attention has been focused on new National Monitoring Standards and health care reform. Additionally, no major issues have arisen since the last assessment to prompt an emergency grantee assessment. The Planning Council and the Office of AIDS Administration have been working on a Memorandum of Understanding (MOU) for the past three years which is expected to be approved before the end of the 2014 calendar year. The MOU is expected to outline key agreements between the Council and OAA that will further secure the strong collaborative relationship between the two entities.

The Planning Council's most recent survey process compared funding prioritization and allocation decisions made in 2005 against actual Part A funds distributed in Fiscal Year 2006-2007. A review of Council members' responses reflected **no concerns** with the Grantee's performance with managing and distributing Care Funds. However, the Council did voice concern that the merger of care and prevention roles was proving problematic, and requested technical assistance. The OAA responded by contacting the Centers for Disease Control and Prevention and arranging for training on the implementation of the merger. Since then, the Council has continued to streamline the process for integrating care and prevention services, and

incorporated significant additional enhancements in its newly produced 2012 - 2014 Comprehensive HIV Services Plan.

1.E) Maintenance of Effort - See **Attachment 11.**

ENDNOTES

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