



Grant Number: 1U62PS003219-01

Principal Investigator(s):
Heidi Jenkins

Project Title: PS10-10138, EXPANDED HIV TESTING FOR DISPROPORTIONATELY AFFECTED POPULATIONS

CONNECTICUT DEPARTMENT OF PUBLIC
CHIEF FISCAL OFFICER
410 CAPITOL AVENUE
PO BOX 340308, MS# 13FIS
HARTFORD, CT 061340308

Award e-mailed to: Mary.Fuller@ct.gov

Budget Period: 09/30/2010 – 09/29/2011

Project Period: 09/30/2010 – 09/29/2013

Dear Business Official:

The Centers for Disease Control and Prevention hereby awards a grant in the amount of \$1,071,785 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to CT ST DEPT OF PUBLIC HEALTH in support of the above referenced project. This award is pursuant to the authority of 307,317K2 PHSA,42USC241,247BK2,PL108 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact the individual(s) referenced in Section IV.

Sincerely yours,

Roslyn Curington
Grants Management Officer
Centers for Disease Control and Prevention

Additional information follows

SECTION I – AWARD DATA – 1U62PS003219-01**Award Calculation (U.S. Dollars)**

Salaries and Wages	\$333,903
Fringe Benefits	\$203,881
Personnel Costs (Subtotal)	\$537,784
Supplies	\$2,227
Travel Costs	\$28,812
Other Costs	\$240,928
Consortium/Contractual Cost	\$141,161

Federal Direct Costs	\$950,912
Federal F&A Costs	\$120,873
Approved Budget	\$1,071,785
Federal Share	\$1,071,785
TOTAL FEDERAL AWARD AMOUNT	\$1,071,785

AMOUNT OF THIS ACTION (FEDERAL SHARE) \$1,071,785

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

02	\$1,071,785
03	\$1,071,785

Fiscal Information:

CFDA Number: 93.943
EIN: 1066000798A9
Document Number: 003219HT10

IC	CAN	2010	2011	2012
PS	921Z9HC	\$873,388	\$1,071,785	\$1,071,785
PS	939ZCLQ	\$52,830		
PS	939ZDEV	\$145,567		

SUMMARY TOTALS FOR ALL YEARS		
YR	THIS AWARD	CUMULATIVE TOTALS
1	\$1,071,785	\$1,071,785
2	\$1,071,785	\$1,071,785
3	\$1,071,785	\$1,071,785

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project

CDC Administrative Data:

PCC: N / OC: 4151 / Processed: CURINGTONR 09/17/2010

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U62PS003219-01

For payment information see Payment Information section in Additional Terms and Conditions.

INSPECTOR GENERAL: The HHS Office Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such reports are treated as sensitive material and submitters may decline to give their names if they choose to remain anonymous. This note replaces the Inspector General contact information cited in previous notice of award.

SECTION III – TERMS AND CONDITIONS – 1U62PS003219-01

This award is based on the application submitted to, and as approved by, CDC on the above-titled project and is subject to the terms and conditions incorporated either directly or by reference in the following:

- a. The grant program legislation and program regulation cited in this Notice of Award.
- b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
- c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
- d. The HS Grants Policy Statement, including addenda in effect as of the beginning date of the budget period.
- e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

This award is funded by the following list of institutes. Any papers published under the auspices of this award must cite the funding support of all institutes.

National Center For Hiv, Viral Hepatitis, Stds And Tb Prevention (PS)

Treatment of Program Income:
Additional Costs

SECTION IV – PS Special Terms and Conditions – 1U62PS003219-01

Funding Opportunity Announcement Number (FOA), PS10-10138
Award Number, 1U62PS003219-01 (CONNECTICUT)
Approval List Number, C0143R10

ADDITIONAL TERMS AND CONDITIONS OF THIS AWARD

NOTE 1. INCORPORATION. Funding Opportunity Announcement Number PS10-10138 titled, Expanded HIV Testing for Disproportionately Affected Populations, as amended, additional requirements, the application dated June 17, 2010 and the budget discussions dated August 31, 2010, are made a part of this award by reference.

NOTE 2. SUMMARY STATEMENT. Attached to this Notice of Award is a Summary Statement, which is a summary of reviewer comments, recommendations, strengths, and weaknesses.

NOTE 3. APPROVED FUNDING. Funding in the amount of \$1,071,785 is approved for the Year 01 budget period, which is September 30, 2010, through September 29, 2011. All funding for future years is based on satisfactory programmatic progress and subject to the availability of funds.

NOTE 4. APPROVED INTERVENTIONS. Funds are approved to implement the following:

Part A: \$846,785
Part B: \$225,000
Total: \$1,071,785

NOTE 5a. SPECIAL AWARD CONDITION:

- a. REVISE BUDGET: As discussed during the budget discussion, adjustments to the budget were made to match approved funding level. The difference was deducted from the Supplies budget category. A revised budget for the amount of the approved funding level listed above must be submitted no later than October 30, 2010. Failure to submit the required information in a timely manner may adversely effect the future funding of this project. If the information cannot be provided by the due date, you must submit a letter explaining the reason and state the date by which the Grants Officer will receive the information.

NOTE 5b. ADDITIONAL PROGRAMMATIC REQUIREMENTS.

- a. Appropriate grantee staff is required to attend all CDC mandatory meetings, trainings, and conferences, including a weeklong orientation meeting as scheduled by CDC.
- b. Grantees will be expected to follow CDC guidance on assuring confidentiality and security of data, including signatures from each directly funded agency on (1) the Data Security Memorandum of Understanding and (2) the associated Rules of Behavior for CDC Grantees Regarding National HIV Prevention Program Monitoring and Evaluation Data, both of which will be provided by CDC.

Grantees will also be provided with a copy of the Assurance of Confidentiality for National HIV Prevention Program Monitoring and Evaluation Data, which describes CDC's roles and responsibilities for the protection of these data.

NOTE 6. INDIRECT COSTS. Indirect costs are approved based on the Indirect Cost Rate Agreement dated February 29, 2008, which calculates indirect costs as follows, a Fixed is approved at a rate of 36.2% of the base, which includes, direct salaries and wages including vacation, holiday, sick pay and other paid absences but excluding all other fringe benefits. The effective dates of this indirect cost rate are from July 01, 2007 to June 30, 2012.

NOTE 7. REPORTING REQUIREMENTS.

a.) Annual Financial Status Report (FSR, SF 269 or SF 269A). The FSR for this budget period is due to the Grants Management Specialist by December 30, 2011. Reporting timeframe is September 30, 2010, through September 30, 2011 (Year 01). The FSR should only include those funds authorized and disbursed during the timeframe covered by the report. If the FSR is not finalized by the due date, an interim FSR must be submitted, marked not final, and an amount of unliquidated obligations should be annotated to reflect unpaid expenses. Electronic versions of the form can be downloaded into Adobe Acrobat and completed on-line by visiting, <http://www.whitehouse.gov/omb/grants/sf269a.pdf> (short form) or <http://www.whitehouse.gov/omb/grants/sf269.pdf> (long form).

Failure to submit the required information in a timely manner may adversely effect the future funding of this project. If the information cannot be provided by the due date, you must submit a letter explaining the reason and state the date by which the Grants Officer will receive the information.

ANNUAL PROGRESS REPORTING. Annual progress reports are a requirement of this program, due 90 days following the end of each budget period.

a.) Interim Progress Report (IPR). The IPR will serve as the non-competing continuation application. IPR reporting timeframe is September 30, 2010, through March 29, 2011. This report must be submitted via www.grants.gov. A due date and specific IPR guidance will be provided at a later date.

b.) Annual Progress Report (APR). The APR will be due 90 days after the end of the budget period, December 30, 2011. Reporting timeframe is September 30, 2010, through September 30, 2011 (Year 01). APR programmatic guidance will be provided by the program office at a later date.

NOTE 8. HIV PROGRAM REVIEW PANEL REQUIREMENT. All written materials, audiovisual materials, pictorials, questionnaires, survey instruments, websites, educational curricula and other relevant program materials have to be reviewed and approved by an established program review panel. A list of reviewed materials and approval dates must be submitted to the CDC Grants Management Specialist with the Interim Progress Report.

NOTE 9. ASSURANCE OF COMPLIANCE. Web page notices must be used on websites to alert individuals who may be searching or browsing the web. The certification of compliance with this requirement must be signed and returned to the Procurement and Grants Office. Not complying with these requirements will result in restrictions or disallowance of funds related to the use of the unapproved materials and related staff activities.

NOTE 10. CORRESPONDENCE. ALL correspondence (including emails and faxes) regarding this award must be dated and identified with the AWARD NUMBER as shown at the top left of this page, and include a point of contact (name, phone, fax, and email). All correspondence should be addressed to the Grants Management Specialist.

NOTE 11. PRIOR APPROVAL. All requests, that require prior approval, must bear the signature of an authorized official of the business office of the grantee organization as well as the principal investigator or program or project director named on this notice of award. The request must be postmarked no later than 120 days prior to the end date of the current budget period. Any requests received that reflect only one signature will be returned to the grantee unprocessed. Additionally, any requests involving funding issues must include an itemized budget and a narrative justification of the request. Refer to the HHS Grants Policy Statement, <http://www.hhs.gov/grantsnet/adminis/gpd/>

Prior approval is required but is not limited to the following types of requests. 1) Use of unobligated funds from prior budget period (Carryover), 2) Lift funding restriction, withholding, or disallowance, 3) Redirection of funds, 4) Change in Contractor/Consultant, 5) Supplemental funds, 6) Response to Technical Review, or 7) Change in Key Personnel.

NOTE 12. INVENTIONS. Acceptance of grant funds obligates recipients to comply with the standard patent rights clause in 37 CFR 401.14.

NOTE 13. PUBLICATIONS. Publications, journal articles, etc. produced under a CDC grant support project must bear an acknowledgment and disclaimer, as appropriate, such as,

This publication (journal article, etc.) was supported by the Cooperative Agreement Number above from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

NOTE 14. CANCEL YEAR. 31 U.S.C. 1552(a) Procedure for Appropriation Accounts Available for Definite Periods states the following, On September 30th of the 5th fiscal year after the period of availability for obligation of a fixed year appropriation account ends, the account shall be closed and any remaining balances (whether obligated or unobligated) in the account shall be canceled and thereafter shall not be available for obligation or expenditure for any purpose. An example is provided below:

FY 2005 funds will expire September 30, 2010. All FY 2005 funds should be drawn down and reported to Payment Management System (PMS) prior to September 30, 2010. After this date, corrections or cash requests will not be permitted.

NOTE 15. CONFERENCE DISCLAIMER AND USE OF LOGOS.

Disclaimer. Where a conference is funded by a grant or cooperative agreement, a subgrant or a contract the recipient must include the following statement on conference materials, including promotional materials, agenda, and Internet sites,

Funding for this conference was made possible (in part) by the cooperative agreement award number above from the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government

Logos. Neither the HHS nor the CDC logo may be displayed if such display would cause confusion as to the source of the conference or give the false appearance of Government endorsement. A non-federal entity unauthorized use of the HHS name or logo is governed by U.S.C. 1320b-10, which prohibits the misuse of the HHS name and emblem in written communication. The appropriate use of the HHS logo is subject to the review and approval of the Office of the Assistant Secretary for Public affairs (OASPA). Moreover, the Office of the Inspector General has authority to impose civil monetary penalties for violations (42 C.F.R. Part 1003). Neither the HHS nor the CDC logo can be used on conference materials, under a grant, cooperative agreement, contract or co-sponsorship agreement without the expressed, written consent of either the Project Officer or the Grants Management Officer. It is the responsibility of the grantee (or recipient of funds under a cooperative agreement) to request consent for the use of the logo in sufficient detail to assure a complete depiction and disclosure of all uses of the Government logos, and to assure that in all cases of the use of Government logos, the written consent of either the Project Officer or the Grants Management Officer has been received.

NOTE 16. EQUIPMENT AND PRODUCTS. To the greatest extent practicable, all equipment and products purchased with CDC funds should be American-made. CDC defines equipment as Tangible non-expendable personal property (including exempt property) charged directly to an award having a useful life of more than one year AND an acquisition cost of \$5,000 or more per unit. However, consistent with recipient policy, a lower threshold may be established. Please provide the information to the Grants Management Officer to establish a lower equipment threshold to reflect your organization policy.

The grantee may use its own property management standards and procedures provided it observes the provisions of the following sections in the Office of Management and Budget (OMB) Circular A-110 and 45 CFR Part 92:

i. Office of Management and Budget (OMB) Circular A-110, Sections 31 through 37 provides the uniform administrative requirements for grants and agreements with institutions of higher education, hospitals, and other non-profit organizations
<http://www.whitehouse.gov/omb/circulars/a110/a110.html>

ii. 45 CFR Parts 92.31 and 92.32 provides the uniform administrative requirements for grants and cooperative agreements to state, local and tribal governments: http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr92_03.html

Note 17. TRAFFICKING IN PERSONS. This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term and condition, go to
http://www.cdc.gov/od/pgo/funding/grants/Award_Term_and_Condition_for_Trafficking_in_Persons.shtm

Note 18. ACKNOWLEDGMENT OF FEDERAL SUPPORT. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all awardees receiving Federal funds, including and not limited to State and local governments and recipients of Federal research grants, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the project or program, and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

NOTE 19. AUTOMATIC DRAWDOWN.

PAYMENT INFORMATION: Payment under this award will be made available through the Department of Health and Human Services (HHS) Payment Management System (PMS). The Division of Payment Management; Program Support Center, administers PMS, HHS administers PMS. PMS will forward instructions for obtaining payments.

A. PMS correspondence, mailed through the U.S. Postal Service, should be addressed as follows:

Director
Division of Payment Management
OS/ASAM/PSC/FMS/DPM
P.O. Box 6021
Rockville, MD 20852

Phone Number: (877) 614-5533

Fax Numbers: Governmental and Tribal Payment Branch (301) 443-2569

Email PMSSupport@psc.gov

Website: http://www.dpm.psc.gov/grant_recipient/shortcuts/shortcuts.aspx?explorer.event=true

B. If a carrier other than the U.S. Postal Service is used, such as United Parcel Service, Federal Express, or other commercial service, the correspondence should be addressed as follows:

Division of Payment Management
FMS/PSC/HHS
Rockwall Building #1, Suite 700
11400 Rockville Pike
Rockville, MD 20852

To expedite your first payment from this award, attach a copy of the Notice of Grant/Cooperative Agreement to your payment request form.

NOTE 20. CERTIFICATION STATEMENT: By drawing down funds, Awardee certifies that proper financial management controls and accounting systems to include personnel policies and procedures have been established to adequately administer Federal awards and funds drawn down are being used in accordance with applicable Federal cost principles, regulations, and the President's Budget and Congressional intent.

Note 21. AUDIT REQUIREMENT. An organization that expends \$500,000 or more in a year in Federal awards shall have a single or program-specific audit conducted for that year in accordance

with the provisions of OMB Circular A-133, Audit of States, Local Governments, and Non-Profit Organizations. The audit must be completed along with a data collection form, and the reporting package shall be submitted within the earlier of 30 days after receipt of the auditors report(s), or nine months after the end of the audit period. The audit report must be sent to:

Federal Audit Clearing House
Bureau of the Census
1201 East 10th Street
Jeffersonville, IN 47132

Should you have questions regarding the submission or processing of your Single Audit Package, contact the Federal Audit Clearinghouse at: (301) 763-1551, (800) 253-0696 or email: govs.fac@census.gov

The grantee is to ensure that the sub-recipients receiving CDC funds also meet these requirements (if total Federal grant or grant funds received exceed \$500,000). The grantee must also ensure that appropriate corrective action is taken within six months after receipt of the sub-recipient audit report in instances of non-compliance with Federal law and regulations. The grantee is to consider whether sub-recipient audits necessitate adjustment of the grantees own accounting records. If a sub-recipient is not required to have a program-specific audit, the Grantee is still required to perform adequate monitoring of sub-recipient activities. The grantee is to require each sub-recipient to permit independent auditors to have access to the sub-recipients records and financial statements. The grantee should include this requirement in all sub-recipient contracts.

NOTE 22. CDC CONTACT NAMES.

Business and Grants Policy Contact

Louvern Asante, Grants Management
Centers for Disease Control, PGO, Branch I
2960 Brandywine Road, Mail Stop E-15
Atlanta, GA 30341-4146
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Fax: (770) 488-2820
Email: LHA5@cdc.gov

Programmatic and Technical Contact

David Miller, Project Officer
Centers for Disease Control and Prevention
Division of HIV/AIDS Prevention
Prevention Program Branch
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Atlanta, GA 30329
Telephone: 404-639-6280
Email: znl0@cdc.gov

STAFF CONTACTS

Grants Management Specialist: Louvern Asante
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Procurement and Grants Office
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2920 Brandywine Road, Mailstop E15
Atlanta, GA 30341
Email: lha5@cdc.gov Phone: (770) 488-2835 Fax: 770-488-2868

Grants Management Officer: Roslyn Curington
Centers for Disease Control and Prevention
OD/OCOO/PGO/AABI
Koger Center, Colgate Builder
2920 Brandywine Road, Mailstop E15

SPREADSHEET SUMMARY
GRANT NUMBER: 1U62PS003219-01

INSTITUTION: CONNECTICUT STATE DEPT OF PUBLIC HEALTH

<i>Budget</i>	<i>Year 1</i>	<i>Year 2</i>	<i>Year 3</i>
Salaries and Wages	\$333,903		
Fringe Benefits	\$203,881		
Personnel Costs (Subtotal)	\$537,784		
Supplies	\$2,227		
Travel Costs	\$28,812		
Other Costs	\$240,928		
Consortium/Contractual Cost	\$141,161		
TOTAL FEDERAL DC	\$950,912	\$950,912	\$950,912
TOTAL FEDERAL F&A	\$120,873	\$120,873	\$120,873
TOTAL COST	\$1,071,785	\$1,071,785	\$1,071,785

May 28, 2010

To Whom It May Concern:

The Connecticut Department of Public Health (CTDPH) is pleased to submit this application for the Expanded Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations grant (CDC-RFA-PS10-10138). All correspondence regarding this grant application should be forwarded to:

Mary Fuller, Chief Fiscal Officer
Connecticut Department of Public Health
410 Capitol Avenue, MS#13FIS
P.O. Box 340308
Hartford, CT 06134

CTDPH is submitting this application to request funding to target Black or African Americans and Latinos for routine HIV screenings in healthcare settings under Part A, Category 1 of this FOA. CTDPH is also applying for funds to provide enhanced linkage to medical care and partner services to newly diagnosed HIV-infected persons under Part B of this FOA.

Should you have any questions, please feel free to contact me at (860) 509-7801.

Sincerely,

A handwritten signature in black ink, appearing to read "Christian D. Andresen". The signature is fluid and cursive, with the first name being the most prominent.

Christian D. Andresen
Acting AIDS and Chronic Diseases Section Chief

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I. Project Narrative

Part A – HIV Screening and HIV Counseling, Testing and Referral

1. Program Services

Category 1 – HIV Screening in Healthcare Settings, Program Services

A. Past Experience

The Connecticut Department of Public Health (DPH) currently receives funding (2007-2010 funding cycle) under PS07-768 Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans. The primary goal of this project is to assist health care facilities that are serving a significant number of Black or African Americans with the provision of routine HIV screening services within the context of their clinical practice. We have entitled this project the Expanded and Integrated HIV Testing Initiative (ETI). DPH provides the healthcare facilities participating in the ETI with HIV rapid test kits (OraQuick and Clearview), as well as DPH Laboratory services for confirmation of preliminary positive results, standard HIV testing, and processing of HCV, STD, and TB specimens. Training to perform routine screenings was conducted by DPH in conjunction with the manufacturers of the rapid test kits. Technical assistance and monitoring are provided by DPH staff throughout the funding cycle. A protocol was put in place by DPH for the referral and linkage of patients identified as positive to Infectious Disease Providers and other resources such as Ryan White case management. Through the grant, DPH was able to assign to each site a Disease Intervention Specialist (DIS) to ensure that HIV positive patients received screening for STDs, TB, and HCV. DIS also offered partner notification services to all positive patients and ensured that referrals had been made to medical and psychosocial services.

The DIS was also available to follow-up on positive patients who did not return for their test results.

Clinical sites that participate in this project include three community health centers (CHCs), a community health care van, three hospital emergency departments, eleven substance abuse treatment facilities, eleven STD clinics, ten TB clinics, and two state university student healthcare centers. Two of the participating community health centers have multiple sites, and one has begun HIV testing in the dental clinic. A fourth community health center, that is located in a community with a large Hispanic or Latino population and has multiple locations, is slated to join the ETI in June 2010.

The current clinical sites are located in the following Connecticut towns: Bridgeport, Danbury, Greenwich, Hartford, New Britain, New Haven, New London, Norwalk, Norwich, Stamford, Waterbury, Westport, and Willimantic. DPH data records indicate that there were 11,120 HIV tests reported from the clinical sites that participated in the ETI between October 2008 and April 2010. Fifty-six new HIV-positive cases were identified during this time period (.50% seropositivity rate). HIV Test Form data from April 1, 2009 to March 31, 2010 show that of the 8,370 patients tested at the clinical sites, 3,077 (37%) were Black or African American and 2,284 (27%) were Hispanic or Latino. Of the 56 newly-identified HIV positives during this time period, 14 (58%) were Black or African American and six (25%) were Hispanic or Latino. These data demonstrate the need to continue to target these populations for routine HIV testing in an effort to increase the numbers of newly-diagnosed HIV positives and referrals to healthcare services.

We present here data from October 2008 through April 2010 because we experienced data management and analysis challenges throughout the first year of the ETI. In August 2009,

Connecticut began using the X-PEMS application provided by Luther Consulting as part of a CDC pilot project. We chose to participate in the pilot because of the many problems encountered with scanning HIV Test Forms and processing data using the Read Soft/ CDC Tool interface. Data from April 2009 were the first entered into X-PEMS.

Until July 2009, Connecticut had an HIV Informed Consent law that required separate informed consent and pretest counseling for individuals being tested for HIV. This presented a barrier to the full implementation of opt-out testing. Most of the clinical sites chose to routinely offer the HIV test through the use of one staff person such as an HIV counselor. This, in most cases, limited the number of tests that could be conducted. The STD clinics are now doing opt-out testing and we are working with the remaining clinical sites to implement opt-out testing. We would like to go out to bid for CHCs in the second year of this grant because in our current project, of the various venues where routine testing was offered, the CHCs reported the second highest number of HIV tests. Our belief is that if we fund a service coordinator at four to six community health centers, the CHCs be able to fully implement opt-out testing using existing clinical staff.

During this funding cycle, the DPH provided ongoing training and technical assistance on quality assurance policies and procedures to all involved staff and providers. DPH collaborated with the Connecticut AIDS Education Training Center (CAETC) and the STD/HIV Prevention Training Center of New England to provide training for clinical staff involved in this project. Clinical staff were provided with training on abbreviated counseling and testing sessions based on Connecticut's informed consent requirements. They were also provided with training on rapid testing procedures, resources available to patients in their area, and cultural competence. DPH also provided the non-clinical sites that participated in this project with training on the social

networks strategy and prevention counseling. Training was also provided on testing methods, which included rapid testing, OraSure and phlebotomy. DPH also provided staff involved with the project cultural competency training.

B. Target Population and Justification of Need

Funding from this grant for Part A Category 1 will be open to agencies that primarily serve a high percentage of Black or African Americans and/or Hispanics or Latinos. During Year One, DPH would continue to work with the clinical sites that are currently participating in the ETI, which include the following: 4 CHCs, 11 STD clinics, 3 hospital emergency rooms, 10 TB clinics, two state university student health centers and selected drug treatment centers. During Year One, the CHCs would also be eligible to apply for funds through an RFP process that will culminate in contracts for year two and three between DPH and four to six community health centers. DPH also seeks to provide services, through the CHCs, to intravenous drug users. During Years Two and Three, routine HIV testing would be provided at the contracted CHCs and the STD clinics, TB clinics and state university student health centers that are current ETI participants.

From 1981 through 2009, 19,473 HIV/AIDS cases have been reported in Connecticut. Of these, 8,899 (46%) have died and 10,574 are living with HIV/AIDS (PLWHA). Among all cases reported, 70% were male and 30% female; 36% were white, 35% black, and 28% Hispanic; 2% were less than 20 years of age at diagnosis, 15% were 20-29 years of age, 70% 30-49 years, 10% 50-59, and 3% were 60 or more years of age; 44% had injection drug use (IDU) as a probable source of infection, 22% were men who had sex with men (MSM), 18% had heterosexual risk, and 2% were infected perinatally. Among the 10,574 PLWHA (300 per 100,000), 66% are male and 34% are female. HIV/AIDS is found disproportionately in blacks and Hispanics who,

although they make up only 20% of Connecticut's population, comprise 64% of all HIV/AIDS cases (32% are black and 32% are Hispanic). Forty-three percent of PLWHA are associated with IDU risk, 26% with MSM and 27% with heterosexual risk. Only 6% of PLWHA are currently less than 30 years of age and 15% are 30-39. The majority of cases are 40-49 (37%) and 50-59 (32%) years of age. Reflecting the aging of the PLWHA population, 10% (n = 1,081) of cases are 60 or more years of age.

CDC estimates that in addition to PLWHA who are aware of their status, there are an additional 21% of PLWHA who are not aware of their HIV-positive status because they have yet to be tested. In Connecticut, this 'unaware' population is estimated to be 2,811 people giving a total of 13,385 PLWHA in Connecticut. During 2005-2009, 2,137 HIV/AIDS cases were diagnosed. Of these, 70% were male, 30% female; 32% were white, 35% black, 32% Hispanic, 1% Asian, and 0.5% multi-race; 1% were less than 20 years of age, 15% 20-29, 57% 30-49, and 27% were 50+; 37% were MSM, 30% IDU, 2% MSM/IDU, 31% heterosexual, 0.3% perinatal, 0.3% other/unknown.

Over one-third (39%) of all cases diagnosed during 2005-2009 were from the three largest cities, Hartford, Bridgeport, and New Haven. Of the cases residing in these cities, nearly 50% were black, ranging from 44% in Hartford to 50% in New Haven. Hispanics ranged from 26% in New Haven to 44% in Bridgeport. In addition, 290 (14%) cases were from medium to small cities with fewer than 10 cases per city over the five-year period. The number of cases diagnosed in Connecticut cities during 2005-2009 ranged from zero to 312.

C. Program Objectives

Year 1 – By September 30, 2011, provide HIV tests to 12,000 patients at selected healthcare facilities that serve primarily Black or African Americans and/or Hispanics or Latinos.

Methods

- Continue to provide routine HIV screenings at four CHCs, 11 STD clinics, three hospital emergency rooms, 10 TB clinics, two state university student health centers and selected drug treatment facilities.
- Provide technical assistance on the full implementation of opt-out testing to clinical sites.
- Conduct a RFP process to select four to six CHCs to provide routine HIV testing.
- Provide resources such as OraSure, rapid test kits, DIS services, laboratory services, training and technical assistance to the healthcare facilities involved in the project.

Year 2 – By September 30, 2012, provide HIV tests to 18,000 patients at selected healthcare facilities that primarily serve Black or African Americans and/or Hispanics or Latinos.

Methods

- Provide routine HIV screenings at four to six CHCs, 11 STD clinics, 10 TB clinics, and two state university student health centers.
- Provide resources such as OraSure, rapid test kits, DIS services, laboratory services, training and technical assistance to the healthcare facilities involved in the project.

Year 3 – By September 30, 2013, provide HIV tests to 20,000 patients at selected healthcare facilities that primarily serve Black or African Americans and/or Hispanics or Latinos.

Methods

- Provide routine HIV screenings at four to six CHCs, 11 STD clinics, 10 TB clinics, and two state university student health centers.

- Provide resources such as OraSure, rapid test kits, DIS services, laboratory services, training and technical assistance to the healthcare facilities involved in the project.

The numbers that we propose for testing in the first year are based on the ETI data on HIV tests conducted between October 2008 and April 2010. Due to the fact that we will continue with the clinical sites that are currently participating in our 07768 project until we are able to conduct a bid process for the second and third years, we want to be realistic about the numbers of tests that we are proposing. We will increase our goals for numbers tested in the second and third year. At that time we will have contracts in place, which we do not have now, that will ensure that opt-out testing is fully implemented. These numbers are based on our estimated cost of testing which ranges between the \$42 average that CDC has found and our calculation of \$50. Our \$50 cost is based on \$12.41 to run the test, \$1 shipping/courier/mailing, \$3 personnel cost to fill out the data forms, \$3 training time on test kits, \$30 staff time for reporting, follow-up, ordering test kits, and laboratory staff.

D. Program Plan

1) HIV Screening

The DPH plans to provide HIV screenings to persons in selected healthcare facilities. These agencies would consist of four to six newly-funded CHCs, three hospital emergency departments, eleven STD clinics and selected substance abuse treatment facilities funded by the Connecticut Department of Mental Health and Addiction Services (DMHAS). The CHCs that will be funded under this grant will be selected as a result of a request for proposal bidding process by the DPH.

The DPH currently receives funding from the Health Resources and Services Administration (HRSA) for ten CHCs throughout the state. These federally qualified health centers are located in the following cities: Bridgeport, East Hartford, Hartford, Middletown, New Haven and Willimantic. Based on the 2008 Uniform Data System (UDS) report from HRSA, a total of 133,143 persons, between the ages of 20 and 64, received services from the ten CT community health centers. Of the total number of persons seen, 45.7% (110,727) were Hispanic or Latino and 22.9% (55,409) were African American. These populations represent the two largest groups receiving services at this particular type of venue. Based on these numbers, CHCs would be the ideal venues in which Black or African Americans and Latinos could be targeted for routine HIV screenings.

According to the 2008 UDS report, approximately 24% of persons twenty years and older who were seen at CT community health centers, had no health insurance. Approximately fifty percent received Medicaid (Title XIX or CHIP).

Relationships have been established with the clinical sites that we will be working with in year one and the majority of the sites that participate in year two will be the same. We have worked with the administrators, managers, and clinical directors of these sites over time to promote routine HIV screening. On May 18, 2010, we had a meeting of the clinical site managers to discuss the need to work on full implementation of opt-out testing as recommended in the CDC guidelines, now that Connecticut has passed legislation that supports them. This meeting will be followed up by meetings with each clinical site to develop individualized plans for implementation. We will continue to work with physician champions identified in each site to promote routine HIV screening.

The clinical sites that are currently participating in ETI would continue as part of the project during Year One of the new funding cycle. This would include four community health centers: Hill Health Center in New Haven, Southwest Community Health Center in Bridgeport, Community Health Services in Hartford, and Generations in Willimantic; the Yale Health Care Van, three hospital emergency departments: Yale in New Haven, Lawrence and Memorial in New London, and Waterbury Hospital; eleven STD clinics funded by DPH and ten co-located TB clinics located in Norwich, Norwalk, Greenwich, Bridgeport, New Britain, Stamford, New Haven, Waterbury, Hartford and Danbury; and two state university student health centers: Eastern in Willimantic and Southern in New Haven. During Year One, DPH would also go out to bid, through a Request for Proposal, to fund four to six community health centers. Funding for the community health centers would start in Year Two and continue in Year Three with two-year contracts. DPH would like to have contracts with community health centers so that we can provide them with funding for a service coordinator who would be responsible for ensuring that all patients are being screened unless they refuse. The Service Coordinator at each of the selected Community Health Centers will also be responsible for making sure that the appropriate data is collected and submitted to DPH. Along with the community health centers, in Year Two and Three, DPH would continue to provide resources including rapid test kits, free laboratory services, and an assigned DIS to the 11 STD clinics, 10 TB clinics, two state university health clinics and in some of the drug treatment centers that are currently participating in ETI so that they may continue to provide routine HIV screening. We will no longer include the three hospital emergency departments, the community health care van, or the substance abuse treatment centers in the project due to our efforts to ensure that all project participants are able to achieve the goal of providing opt-out testing to all patients. The eleven STD clinics will remain in the project

because they conducted the highest number of tests. The TB clinics will also remain as part of the project. They are co-located with the STD clinics. They do not conduct opt-out HIV testing, but they do routinely provide HIV testing to TB suspects based on a short risk assessment. In addition, we will continue to work with the two state university health centers that began testing in 2010. These student health centers, although not testing all students at this point, are testing a high percentage of African Americans. We will maintain them in the project and work with them to fully implement opt-out testing.

The Health Program Associate funded under this grant, would be responsible for working with selected healthcare facilities to develop a plan and protocols for the implementation of routine HIV screening. These facilities would also be required to submit a request for proposal, as part of the DPH bidding process, detailing how they plan to implement and integrate routine HIV screenings into their respective agencies.

The promotion of HIV screening activities to staff and the education of providers and staff about routine HIV screening would be explained during the RFP process. Providers and staff would be required to attend a bidder's conference prior to submitting the RFP, which would give interested agencies the opportunity to ask questions about the grant. Technical assistance would also be provided to the newly funded sites, once the RFP process is completed, which would assist with the implementation of HIV screening activities, educating providers about routine screenings and gaining their support for the program. The language in the contracts between the Department of Public Health and the funded agencies would also specify what the agencies are required to provide to the State of CT and what the State is required to provide to the agencies.

Agencies would also be required to state how they would promote HIV screening to their clients and provide routine, voluntary screening to their clients through the RFP process. Materials developed during the current funding cycle may continue to be used to market routine HIV screening to patients in the waiting rooms and in the community.

The DPH will continue to provide rapid test kits (OraQuick and/or Clearview) and OraSure kits to the existing funded agencies (three hospitals, STD clinics and TB clinics). These sites will also continue to have the use of the DPH Laboratory services for the confirmation of preliminary positive test samples. Newly-funded community health centers would also receive test kits and training on the use of them from test manufacture representatives (OraSure Technologies and Alere). The CHCs will also be able to submit confirmatory samples to the DPH Laboratory for those tests that are not reimbursable. Discussion will be held with the clinical sites to determine whether rapid or the standard method of testing would be more efficient in their programs. Those who prefer to use standard testing will be provided with OraSure kits and access to the DPH laboratory for processing of HIV samples.

HIV counseling and testing services will be provided in a manner that is respectful of the cultural and linguistic needs of the African American and Latino populations being served. The staff, employed by the programs that will be funded by DPH, will reflect the populations that they serve.

All services will be delivered in manner consistent with applicable CDC guidelines, which includes screening all people 13-64 years old in all healthcare settings, identifying all HIV+ people and connecting them to care and educating people about risk factors to empower them to stay healthy.

Now that Connecticut has legislation that permits opt-out testing, health care settings are required to include HIV testing in their general consent in order to test patients on a routine basis. Once it is clear that HIV testing is included in the general consent for treatment, patients will then be informed that an HIV test is included as part of their visit unless they object.

Protocols will be established in the clinical settings to ensure that patients receive their test results. Rapid HIV tests will be used that provide results in 15-20 minutes (via Clearview or OraQuick Advance tests). Clearview Complete HIV 1/2 is a single-use rapid test that detects antibodies to HIV-1 and HIV-2 in fingerstick whole blood, venous whole blood, and serum or plasma specimens. The Clearview HIV 1/2 Stat Pak is a single-use rapid test that detects antibodies to HIV-1 and HIV-2 in fingerstick whole blood, venous whole blood, serum or plasma specimens. Both of these Clearview tests provide results within 15-20 minutes. The OraQuick Advance Rapid HIV-1/2 Antibody Test is an FDA approved for use with oral fluid, fingerstick or venous whole blood and plasma that provides results in 20 minutes. Sites will be provided with OraSure, Clearview and/or OraQuick test kits by DPH. Patients, who test preliminary positive, will be given a confirmatory test (OraSure or venipuncture) at the time that they receive the preliminary result, and then be scheduled to return to the site within one week for their result. Patients would then be linked to medical and support services. Patients who do not return for their confirmatory results within two weeks will be contacted by telephone and, if unreachable, will be sent a nondescript letter asking them to contact the clinical setting. Patients who are confirmed positive will receive further prevention counseling through CTR sites that are funded by DPH through the Cooperative Agreement. Patients who test HIV positive and do not respond to telephone calls or nondescript letters, will be referred to the program's outreach staff for follow-up. If the site does not have outreach staff, then the case will be referred to DIS staff, who

will locate the patient, deliver the results and ensure that they are referred back into medical care and support services.

Partner services will be initiated after diagnosis as follows:

- On a weekly basis, the DPH Virology Lab will send a line list of positive HIV test results to surveillance staff in the STD Program. The positives will be separated by site number.
- Surveillance staff will initiate appropriate paperwork (field record) for the Disease Intervention Specialist (DIS) assigned to the facility reporting the positive case.
- Once the field record is assigned to the DIS, the DIS will contact the appropriate staff person from the facility to assure follow up has been initiated with the HIV positive client. This follow up includes:
 1. Assuring the client receives confirmation posttest results.
 2. Referral to prevention case management.
 3. Referral for STDs, hepatitis C and TB screening.
- The site will have two weeks to complete this follow up. The two weeks starts upon receipt of the positive Western Blot lab report confirmation from the DPH Laboratory.
- The DIS will be available to assure follow up is completed, if the site chooses to have them assist.
- The DIS is responsible for conducting partner notification services (PNS) on all HIV positive clients. When the appropriate staff person from the site is contacted by the DIS, all locating and other necessary confidential information will be collected by the DIS to complete PNS activities, including name. The lab report will only include a unique patient identifier (e.g., HIV Test Form barcode). A name is necessary before the DIS can contact the client. This information should be readily available from the HIV Client

Locating Form that is to be completed by the staff person once there is a positive rapid test reported on any client.

- If staff from the site is able to complete the referrals as listed above, the outcome of the test results should be shared with the DIS at the conclusion of the follow up.
- After the two-week time period, if any of the referrals for follow up have not been completed, the DIS will become responsible for assuring the completion of all follow up on behalf of the client.

If the posttest is not completed within the two-week time frame, the yellow copy of the CDC HIV Test Form Part 1, which includes the remaining labels, will need to be given to the DIS. This form should be obtained from the site by the DIS. The DIS will then be responsible for the completion and submission of this form as well as Parts 2 and 3.

We are beginning to work on issues of sustainability of routine HIV testing in clinical sites. During the summer of 2010 we hope to have a law intern who will draft language to require insurance companies to cover routine HIV testing in Connecticut as outlined in CDC's 2006 recommendations. Lack of coverage for routine HIV testing, as opposed to diagnostic testing, is a barrier to expanding routine HIV testing in health care settings. The ETI Project Coordinator and the Durational Health Program Assistant 2 will begin to work with all clinical sites during year one on developing plans for continuation of their programs beyond the end of the funding cycle. They will research information regarding insurers and their coverage of HIV testing and provide this information to the clinical sites directly and to other health care providers through a website dedicated to the promotion of HIV screening in health care settings. Once the funding no longer exists, the sites will not be required to participate in the data

collection, which is perceived as burdensome to many clinical practices. We will continue to provide as many resources as we can in terms of free laboratory services, provision of test kits, training, and technical assistance through other sources of state and federal funding.

The Health Program Associate (HPA), funded under this grant, would be responsible for investigating reimbursement for HIV screenings from third party payers. Reimbursement information would be posted on DPH's website as a resource guide for sites that are interested in or are currently conducting routine HIV screenings.

The DPH will continue to provide rapid test kits for the provision of HIV screenings and laboratory services (for confirmatory samples) to those healthcare facilities previously funded by this grant. Community health centers that would receive, funding under this grant, would also receive rapid test kits. DPH Laboratory services would also be provided for those patients that receive HIV screenings that are non-reimbursable. These healthcare facilities will be encouraged to bill third party payers, such as Medicaid, Medicare and private insurance companies, to assist with the sustainability and expansion HIV screening services.

Opportunities to integrate HIV screening services into other screening programs that are provided by the community health centers funded by this grant (such as blood pressure, diabetes and cholesterol screenings), would be discussed with staff to determine how such efforts could be implemented. DPH's Diabetes Program currently works with several community health centers around education and awareness of diabetes. The DPH Heart Disease and Stroke Prevention Program also funds one community health center, in New Haven, for education and awareness of stroke prevention. Due to limited funds, this program provides some blood pressure and cholesterol screenings to their patients. The relationships DPH already has with these

facilities would serve to enhance the possibilities of dialogue around the integration of HIV screening services.

STD data that is accessible through the STD*MIS system used by the STD Control Program gives us information regarding the co-morbidity of HIV and STDs, particularly syphilis and gonorrhea. Past studies conducted in our HIV Counseling, Testing, and Referral sites and in DMHAS drug treatment centers has also demonstrated that the rate of HCV in intravenous drug users being tested for HIV was higher than the HIV seropositivity in those sites. These factors are indicators that ensuring that all HIV positive patients identified through the project are screened for STDs, HCV, and TB is critical.

The DPH Health Program Associate, funded by this grant, will be responsible for working with providers to develop strategies for the promotion of routine HIV screenings within their respective organizations. Information on third party reimbursements will also be posted on the DPH website, along with links for other resources. Information from sites currently providing routine HIV screenings will also be listed on the website as a resource for other agencies interested in such screenings. The DPH will work with the New England AIDS Education and Training Center (NEAETC) to incorporate information on routine HIV screening into the medical education that physicians are required to have. Section 20-10b of the CT General Statutes states that a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four month period. Continuing medical education includes at least one contact hour of training or education on topics including acquired immune deficiency syndrome and human immunodeficiency virus.

2. Program Support – Category 1

a. Management and Planning

Job Title	Responsibilities
Health Program Associate Health Program Assistant 2 (Year 1)	Oversee implementation of routine testing at all clinical sites. Provide technical assistance; determine training needs and coordinate training events; and monitor contract compliance. Research health insurance reimbursement issues.
STD Coordinator and Epidemiologist II	Oversee integration of STD screenings into routine testing activities. Provide technical assistance, determine training needs, and coordinate training on screening for STDs and TB (if necessary). Serve as DIS.
Partner Notification Services Coordinator	Ensure that referrals for partner services are made to DIS staff by all sites.
DPH HIV Test Data Team	HIV Test Form data entry, management, analysis, and submission to CDC. Provide and document training on data management, confidentiality, and security.
DPH HIV/AIDS Surveillance Unit	Monitor the number of newly-diagnosed HIV positives.
DPH Hepatitis Coordinator	Oversee integration of hepatitis screenings into routine testing activities. Provide technical assistance, determine training needs, and coordinate training on hepatitis screening (if necessary).
DPH Virology Lab	Process HIV and Hep C samples. Send results to the testing sites. Provide confirmatory test results to designated DPH infectious disease epidemiologists.

b. Training

Health Department Staff

The Health Program Associate, funded under this grant, will attend educational opportunities related to this grant, including insurance reimbursement for HIV testing. This person will also attend other on-site trainings as required.

DPH will work with the NEAETC to provide trainings for providers on opt-out testing. DPH will also work with representatives from the OraSure and Alere companies (OraSure, OraQuick and Clearview) to provide trainings for participating clinical sites.

The Health Program Associate, funded under this grant, will be responsible for tracking the provision of training of staff at the participating clinical agencies (4-6 community health centers). This person would keep track of trainings via quarterly reports submitted to DPH, site visits with the participating agencies and correspondence with the rapid test companies.

Staff at Participating Agencies

The Health Program Associate assigned to this project, in collaboration with the HIV Test Data Coordinator, will identify the training curriculum for staff at contract agencies. Based on our current experience with expanded and integrated HIV testing, the trainings that will most positively influence implementation of routine HIV testing are, in order of priority:

- Referring clients to the DIS.
- Data collection, management, confidentiality, and security.
- Implementing opt-out HIV testing in the clinical setting:
 - Revising general consent forms.
 - Using appropriate language.
 - Streamlining data collection.

- Analyzing patient flow to determine optimal strategies for integrating HIV screening into clinic operations.
- Insurance reimbursement issues.
- Developing written policies, protocols, and procedures for all steps in the routine HIV testing process.
- Cultural and linguistic competency.
- Developing educational and promotional materials that target staff and clients.
- Using data to monitor and guide services.

An existing online training database, CT TRAIN, will be used to advertise trainings, record registration, and administer course evaluation surveys. Persons attending training sessions will receive certificates of attendance.

c. Technical Assistance

The Health Program Associate will be responsible for overseeing the clinical sites. This person would determine the technical assistance needs of the sites through monitoring efforts such as site visits and then coordinate trainings, as needed with DPH staff. DPH would also coordinate trainings, as necessary, with NEAETC, the CDC (submission of TA request through CRIS) or the Sylvie Ratelle STD/HIV Prevention Training Center in Massachusetts.

All of the participating sites would be encouraged to use United Way of Connecticut's 2-1-1 system as a source of referrals for patients and information in general. 2-1-1 is an integrated telephone system, which provides information about community services, referrals to human services and crisis intervention to anyone who calls in the state. It is a toll-free number that can be accessed from anywhere in Connecticut, 24 hours a day, 365 days a year. Many of the participating sites currently use 2-1-1 as a referral source. In 2007, DPH worked with 2-1-1 to

develop an HIV Care and Prevention Guide that provides a listing of HIV-related providers/services throughout the state. This list of providers/services is updated on a regular basis. The guide also provides links to services that are non-HIV related. Many of the participating sites receive prevention (for CTR) and Ryan White Part A and B funding. This co-location of services allows for an easy referral process from prevention to care.

Connecticut's HIV prevention planning body was fully integrated with care in the fall of 2007. The DPH now convenes a Connecticut HIV Planning Consortium (CHPC) with a primary mission to conduct statewide planning and to facilitate information sharing across local, regional and statewide programs involved in HIV/AIDS care and prevention service delivery. The combined prevention and Ryan White Parts A and B groups will also continue to serve as a referral network base for participating agencies.

Technical assistance for DPH staff will be tracked and documented via progress reports for the grant and the organizations providing the assistance, such as the CDC CRIS system. The Health Program Associate, funded under this grant, would also document technical assistance provided to participating sites via site visit reports, feedback from HIV counseling and testing chart audits. Periodic site visits to follow-up on the implementation of suggestions and feedback by the Health Program Associate will be conducted to track the technical assistance provided and overall program improvement.

D. Staffing

A Health Program Associate will be hired under Part A of this grant. This person will spend 100% of their time on this program and be the Project Coordinator. This Health Program Associate will manage the daily project activities, having responsibility for the oversight of the clinical sites, quality assurance, and monitoring the progress of the project. The Project

Coordinator will develop and conduct a Request for Proposal process that results in contracts being established with community health centers. She will oversee and provide technical assistance to these contractors. The Health Program Associate will identify and work to address barriers to the implementation of opt-out testing such as reimbursement issues, lack of buy-in, and lack of training. She will oversee the development of a website and other resources for health care providers that enhances their ability to conduct routine HIV screening in their practices.

Two full-time Epidemiologist II positions will be hired under Part A of this grant. These persons will spend 100% of their time on this program. They will be assigned to the DPH STD Control Program. They will be assigned to several of the clinical sites to provide assistance with follow-up on positive patients. This includes partner notification services as well as referrals to medical care, STD, TB and HCV screening and social support. This assignment is extremely labor intensive and requires a large amount of staff time when working with the newly-diagnosed HIV patients. These staff will also continue to work with HIV clients who do not continue in care for HIV. As required, partner notification services will be offered on those who continue to practice high risk behaviors.

A Health Program Assistant 2 will be hired (as a durational employee) under Part A of this grant. This person will spend 50% of their time on this program. This one year durational position will assist the Project Coordinator with responsibilities such as researching insurance reimbursement and working with sites individually to provide technical assistance to the clinical sites around full implementation of opt-out testing and developing plans for sustainability of routine HIV screening beyond the end of the funding cycle. This person will also assist with the development of resources for health care providers around the area of routine HIV screening and

on maintaining the website that is developed for this purpose. In addition, this position will assist with the Request for Proposal Process that will be conducted during the first year of the grant and with the development of contracts with the selected Community Health Centers. At the end of the first year of the grant this position will be eliminated and the money will be used to help fund the selected Community Health Centers.

Other staff, not funded under this grant, will include the HIV Test Data Coordinator (Epidemiologist III) who will oversee the Data Unit and a Data Entry Operator II who will assist with data entry and file management.

e. Quality Assurance (QA)

The DPH HIV Prevention Unit has already developed and implemented a QA policy and related procedures for programs funded on the cooperative agreement. This policy will be applied to the proposed program. Existing assurance procedures and site assessment tools will be modified. The Project Coordinator has principal responsibility for QA. She will work closely with staff at the participating sites and the STD Control program to ensure that the referral and linkage mechanisms for HIV + and high-risk clients/patients are maintained.

The Project Coordinator will maintain a roster of workers at participating sites and ensure that all persons providing HIV tests at contracted sites have received training on how to administer the HIV tests. Cultural and linguistic competency will be emphasized to ensure that providers appropriately and effectively interact with target populations. The DPH provides Core & Continuing Education (CE) trainings which integrate cultural competency theory and principles. In addition, DPH requires that materials disseminated to clients by programs be reviewed and approved by the DPH Review Committee.

HIV has been staff and physician reportable to DPH since 2002. Program staff and medical providers are required to complete the *Adult HIV/AIDS Case Report Form* for all HIV positive clients/patients. Reportable disease information is used only for public health purposes and the information collected is kept confidential in accordance with Connecticut Public Health Act No.93-291

The HIV Prevention Services Unit's QA system has a mechanism in place to ensure that HIV-infected persons learn of their test results whether they are tested traditionally or by the waived rapid test method. Trained staff (e.g., medical providers) will give results and make referrals to DIS to ensure the linkages to care and other support services.

Information on the outcome of positive HIV tests will be required documentation in client/patient records and will be reviewed on quarterly basis by the Health Program Associate. Using reports on HIV Test Form data that will be provided by the HIV Test Data Team, the Health Program Associate will follow-up with sites that have higher than expected instances of not providing test results.

To ensure that rapid testing (including storage and use of kits and supplies) is carried out in accordance with manufacturers' instructions, the DPH provides, and makes available through the manufacturer representative, training and technical assistance on proper rapid testing procedures. As part QA site visits, DPH staff will observe staff and review rapid test documentation (e.g., testing records, temperature logs, corrective action plans).

The DPH Laboratory processes confirmatory HIV tests. The DPH Laboratory has a QA policy to ensure that appropriate laboratory standards and practices are in place. DPH Virology Lab staff provide education to HIV counselors and healthcare providers on specimen submission and ordering the OraSure oral specimen collection device.

DPH will provide programs with a revised QA policy and procedures that will address opt-out routine testing activities. Programmatic QA will include: staff qualifications; training; supervision; testing procedures (including storage, shelf life, specimen collection, test performance, interpretation of results, and confirmatory testing); documentation (record/chart keeping, filling out HIV Test Forms); and client satisfaction.

F. Data Collection and Reporting

Per the Connecticut Public Health Code, Sections 19a-36-A2 and 19a-36-A3, HIV infection and AIDS are reportable conditions and reportable laboratory findings. Health care providers are mandated to report cases to the DPH HIV Surveillance Unit using the *HIV Adult HIV/AIDS Case Report*. Laboratories are required to report positive antibody or viral load tests to the DPH using the *Laboratory Report of Significant Findings*. Sites that will participate in the ETI are already familiar with these requirements and will be reminded that they are required to comply with them.

The DPH HIV Prevention Unit has established a protocol, in conjunction with the HIV/AIDS Surveillance Unit, to have the Electronic HIV/AIDS Reporting System (EHARS) checked for case reports that correspond with reports of positive tests on HIV Test Forms. In effect since May 2010, the protocol has enabled us to distinguish newly identified positives from previously positive cases. The protocol was needed to work within the existing framework of the *Technical Guidance for HIV/AIDS Surveillance Programs, Volume III: Security and Confidentiality Guidelines*.

HIV Test Forms will be submitted to DPH on a monthly basis. The codes on these forms will be generated by the Program Evaluation and Monitoring System (PEMS). All agencies will be given a *quick sheet* that summarizes the codes specific to their agency and testing venues.

Currently, Connecticut uses a secure, web-based system (X-PEMS) as part of CDC pilot project to examine use of an alternative to scanning HIV Test Forms. The X-PEMS is secure, user-friendly, does not require a digital certificate, and makes testing performance data instantly available for query. The data are transmitted quarterly to CDC by the X-PEMS service provider. We have had great success using X-PEMS. Specifically, we have been able to eliminate the ETI data entry backlog, increase data accuracy and timeliness, meet quarterly data submission guidelines, provide feedback to participating agencies on their performance, and reduce the workload of the supervising epidemiologist (who is also responsible for the management of the HIV testing data for the cooperative agreement and administration of PEMS). If we are able to continue using X-PEMS exclusively for the management of ETI data, by the second year of funding, the participating agencies would be trained on how to use X-PEMS to analyze and perhaps enter their own HIV Test Form data. In the absence of X-PEMS, the HIV Test Forms will be scanned using Read Soft, transformed using the CDC Data Tool, encrypted using SEAL, and uploaded to PEMS by DPH staff.

Only persons with HIV positive test results will be screened for syphilis, gonorrhea, chlamydial infection, hepatitis B, hepatitis C, and TB. Participating sites will receive information on reporting requirements and referral to the DIS for positive clients. The DIS (and HPA2s if funding for enhanced linkage is awarded) will track these services. Data will be submitted to the CDC using either STD*MIS or another CDC-approved system determined by the STD Control Program.

HIV Test Forms submitted to the DPH will be reviewed for accuracy and completeness. Forms missing required variables (e.g., year of birth, gender) will be returned for correction to

the worker who performed the test at the testing site on record. Positive reports will be verified by the HIV Surveillance Unit before addition to the project's electronic database.

A guidance document delineating the minimum requirements for the confidentiality and security of client-level data will be provided to all contractors. A signed statement of acknowledging receipt and comprehension of these requirements will be required of all persons who will be providing and recording tests, and any staff members who will be working with electronic client-level data. Moreover, as part of their applications for funding, the contract agencies will submit a summary of their existing data security and confidentiality guidelines.

Because the HIV Test Form will be used to record HIV testing activities, only 12 of the 21 indicators of HIV Prevention Program Performance listed in the *HIV Prevention Strategic Plan: Extended Through 2010* can be reliably informed by the ETI data. These are listed in Table 1, alongside the corresponding variables on the HIV Test Form.

In February 2009, the Connecticut HIV Test Form Quality Assurance Strategy was implemented. A key part of this strategy is attention to the coding of HIV Test Forms. All contractors will be provided with lists of the codes that they should use to fill in the HIV Test Forms and agency-specific sample forms. HIV Test Data Team members will sort completed forms by site and session date, count them, and review them for completeness. Systematic coding errors and patterns of missing data will be noted. Agencies will be contacted by telephone or e-mail and encouraged to improve accuracy and/or timeliness of reporting. HIV Test Forms that are missing required variables will be mailed back to contractors for correction. HIV positive test results will immediately reviewed and forwarded for confirmation to the HIV Surveillance Unit. Once forms are cleared for data entry, a *fix sheet* containing all of the correct PEMS codes will be affixed to the form stack and given to data entry staff. Data entry personnel

will either enter form data into X-PEMS or scan forms using Read Soft. These forms will be filed by site ID number in a dedicated cabinet in a secure area. Work is underway to update current QA practices to align with the *2009 Standards for Quality Assurance for HIV Counseling, Testing, and Referral Data*. A summary of these standards will be distributed to participating sites.

All staff handling HIV Test Form data will receive in-person training on data entry and written materials on the guidelines for handling, storage, analysis, utilization, dissemination, confidentiality, and security of HIV Test Form data and related client-level data. The data confidentiality and security guidelines will be in accordance with the *PEMS Security Summary* and the *PEMS Rules of Behavior*.

Table 1. Program Performance Indicators and Corresponding HIV Test Form Sections and Variable Numbers

Performance Indicator	HIV Test Form Sections	Form Variable Numbers
3. Decrease the annual HIV incidence.	HIV Test Information Referrals Incidence	32, 37, 46, 51, 60, and 65 90 – 95 127 – 147
3a. Decrease the number of new HIV cases among MSM.	Client HIV Test Information Risk Factors Referrals	17 – 25 32, 37, 46, 51, 60, and 65 72 – 86 90 – 95
3b. Decrease the annual HIV incidence among non-Hispanic African Americans.	Client HIV Test Information Referrals Incidence	17 – 24 32, 37, 46, 51, 60, and 65 90 – 95 127 – 147
3c. Decrease the annual HIV incidence among Hispanics.		
4. Reduce the Black or African American: White rate ratio of HIV/AIDS diagnoses.		
5. Reduce the Hispanic or Latino: non-Hispanic White rate ratio of HIV/AIDS diagnoses.		
10. Increase the proportion of HIV-infected people in the United States who know they are infected.	Client HIV Test Information Referrals Incidence	11 – 29 32, 37, 46, 51, 60, and 65 90 – 95 127 – 147
11. Increase the proportion of persons with HIV-positive test results from publicly funded counseling and testing sites who receive their test results.	Agency HIV Test Information Referrals	5 – 9 32, 37, 46, 51, 60, and 65 90 – 95
13. Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to PCRS.		
14. Increase the percentage of HIV-infected persons in publicly funded counseling and testing sites who were referred to HIV prevention services.		
16. Increase the percentage of HIV-infected persons in medical care who initiated medical care within three months of diagnosis.		
12. Increase the proportion of people with HIV diagnosed before progression to AIDS.	HIV Test Information HIV Incidence	32, 37, 46, 51, 60, and 65 127 – 147

G. Monitoring and Evaluation

Staff supported under this application will work with CDC to develop and implement a monitoring and evaluation plan, with cross-site and outcome measures for all activities. This plan will also include the collection of cost data.

A comprehensive monitoring and evaluation plan will be developed by the end of Year One. The first year of funding will be spent piloting a site assessment tool, (which we began developing in Year Three of the current ETI), developing and streamlining data analysis protocols so that the data required to inform measures can be regularly extracted from the project database, and working with sites to identify additional performance indicators.

Based on the program proposed in this application, the goal of monitoring activities will be to ensure compliance with requirements contracts or memoranda of understanding. The Project Coordinator will conduct quarterly site visits to assure that: 1) opt-out HIV testing is being implemented; 2) HIV testing (rapid or conventional) is being performed correctly; 3) HIV test materials are properly maintained (e.g., quality control, storage); 4) HIV Test Forms are being completed and submitted regularly to DPH; and 5) HIV positive clients are receiving appropriate referrals and linkages to care in a timely manner.

The HIV Test Data Coordinator will analyze HIV Test Form data each quarter to determine for each site the numbers of: 1) clients tested; 2) clients who test negative; and 3) clients who test positive. The Epidemiologist IIs will analyze data each quarter to determine for each site the number of HIV positive clients who are: 1) linked to care; 2) receive partner notification services; 3) receive screening for STDs, HCV, and TB; and 4) the length of time from diagnosis to referrals.

Participating agencies will receive quarterly reports from the HIV Test Data Coordinator that summarize their progress toward their annual routine HIV testing goals, the demographic breakdown of the clients they have tested, and the most productive testing sites. The Project Coordinator will discuss these findings with agency-based testing coordinators to determine how program performance can be improved (e.g., which sites should be dropped).

Part B – Enhanced Linkage to Medical Care and Partner Services

1. Program Services

B. Program Objectives

Goals for newly diagnosed HIV-infected persons

Goal 1: By 09/30/13, 85% will attend an initial medical evaluation within 90 days of diagnosis.

Year 1 Objective: By 09/30/11, 60% will attend an initial medical evaluation within 90 days of diagnosis.

Methods: During Year 1, staff will be hired to assure that appropriate sites are in place throughout the state to provide medical evaluation to HIV-infected persons. These staff will assure that appropriate and timely referral mechanisms are in place and ongoing communication will be implemented to confirm the appropriate care of these HIV-infected individuals.

Year 2 Objective: By 09/30/12, a specific percentage, based on Year 1 outcomes, will attend an initial medical evaluation within 90 days of diagnosis.

Goal 2: By 09/30/13, 85% will have partner services initiated within 30 days of diagnosis.

Year 1 Objective: By 09/30/11, 60% will have partner services initiated within 30 days of diagnosis.

Methods: In Year 1, staff will be hired to establish relationships with the clinical HIV routine screening sites to assure appropriate and timely referrals for partner services of all newly diagnosed HIV-infected persons. Relationships will also be established with Disease Intervention Specialists (DIS) within the STD Control Program (STDCP). Referrals from the clinical site to the DIS will be processed by the newly-hired staff to assure completion of partner service activities in a timely manner.

Year 2 Objective: By 09/30/12, 75% will have partner services initiated within 30 days of diagnosis.

Methods: Year 2 will focus on increasing the frequency of partner service referrals made to DIS.

Goal 3: By 09/30/13, 85% of those linked to care will receive appropriate STD, hepatitis and TB screening services during their initial medical visit.

Year 1 Objective: By 09/30/11, 60% of those linked to care will receive appropriate STD, hepatitis and TB screening services during their initial medical visit.

Methods: During Year 1 of this project, staff will be hired to assure that HIV-infected persons receive appropriate STD, hepatitis and TB screening services at the initial medical visit. This will be accomplished either through the HIV care provider or with the assistance of the DIS. The staff hired through this grant will manage appropriate documentation of the outcomes of these additional screening services.

Year 2 Objective: By 09/30/12, 75% of those linked to care will receive appropriate STD, hepatitis and TB screening services during their initial medical visit.

Methods: Year 2 efforts will be centered on assuring that more screening services occur.

Goal 4: By 09/30/13, 70% of those linked to care are still in care three months after their first medical appointment.

Year 1 Objective: By 09/30/11, 50% of newly diagnosed HIV-infected persons those linked to care are still in care three months after their first medical appointment.

Methods: In Year 1 of this project, newly-hired staff will establish a secure, computerized system for follow up on HIV-infected persons in care. Relationships and ongoing communication will be established with care providers to assist with the data needs and determine if these individuals continue care three months after the first medical visit. DIS may be assigned to follow up with

the HIV-infected persons to assure they remain in care. The AIDS Surveillance database will also be a resource to determine if patients go to other providers and receive care (e.g., viral load monitoring). Currently, the percentage of persons that are still in care three months after the initial medical appointment is unknown. Therefore, these percentages may require adjustments after Year 1.

C. Program Plan

Enhanced Linkage

Enhanced linkages, as included in this application, are a key component of program collaboration and service integration (PCSI). This initiative maximizes the health benefits for HIV-positive patients through prevention services by increasing service efficiency, capitalizing on opportunities to screen, test, treat or vaccinate those in need of these services. HIV-positive individuals are often affected by multiple diseases, which can be addressed through service integration. Also, addressing these co-infections through shared data can assist in improving program operations of the participating agencies. The risk for acquiring infection, clinical course and health outcomes of STDs, TB, and hepatitis B and C are greatly influenced by co-infection with HIV and should be addressed strategically in a comprehensive fashion.

The proposed Enhanced Linkages builds upon the services that will be provided by the DPH Disease Intervention Specialist in Part A of this grant application. For Part A, follow-up of HIV patients is assured through the assignment of DIS to the clinical sites. We propose in Part B to have concrete measures used in tracking clients. The Part B funding will allow us to allocate additional resources to ensure that newly diagnosed HIV-positive clients get into medical care within an appropriate time frame and that they remain in care beyond their first medical appointment. The proposed Enhanced Linkages will also facilitate stronger communication

between the referring DIS and the Infectious Disease and Support Service providers. The staff of the Enhanced Linkages Project will also play a vital role in educating providers about appropriate screening and medical follow-up of HIV-positive patients. There will also be more education of providers in the area of Partner Services.

As described in more detail of Part A of this application, Community Health Centers and STD clinics will be recruited for this enhanced linkage project through several criteria. Community Health Centers that provide services to primarily Black or African Americans and/or Hispanics or Latinos will be identified. Requests for Proposals (RFPs) will be announced to those particular sites, allowing them to submit proposals to participate in this project. Based on the population targeted for this project, the RFPs will be reviewed and evaluated, selecting those sites that meet the criteria and provisions for this project. Contracts between the Department of Public Health and the participating sites will then be implemented with clear instructions provided on the requirements of this initiative.

Several HIV medical care providers have been identified through the first cycle of this grant. Others may be determined through the RFP process. All participating providers will receive a thorough explanation of their role in routine screening and care of HIV-infected persons, including assurance of completing and submitting all required data elements, providing additional screening services and maintaining care for those who are HIV-infected.

With the funding requested in this application, two Health Program Assistant II (HPA2) staff will be hired to assure linkage to medical care and partner services. Each will be assigned to specific areas of the state where the participating healthcare facilities, CBOs, service organizations and HIV medical care providers are located. Once the HPA2s have been trained, they will meet with all key staff at their assigned sites to introduce themselves, describe their

roles as liaisons for the sites and work with staff from the selected sites to develop and implement detailed plans for enhanced linkage services and data collection and reporting. The requirements for these services will have already been described through the RFP and contractual process. The HPA2s will work with staff to determine protocols and procedures to actively link and assure that all newly diagnosed HIV-infected persons and those previously diagnosed but not in care, are appropriately managed, with direct oversight of this process facilitated by the HPA2s. The HPA2s, under direction of the HIV Prevention Unit Data Coordinator, will also assure that HIV test data collection is timely and accurate and provided to the HIV Prevention Unit for data analysis.

Once a patient seen at one of the participating organizations is identified as newly diagnosed HIV-infected or previously diagnosed but not in care, the appropriate HPA2 will be contacted to initiate a referral for follow up of the necessary linkages. If the referral is for a newly diagnosed HIV-infected person, the HPA2 will work with staff from the referral site to determine if the particular site can complete all the linkage services, including screening, treatment, and prevention and vaccination services for syphilis, gonorrhea, chlamydia, HPV (if age appropriate and female), hepatitis A, hepatitis B, hepatitis C and TB. If the referral site cannot provide any or all of these services, the HPA2 will immediately assign the person to a DIS for follow up. All cases will automatically be referred to DIS for partner notification services (PNS). Once all linkages have been completed, regardless of the site where these services were provided, the HPA2 will determine the outcomes and results of tests and document these outcomes in a secure and confidential database.

Anyone found to be a previously diagnosed HIV-infected person who is not in care will be referred to the HPA2. The history of care the person has received will be reviewed from the

AIDS Surveillance database. The HPA2 will either work with the facility that made the referral if care services are available through the site, or the referral will be assigned to a DIS for follow up. The DIS will then attempt to get this individual back into care. Outcomes of these referrals will be determined by the HPA2 and all required data elements will be documented in a database managed by this staff person.

In a similar fashion, the HPA2 will establish an ongoing relationship with HIV medical care providers, educating them on the services provided through this initiative. Any of their HIV-infected patients who are lost to follow-up within three months after their first medical appointment should be referred to the HPA2 liaison. The HPA2 will assign the patient to a DIS to locate the individual and facilitate their re-entry into care. The status of care for these individuals can also be monitored through the AIDS Surveillance database (EHARS). The outcome of this referral will be managed by the HPA2, communicated to the care provider and documented in the database managed by the HPA2.

Materials describing PNS are currently available and distributed to providers throughout the state. During initial meetings between the HPA2 and participating healthcare facilities and HIV medical care providers, these materials will be shared and discussed in detail to assure a clear understanding of the need for partner services. Educational presentations may also occur for larger groups in order to facilitate this process. Included in the contractual language will be a provision to assure timely and immediate referral of newly diagnosed HIV-infected people and those that have been lost to care, in accordance with CDC recommendations. Staff will have a clear understanding that these individuals will be referred to a DIS for appropriate follow up.

Those providing ongoing care to HIV-infected patients will also be trained on the need to maintain prevention and risk reduction counseling to determine if additional screening

services or PNS should be offered. Anyone found in need of these services will be referred to the designated HPA2 and follow up will be provided by a DIS.

Partner services referrals need to be initiated in a timely manner, regardless if it is for a newly-diagnosed person or one who has been previously diagnosed as positive, but is not in care. The HPA2 will maintain an ongoing relationship with all participating sites to determine results of all who are routinely tested and that those who are receiving care remain active in keeping scheduled appointments. The HPA2 will maintain a computerized “tickler” system to serve as a reminder to contact the care provider and assure that scheduled appointments took place. Anyone newly diagnosed for HIV will automatically be referred by the HPA2 to a DIS for partner services, and those who do not maintain their medical care services will also be initiated to a DIS. When the DIS works with an individual who is not in care, a discussion concerning partners will always occur to determine if there is a need for additional partner services. The history of care will also be shared with the DIS to facilitate the discussion concerning the need for continued medical care services. The database maintained by the HPA2 will also provide the data needed to determine the length of time between the date of diagnosis, date of initiation to a DIS, and the date from notification of lost to care to initiation to a DIS. This will assure that all partner services activities are initiated in a timely manner.

The HPA2 will be responsible for the follow up and closure of all cases assigned to DIS and for the ongoing care of HIV-infected individuals. One aspect of ongoing care is to review records to assure documentation of appropriate HIV/STD prevention counseling and other HIV/STD prevention services, as needed, in accordance with CDC guidelines and recommendations. Cases will routinely be discussed with the appropriate care provider to assure these procedures are adhered to. The care provider will maintain a check off list of topics that

must be reviewed with the patient every three months. This list will be reviewed by the HPA2 to assure all counseling and interventions are documented. This process will also be outlined in the contract language with each site providing ongoing care to HIV-infected patients.

The HPA2 will be responsible for assuring that HIV-infected persons will receive linkage services, including screening, treatment, and prevention and vaccination services for syphilis, gonorrhea, chlamydia, HPV (if age appropriate and female), hepatitis A, hepatitis B, hepatitis C and TB at the initial evaluation according to CDC recommendations. Test results will be reviewed and documented in the confidential database managed by the HPA2. These results will be obtained either from the care provider who completed these linkage services or through the DIS if a referral was made from the HPA2 for the DIS to work with the HIV-infected person to assure the linkage services took place. At times, these linkage services may take place at an STD clinic and care for HIV may occur at another provider site. The DIS will be responsible for the linkage services, referral to the care provider and PNS services. All outcomes will be reported to the HPA2.

One element of the check off list that will be maintained in the HIV-infected patient's case record involves routine follow-up visits every three months, in accordance with CDC recommendations. At each visit, the provider will complete a risk assessment to determine the need for screening for other STDs, ongoing high risk behaviors and if the patient has new partners. The provider will share this check off list with HPA2. Through a discussion, if it is determined that a referral should be made to the HPA2 for additional follow up, the HPA2 will assign the patient to a DIS or case manager, specifying the reasons for intervention, in accordance with CDC recommendations. Again, the HPA2 will be responsible for the outcome of the referral with the DIS or case manager and communicate this with the provider. If the

patient needs screening for other STDs and is found infected, the DIS will complete PNS activities with this patient to locate and treat exposed sexual partners. This is also the process that would occur if the patient admits exposure to HIV with new sexual partners. If a patient is referred to a prevention counselor or Comprehensive Risk Counseling Services provider because of reported high risk behaviors, the outcome of the risk reduction counseling session will be reviewed with the HPA2 and shared with the care provider. This will be an ongoing process as long as the patient remains in care.

The HPA2 will collect and maintain all data reported on screening and testing conducted for syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C and TB in HIV-infected persons linked to care. This will be ongoing and completed through regular communication with the DIS and care provider to assure, based on DIS referrals and chart reviews at care providers, the tests were conducted and results documented. These results, including the date of referral and date the tests were completed, with results, treatment dates and medication provided (if necessary) will be documented, analyzed and reported regularly by the appropriate HPA2.

Staff supported under this application will work with CDC and other grantees to develop and implement a monitoring and evaluation plan, with cross-site and outcome measures for all activities. This plan will also include the collection of cost data.

2. Program Support

B. Training and Technical Assistance

The HPA2s supported by this grant application will be trained collaboratively through the STD and TB Control Programs, Hepatitis Program and AIDS Division. Training will include Excel and other Microsoft Office applications, as well as learning the STD*MIS database and AIDS database to record, search, and determine histories of individuals screened through this

project. They will also receive training from the HIV Test Data Coordinator on the HIV Test Form, data confidentiality and security, and data quality assurance. The HPA2 will work closely with the DIS staff to learn how they establish rapport and manage client and provider interactions in the field setting. The DIS can also assist with an overview of how to complete linkages to medical care and other prevention services, access to STD, TB and hepatitis screening, vaccinations and treatment services for anyone who tests positive. Some of the pertinent modules provided by CDC for a new DIS will also be reviewed during this training process. Organization skills will be a key component of this training to assure appropriate documentation and completion on all assigned work. Confidentiality and cultural competency training will also be provided by staff from the AIDS and Chronic Diseases Section. Depending on areas where more skill building may need to take place, additional training activities will be provided. They will learn to incorporate HIV prevention into the ongoing medical care of HIV-infected persons.

Once these skills are acquired, this staff will be able to train others in these areas, particularly staff working at the clinical sites where routine HIV screening is being conducted and at the medical care sites. Once the participating clinical sites have been established with contracts in place, the HPA2 will review the policies and procedures for this project, specifically the need for ongoing prevention in care, assessments of risk and STD screenings. These skills will be periodically reviewed with staff through appropriate documentation of the checklist previously described and technical assistance will be provided by the HPA2 as determined through these ongoing reviews. As new staff are hired at assigned sites, the HPA2 will complete these training activities to assure a thorough understanding of this project, specifically the key components of ongoing prevention and assessment of screening and risk reduction counseling

needs. If enough staff require training or technical assistance, training programs for a larger audience could also take place. This staff will be expected to plan, manage and oversee all aspects of this program.

C. Staffing

The DPH will be staffed with two HPA2s through Part B of this funding application. The rest of the staff needs are addressed in Part A. Each HPA2 will be assigned to specific CHCs and STD clinics as well as collaborating HIV medical care providers that are participating in this project. They will work with staff from these sites to develop and implement detailed plans for enhanced linkage services. The HPA2s will also conduct initial training sessions as well as provide ongoing technical assistance to staff to assure all aspects of this project are completed, particularly relating to data requirements. Staff will also be educated on the need for ongoing partner services, assuring their support for these services, with oversight on referrals managed by the HPA2s. Ongoing feedback will be provided on the outcomes of these referrals.

The HPA2s will assure linkages to medical care for all HIV-infected persons identified through this project. At the initial evaluation, this staff will ensure screening, treatment, and prevention and vaccination services for syphilis, gonorrhea, chlamydia, HPV (if age appropriate and female), hepatitis A, hepatitis B, hepatitis C and TB occur, including documentation of all results. During routine follow up visits, the HPA2s will ensure HIV-infected patients are screened for STDs, risk behaviors and new partners with appropriate documentation maintained on these procedures. Throughout the entire process of screening and care for HIV-infected persons, partner service referrals will be ongoing through discussions between the care providers and HPA2, with referrals made by the HPA2 to the DIS. Partner services will be initiated on all persons who test positive for HIV, HIV-infected people who test positive for STDs on initial and

follow up screenings and HIV-infected persons who admit risk behaviors, especially involving new partners. Referrals will also be made to DIS on those who do not stay in care and PNS will be provided by the DIS if it determined that this high risk behavior is taking place with these individuals.

D. Quality Assurance (QA)

All QA activities will be coordinated by the HPA2s funded through this application. This staff will have complete oversight of this project. They will be responsible for:

- Training staff on collection of data and reporting requirements.
- Collecting and tracking data on HIV-infected persons who are linked to medical care and ensure that they receive all appropriate screening and prevention services for STDs, viral hepatitis, and linkages to other support service. This will include the completion of a check off list that is to be completed by the care provider every three months to determine possible ongoing high risk behaviors and needs for additional services.
- Monitoring the quality of reported data and coordinate with DIS or the medical providers to ensure the outcomes of these services are met via technical assistance.
- Assisting in the development of a revised QA protocol to include appropriate data elements and ensure that quality outcome indicators are documented in the medical record and reported to the DPH in a timely manner.
- Analyzing data and disseminate reports to all staff participating in this proposed project.

The HPA2 will work with the DIS to assure appropriate documentation on all services managed by the DIS. The outcomes, including referrals, test results, treatments and dates of services will be provided to the HPA2 assigned to the case. The HPA2 will maintain thorough

and complete documentation on all linkages and will work with the DIS and care staff to obtain the data related to the attempts and results of these linkages. All data will be entered into a confidential database and reports will be generated and analyzed by the HPA2s. Results of these reports will be provided to the DIS and care providers to share favorable outcomes and discuss areas where improvement could take place.

E. Data Collection and Reporting

As mentioned above, data collection, management and reporting of test-level data on screening and testing for syphilis, gonorrhea, chlamydia, viral hepatitis and TB among HIV-infected persons linked to care will be managed by the HPA2s hired under this application. Whenever a referral is initiated by the HPA2 to a DIS, a “due date” will be determined in order to assure the referral outcomes are obtained and shared with the HPA2. This will assure communication remains ongoing and outcomes will be obtained in a timely manner. Scheduled appointments with care providers will be reviewed and maintained in a tickler system by the HPA2. The HPA2 will then review the outcomes of these appointments and document all outcomes. This staff will work with the DIS and care providers on an ongoing basis to assure all necessary data is collected and documented in the medical record or on the forms utilized by the DIS. The HPA2s will work with these individuals to gather all necessary data and required information, enter this data into a confidential and secure database, and generate reports on outcomes of these efforts. Training will be provided by the HPA2 as needed to assure complete documentation and reporting takes place. Everyone involved in this project will communicate regularly on HIV-infected persons, as care will be ongoing and referrals for additional services, as described throughout this application, could occur at anytime.

II. Appendices

Appendix A: Summary Table of Program Objectives

**Appendix B: Memoranda of Understanding or Agreement with Healthcare
Facilities, Community-Based Organizations, or Other Service Organizations**

Appendix C: Budget and Budget Justification

Appendix D: Letter of Support from Community Planning Group

Appendix E. Other Attachments

Appendix A

84 Attachment 6. Suggested Format for Summary Table of Program Objectives

PROGRAM AREAS		OBJECTIVES		
		YEAR 1	YEAR 2	YEAR 3
Part A – HIV Screening and HIV Counseling, Testing, and Referral				
Number of HIV Tests	Category 1 (<i>Healthcare Settings</i>)	12,000	18,000	20,000
	Category 2 (<i>Non-Healthcare Settings</i>)			
	Total	12,000	18,000	20,000
Part B – Enhanced Linkage to Medical Care and Partner Services				
% of newly diagnosed HIV-infected persons	a. Who attend an initial medical evaluation within 90 days of diagnosis	60%	75%	85%
	b. For whom partner services are initiated within 30 days of diagnosis.	60%	75%	85%
	c. Linked to care who receive appropriate STD, hepatitis, and TB screening services, as recommended by CDC, during their initial medical visit	60%	75%	85%
	d. Linked to care who are still in care three months after their first medical appointment	50%	60%	70%

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May 25, 2010

Janis Spurlock, LCSW
HIV Prevention Unit Supervisor
CT Department of Public Health
410 Capitol Avenue MS#11APV
Hartford, CT 06134-0309

Dear Ms. Spurlock,

This letter is to confirm our intent to continue to collaborate with the Connecticut Department of Public Health (DPH) on the Expanded and Integrated HIV Testing Project funded through the Centers for Disease Control and Intervention. We are currently conducting HIV screening in our clinical program. We have been given access to free rapid test kits and laboratory services through DPH to increase our ability to provide HIV testing to all patients. Training and technical assistance on the use of the test and other quality assurance issues critical to the implementation of routine testing are also being provided through DPH. They have also assigned a Disease Intervention Specialist (DIS) from DPH to our site to make sure that patients identified as HIV positive receive screening for STDs, HCV, TB. The DIS also provide partner notification services and ensure that HIV positive patients are linked with Infectious Disease Providers and with Ryan White Medical Case Management and other support services.

We have been informed by DPH that should they receive funding for the Expanded and Integrated Testing Project through CDC Funding Opportunity PS10-10138 that we would be invited to continue our current collaboration through September 30, 2011. We have also been informed that DPH intends to conduct an RFP process for clinical sites to participate in this project from October 1, 2011 through September 30, 2013. At that time contracts will be developed between DPH and those clinical sites selected to participate in the remainder of the project.

We are committed to working with DPH towards a full implementation of Opt-out HIV screening in our organization. Thank-you for the opportunity to maximize the ability of our patients to receive HIV testing.

Sincerely,


Michael Sherman

Chief Executive Officer

Community Health Services, Inc.
500 Albany Avenue
Hartford, CT 06120
Tel: (860) 249-9625
Fax: (860) 808-1540





GENERATIONS
FAMILY HEALTH CENTER

May 26, 2010

Janis Spurlock, LCSW
HIV Prevention Unit Supervisor
CT Department of Public Health
410 Capitol Avenue MS#11APV
Hartford, CT 06134-0309

Dear Ms. Spurlock,

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We are committed to working with DPH towards a full implementation of Opt-out HIV screening in our organization. Thank-you for the opportunity to maximize the ability of our patients to receive HIV testing.

Sincerely,



Arvind Shaw
Chief Executive Officer



Cornell Scott
Hill Health
Corporation

May 26, 2010

Janis Spurlock, LCSW
HIV Prevention Unit Supervisor
CT Department of Public Health
410 Capitol Avenue MS#11APV
Hartford, CT 06134-0309

Dear Ms. Spurlock,

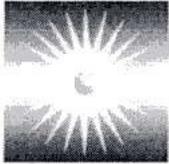
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We are committed to working with DPH towards a full implementation of Opt-out HIV screening in our organization. Thank-you for helping us to provide our patients HIV testing.

Sincerely,
CORNELL SCOTT HILL HEALTH CENTER

Thomas J. Kidder, LCSW
Director: HIV/AIDS/ID Division



OraSure Technologies

June 1, 2010

Janis Spurlock, HIV/AIDS Director
Connecticut Department of Health
410 Capitol Avenue
Hartford, CT 06134

Dear Ms Spurlock:

On behalf of our entire team at OraSure Technologies, I want to let you know that our level of commitment to your program is stronger than ever. Thank you for the excellent work to fight HIV in your community. Over the past several years, on behalf of public health programs nationally, OraSure has been a very strong advocate for increased funding for HIV prevention programs. This places us in a great position to further advocate for increased funding in 2010 and beyond.

We are extremely pleased funding has been identified to support expanded HIV testing and prevention efforts with a focus on disproportionately affected populations. OraSure Technologies supports your application for funding in response to CDC-PS10-10138, "Expanded Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations".

We value our relationship with you and have enjoyed the close partnership that we have cultivated over the years. Your OraSure team recognizes that each and every community is faced with different and often unique challenges. We continue to be committed to developing and supporting a comprehensive program that will be most effective for Connecticut through the provision of marketing support, program development and implementation assistance. Our account managers Andrew Thomits and Michael Profenno along with the rest of the team, have our full support as we work with you to effectively implement this new initiative.

We're very proud of the work and progress we have made together to stem the spread of HIV/AIDS in Connecticut. As always, please feel free to contact me at anytime, and thank you again for your commitment and public service in the fight against HIV/AIDS.

Sincerely,

Douglas A. Michels
President and Chief Executive Officer

cc: K. Zemlachenko
D. Thomits
M. Profenno

220 East First Street • Bethlehem, Pennsylvania 18015-1360
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BRIDGEPORT CT 06605
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(F) 203-382-2954

988 FAIRFIELD AVE
BRIDGEPORT CT 06605
(T) 203-330-6000
(F) 203-382-1436

1046 FAIRFIELD AVE
BRIDGEPORT CT 06605
(T) 203-330-6054
(F) 203-331-4716

743 SOUTH AVE
BRIDGEPORT CT 06604
(T) 203-330-6010
(F) 203-330-6013

May 26, 2010

Janis Spurlock, LCSW
HIV Prevention Unit Supervisor
CT Department of Public Health
410 Capitol Avenue MS#11APV
Hartford, CT 06134-0309

Dear Ms. Spurlock,

This letter is to confirm our intent to continue to collaborate with the Connecticut Department of Public Health (DPH) on the Expanded and Integrated HIV Testing Project funded through the Centers for Disease Control and Intervention. We are currently conducting HIV screening in our clinical program. We have been given access to free rapid test kits and laboratory services through DPH to increase our ability to provide HIV testing to all patients. Training and technical assistance on the use of the test and other quality assurance issues critical to the implementation of routine testing are also being provided through DPH. They have also assigned a Disease Intervention Specialist (DIS) from DPH to our site to make sure that patients identified as HIV positive receive screening for STDs, HCV, TB. The DIS also provides partner notification services and ensure that HIV positive patients are linked with Infectious Disease Providers and with Ryan White Medical Case Management and other support services.

We have been informed by DPH that should they receive funding for the Expanded and Integrated Testing Project through CDC Funding Opportunity PS10-10138 that we would be invited to continue our current collaboration through September 30, 2011. We have also been informed that DPH intends to conduct an RFP process for clinical sites to participate in this project from October 1, 2011 through September 30, 2013. At that time contracts will be developed between DPH and those clinical sites selected to participate in the remainder of the project.

We are committed to working with DPH towards a full implementation of Opt-out HIV screening in our organization. Thank-you for the opportunity to maximize the ability of our patients to receive HIV testing.

Sincerely,


Katherine S. Yacavone
President/CEO



BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Routine HIV Testing	93.940	\$ 0.00	\$ 0.00	\$ 1,071,785.00	\$ 0.00	\$ 1,071,785.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		\$ 0.00	\$ 0.00	\$ 1,071,785.00	\$ 0.00	\$ 1,071,785.00

SECTION B - BUDGET CATEGORIES

Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1)	(2)	(3)	(4)	
	Part A	Part B			
a. Personnel	\$ 232,657.00	\$ 101,246.00	\$	\$	\$ 333,903.00
b. Fringe Benefits	142,060.00	61,821.00			203,881.00
c. Travel	7,220.00	21,592.00			28,812.00
d. Equipment	0.00	0.00			0.00
e. Supplies	0.00	2,227.00			2,227.00
f. Contractual	141,161.00	0.00			141,161.00
g. Construction	0.00	0.00			0.00
h. Other	240,928.00	0.00			240,928.00
i. Total Direct Charges (sum of 6a-6h)	764,026.00	186,886.00	0.00	0.00	950,912.00
j. Indirect Charges	84,222.00	36,651.00			120,873.00
k. TOTALS (sum of 6i and 6j)	\$ 848,248.00	\$ 223,537.00	\$ 0.00	\$ 0.00	\$ 1,071,785.00
7. Program Income	\$	\$	\$	\$	\$ 0.00

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SECTION C - NON-FEDERAL RESOURCES						
(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS		
8. Routine HIV Testing Grant	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
9.						0.00
10.						0.00
11.						0.00
12. TOTAL (sum of lines 8-11)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
SECTION D - FORECASTED CASH NEEDS						
	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	
	\$	\$	\$	\$	\$	\$
13. Federal	0.00	0.00	0.00	0.00	0.00	0.00
14. Non-Federal	0.00					
15. TOTAL (sum of lines 13 and 14)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT						
(a) Grant Program	FUTURE FUNDING PERIODS (Years)					
	(b) First	(c) Second	(d) Third	(e) Fourth		
16. Routine HIV Testing Grant	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
17.						
18.						
19.						
20. TOTAL (sum of lines 16-19)	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
SECTION F - OTHER BUDGET INFORMATION						
21. Direct Charges:		22. Indirect Charges:				
23. Remarks:						

INSTRUCTIONS FOR THE SF-424A

Public reporting burden for this collection of information is estimated to average 180 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0044), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately shown for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A, B, C, and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Sections A, B, C, and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary Lines 1-4 Columns (a) and (b)

For applications pertaining to a *single* Federal grant program (Federal Domestic Assistance Catalog number) and *not requiring* a functional or activity breakdown, enter on Line 1 under Column (a) the Catalog program title and the Catalog number in Column (b).

For applications pertaining to a *single* program *requiring* budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the Catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the Catalog program title on each line in *Column* (a) and the respective Catalog number on each line in Column (b).

For applications pertaining to *multiple* programs where one or more programs *require* a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g)

For new applications, leave Column (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Columns (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase or decrease of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 - Show the totals for all columns used.

Section B Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Line 6a-i - Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount, Show under the program

INSTRUCTIONS FOR THE SF-424A (continued)

narrative statement the nature and source of income. The estimated amount of program income may be considered by the Federal grantor agency in determining the total amount of the grant.

Section C. Non-Federal Resources

Lines 8-11 Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 - Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f), Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object class cost categories that may appear to be out of the ordinary or to explain the details as required by the Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

**PART B
BUDGET ELABORATION AND JUSTIFICATION**

**ENHANCED LINKAGE TO MEDICAL CARE AND PARTNER SERVICES
SEPTEMBER 30, 2010 – SEPTEMBER 29, 2011**

FINANCIAL ASSISTANCE (FA)

I. PERSONNEL TOTAL \$101,246

<u>POSITION TITLE & NAME</u>	<u>ANNUAL SALARY</u>	<u>TIME</u>	<u>MONTHS</u>	<u>AMOUNT REQUESTED</u>
Health Program Assistant II To Be Hired	\$50,623	100%	12	\$50,623
Health Program Assistant II To Be Hired	\$50,623	100%	12	\$50,623

Justification:

Job Description: Health Program Assistant II-Two Positions To Be Hired

These two staff positions will be assigned to participating routine screening providers throughout the state. They will be responsible for overseeing HIV routine screening of clients seen in the designated sites, working with the designated data staff from these sites to assure the reporting of all test results and other required data elements to the Department of Public Health, AIDS Division. Any individual testing positive will be overseen by this staff to assure screening and follow up for other STDs, TB and hepatitis C, vaccination for hepatitis A&B and HPV (if applicable), PNS and providing care for HIV. These individuals will continue to monitor these HIV infected persons, reviewing the status of care every three months. Anyone who does not receive appropriate screening or maintain care for HIV will be referred to DIS by this staff. All data will be maintained and analyzed by this staff in collaboration with staff from the AIDS Division.

II. FRINGE BENEFITS TOTAL \$61,821

Fringe benefits are applicable to direct salaries and wages of all full time employees. The fringe benefit rate is 61.06%. (\$101,246 X 61.06% = \$61,821) The composition of this rate is as follows:

FICA	6.20%
Retirement (SERS)	37.19%
Medical	15.94%
Group Life	0.12%
Medicare	1.45%

Unemployment	0.16%
Fringe Benefit Rate (total).....	61.06%

III. SUPPLIES..... TOTAL \$2,227

Budget Detail:

General Office Supplies.....\$2,227

General Office Supplies (pens, pencils, paper, etc.)
(12 months x \$185.58/mth = \$2,227)

Justification:

Funding is requested to purchase a laptop and desktop computer for two staff to enter and analyze data collected through this initiative. Data can be collected on the laptops at sites as necessary to assure all data is accurately reported to the AIDS Division. Data will be entered into the appropriate confidential databases at the Department of Public Health on the office computers.

Funding is requested to purchase miscellaneous supplies in order to establish adequate work areas for this staff person at the three different sites where the person will be assigned.

IV. TRAVEL..... TOTAL \$21,592

In-State Travel:

Budget Detail:

Two vehicles x \$700each/month x 12 months = \$16,800

Note: (State vehicles that will be used and costs incurred would be fuel, maintenance costs, etc. as they pertain to DPH's guidelines regarding the use and upkeep of State vehicles)

Monthly rental of State vehicles is \$334 per vehicle. Estimated monthly fuel costs would \$200 per vehicle and maintenance costs are \$166 per month. Maintenance includes oil changes, tune ups, tires, etc.

Monthly Rental for (2) state vehicles x \$334 each=	\$668
Fuel for (2) state vehicles x \$200 each =	\$400
Maintenance for (2) state vehicles x \$166 each=	\$332
Total monthly cost for state vehicles=	<u>\$1400</u>
Total yearly cost for state vehicles, \$1400 x 12months=	\$16,800

Justification:

Funding for in-state travel utilizing a state vehicle is requested for the staff to travel to sites participating in this project throughout the state, working with personnel and clients to assure clients receive appropriate screening services, care and follow up as required. This staff will meet on a regular basis with the staff from the participating sites to assure all reports and data requirements are completed, assure appropriate follow up and ongoing care occurs on all newly diagnosed positives and work with the DIS as necessary for the follow up required for these clients.

Out-of-State Travel:

Budget Detail:

2 trips x 2 person x \$550 airfare	= \$2,200
2 trips x 2 persons x 3 days per diem x \$36/day	= \$ 432
2 trips x 2 persons x 3 nights lodging x \$130/night	= \$1,560
Registration-\$100 x 2 trips x 2 persons	= \$ 400
Ground transportation-\$50 x 2 trips x 2 persons	= \$ 200
TOTAL	\$4,792

Justification: Funds are requested to allow select program staff to attend the grantee orientation meeting and another CDC-sponsored conference such as the National HIV Prevention Conference, U.S. Conference on AIDS, etc. Attendance at these meetings is critical to the program to increase the knowledge and skill sets of the staff. These meetings also foster partnerships and linkages with other states and national programs. This is an effective method of increasing programmatic capacity and knowledge to meet goal and objectives.

TOTAL DIRECT COSTS	\$186,886
INDIRECT COSTS	\$ 36,651
\$101,246 x 36.2% = \$36,651	
Base: Direct salaries and wages.	
TOTAL AMOUNT REQUESTED	\$223,537

2011 Routine HIV Testing Initiative - **PART A** - BUDGET SPREADSHEET

[Name / Description]	[Job Title]	[FTE]	[Totals]
Dones-Mendez, Dulce	Health Program Associate	1.0	\$67,434
[vacant] -To be hired	Epidemiologist 2 (step 1)	1.0	\$54,472
[vacant] -To be hired	Epidemiologist 2 (step 11)	1.0	\$73,834
[vacant] -To be hired (for year 1 only)	Health Program Asst. 2 (step 11) durational	0.5	\$36,917
TOTAL Personnel Salaries:			\$232,657

Fringe (rate: 61.06%):

TOTAL Fringe:	\$142,060
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In-State

mileage reimbursement for staff to do site visits to Emergency rooms and in-state meetings

(496) miles for 5 sites x (2) visits per month x (4) months over a year x (1) staff x (\$0.50) reimbursement per mile= **\$1,984*****Out-of-State***

(4) staff to attend the National HIV Prevention Conference [or] the CDC Grantees Meeting of the Expanded HIV Testing for Disproportionally Affected Population Project

--The following allotments are an approximation of travel costs--

1 trip x 4 staff x \$550 airfare =	\$2,200
1 trip x 4 staff x \$120 (4 days) per diem=	\$480
1 trip x 4 staff x \$539 hotel expenses (4 days)=	\$2,156
Registration costs: 4 staff x \$100 each=	\$400
	\$5,236

TOTAL Travel:	\$7,220
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TOTAL Equipment:	\$0
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[Testing Supplies/Kits]State DPH antibody HCV Confirmed serology Testings: \$12,000Home Access Finger Stick Kits: \$7,602Orasure: 250 cases x \$237.60 (per case) = \$59,400Orasure freight charge= \$391Rapid Test Kits/Clearview Kits: \$114,856Oraquick Controls: \$4,634

Total E.R. Testing Supplies	\$198,883
------------------------------------	------------------

[Laboratory Supplies]**Laboratory Testing Kits, Reagents & Supplies****HIV Screening: 10,000 (5000 Serum + 5000 Orasure)**

HIV Serum Enzyme Immunoassay (EIA)	
10 test kits @ \$792.00 per kit	\$7,920
HIV Orasure Enzyme Immunoassay (EIA)	
15 test kits @ \$400.00 per kit	\$6,000
Total HIV Screening Supplies	\$13,920

Confirmatory Testing of EIA positives by Western Blot

Orasure: 145 tests. 10 kits @ \$515.00 / kit	\$5,150
Serum: 270 tests. 8 kits @ \$1080.00 / kit =	\$8,640
Total HIV Confirmatory Testing Supplies	\$13,790

Additional testing on all HIV positive serum specimens

Hepatitis C (HCV) antibody (EIA), 480 tests/kit, 1 kit	\$2,586
Hepatitis C Confirmation (Recombinant Immunoblot Assay), 2 kits	\$4,500
Hepatitis B antibody (EIA), 2 kits @ 400 /kit, 2 kits	\$800
Hepatitis B (HBV) EIA Antigen Screen, 480 tests/kit, 1 kit	\$600
Hepatitis B Antigen Confirmation (EIA), 8 kits @ 94.40 / kit	\$755
Syphilis Screening (VDRL Slide Test) Reagents	\$400
Syphilis Confirmation (TP-PA Test), 220 tests/kit, 2 kit	\$694
Total Additional testing on HIV positive serum specimens supplies	\$10,335

Laboratory Consumables (pipette tips, trays, reagents, gloves)	\$1,000
Specimen collection kits, shipping costs	\$3,000

Total Laboratory Costs **\$42,045**

TOTAL Other: **\$240,928**

TOTAL Supplies: **\$0**

Yale-New Haven Hospital (HIV Prevention Counselor)	\$48,422
- Fringe	\$14,527
- Indirect	\$9,442

Lawrence & Memorial Hospital (HIV Prevention Counselor)	\$47,840
- Fringe	\$11,960
- Indirect	\$8,970

TOTAL Contractual: **\$141,161**

Indirect (rate: 36.2%): - based on in-house salary amount of \$232,657	\$84,222
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TOTAL Indirect: **\$84,222**

SUMMARY

Salary	\$232,657
Fringe	\$142,060
Travel	\$7,220
Equipment	\$0
Other	\$240,928
Supplies	\$0
Contractual	\$141,161
Indirect	\$84,222
Grand Total:	\$848,248

Award (Part A):	\$848,248
Allocations:	\$848,248
Difference:	\$0

2011 Routine HIV Testing Initiative - **PART B** - BUDGET SPREADSHEET

[Name / Description]	[Job Title]	[FTE]	[Totals]
TBD (new hire)	Health Program Assistant 2	1.0	\$50,623
TBD (new hire)	Health Program Assistant 2	1.0	\$50,623
TOTAL Personnel Salaries:			\$101,246
Fringe (rate: 61.06%):			
TOTAL Fringe:			\$61,821
In-State:			
(2) State vehicles x \$700 upkeep per month x 12 months=\$16,800			
Monthly Rental for (2) state vehicles x \$334 each=			\$668
Fuel for (2) state vehicles x \$200 each =			\$400
Maintenance for (2) state vehicles x \$166 each=			\$332
	Total monthly cost for 2 state vehicles=		\$1,400
	Total yearly cost for state vehicles=		\$16,800
Out-of-State:			
2 trips x 2 person x \$550 airfare			\$2,200
2 trips x 2 persons x 3 days per diem x \$36/day			\$432
2 trips x 2 persons x 3 nights lodging x \$130/night			\$1,560
Registration= \$100 x 2 trips x 2 persons			\$400
Ground transportation= \$50 x 2 trips x 2 persons			\$200
			\$4,792
TOTAL Travel:			\$21,592
TOTAL Equipment:			\$0
General Office Supplies - (pens, pencils, paper, etc.)			
TOTAL Supplies:			\$2,227
TOTAL Other:			\$0
TOTAL Contractual:			\$0
Indirect (rate: 36.2%):			
TOTAL Indirect:			\$36,651

SUMMARY	
Salary	\$101,246
Fringe	\$61,821
Travel	\$21,592
Equipment	\$0
Supply	\$2,227
Other	\$0
Contractual	\$0
Indirect	\$36,651
Grand Total:	\$223,537

Award (Part B):	\$223,537
Allocations:	\$223,537
Difference:	\$0



CONNECTICUT HIV PLANNING CONSORTIUM

May 4, 2010

Technical Information Management – PS07-768
Department of Health and Human Services
CDC Procurement and Grants Office
2920 Brandywine Road
Atlanta, GA 30341

The Connecticut HIV Planning Consortium (CHPC) is writing this letter of continued support for the Connecticut Department of Public Health (DPH) for their response to Program Announcement CDC-RFA-PS10-10138.

Community planning in the state of Connecticut is a true partnership between the CHPC and the DPH. In fact, our state has successfully combined care and prevention planning to better meet the needs of people impacted by HIV in Connecticut.

The CHPC fully supports the Department's efforts to Expand Human Immunodeficiency Virus (HIV) Testing for Disproportionately Affected Populations that includes African Americans, Latinos/as, MSM, and IDUs beginning October 1, 2010. The CHPC is currently conducting a statewide needs assessment, surveying providers on counseling and testing, and looking at priority populations and those who are unaware of their status. The dialogue within the CHPC Data and Assessment Committee has been on the importance of routine testing in clinical settings with an option to use a portion of their testing strategies in non-clinical settings.

The CHPC is also in support of the Department's application for Part A and Part B of the grant; Part A to provide funding for clinical settings in the second and third year of the grant, and Part B to support programming focused on referral and linkage to health care for positive patients through its Disease Intervention Specialist (DIS) program by working with clinical settings. The CHPC is confident that the DPH has the capacity and the expertise to carry through their proposal if awarded the funding.

Sincerely,

CT HIV Planning Consortium Co-chairs

Robert Houser

Barbara Mase

Shawn Lang



**ASSURANCE OF COMPLIANCE
with the**

**“REQUIREMENTS FOR CONTENTS OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS,
AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS”**

By signing and submitting this form, we agree to comply with the specifications set forth in the “Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs,” as revised June 15, 1992, 57 Federal Register 26742.

We agree that all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials will be submitted to a Program Review Panel. The Panel shall be composed of no less than five (5) persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. (See additional requirements in attached contents guidelines, especially paragraph 2.c. (1)(b), regarding composition of Panel.)

We agree that all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials will be submitted to a Program Review Panel. The Panel shall be composed of no less than five (5) persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. (See additional requirements in attached contents guidelines, especially paragraph 2.c. (1)(b), regarding composition of Panel.)

The Program Review Panel, guided by the CDC Basic Principles (set forth in 57 Federal Register 26742), will review and approve all applicable materials prior to their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations, and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

NAME	OCCUPATION	AFFILIATION
Bonnie Edmondson	HIV Prevention Coordinator	Connecticut Department of Education
Brian Libert	Public Access Coordinator	Hartford Public Access Television, Inc.
Dominick Maldonado	HIV Prevention Coordinator	New Haven Health Department
Dorine Testori	Health Program Assistant 2	CT Department of Public Health, AIDS and Chronic Diseases Division
Claudio A. Santoro	Health Program Associate	CT Department of Public Health, AIDS and Chronic Diseases Division (Health Department Representative)

Connecticut Department of Public Health	5U62PS123477-05-1
Applicant/Grantee Name	Grant Number (If Known)
<i>Christian J. Anderson</i> Signature: Project Director	<i>Mary Fuller</i> Signature: Authorized Business Official
Date <i>5/26/10</i>	Date <i>5/27/10</i> GA

**Additional Panel Members for the Connecticut Department of
Public Health**

NAME	OCCUPATION	AFFILIATION
Gina D'Angelo	Health program Associate	CT Department of Public Health, AIDS and Chronic Diseases Division
Jose Vega	Assistant Director of Housing Services	CRT, Living Center
Karina Danvers	Connecticut AIDS Education and Training Center Director	Yale School of Nursing
Mathew Lopes, Jr.	Coordinator AIDS Services	New Haven Health Department

Statement of Compliance with Content of HIV/AIDS-Related
Written Materials, Pictorials, Audiovisuals, Questioners,
Survey Instruments, and Education Sessions

SUBMITTED MATERIALS FORM

Agency Name:	Connecticut Department of Public Health
Date:	5/21/10
Program Announcement:	HIV Prevention Project
Award Number:	5U62PS123477-05-1

To comply with the requirements described in the Review of Contents of *HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions*, published in the Federal Register on June 15, 1992, I certify that the following list of materials were submitted and reviewed by our Content Review Panel.

Name of Material	Date of Approval	Date of Disapproval
Invitation to African & Latino Men, VOICES/VOCES	3/9/2009	
Tu decsion.. Ofecta muchos vida.	6/25/2009	
Positively Aware	6/25/2009	
Become Empowered	6/25/2009	
Integrity	6/25/2009	
Street Smarts	6/25/2009	
HIV Prevention Programs	6/25/2009	
APH SISTA Program,	6/25/2009	
ARE YOU AT RISK?, Do u know your HIV status?		6/25/2009
ARE YOU AT RISK?, HIV?, AIDS?		6/25/2009
Peers Educating Peers Curriculum (PEP PHA)	6/25/2009	

Sincerely,

Signature:	
Name:	Claudio A. Santoro
Title:	Health Program Associate

(This page may be duplicated, as necessary.)
Statement of Compliance with Content of HIV/AIDS-Related
Written Materials, Pictorials, Audiovisuals, Questioners,
Survey Instruments, and Education Sessions
Statement of Compliance with Content of HIV/AIDS-Related
Written Materials, Pictorials, Audiovisuals, Questioners,
Survey Instruments, and Education Sessions

CERTIFICATION OF COMPLIANCE

Requirement: Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments and Educational Sessions – Recipient Web Site Notices

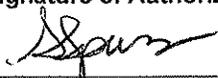
Grant/Cooperative Agreement Number:

Grantee Name: Connecticut Department of Public Health

- I certify that this organization has complied with the terms and conditions of the above referenced requirement.
- I certify that the requirement for a web notice is not applicable to this organization. If the requirement is not applicable, please state why

Please list below the primary web address(es) (URLs) impacted by this requirement:

<http://www.dph.state.ct.us/BCH/AIDS/HPAIDS.html>

Signature of Authorized Certifying Official: 	Title: Epi 3 / Webmaster
Applicant Organization: Connecticut Department of Public Health	Date Submitted: 5/25/10

Position Title	Staff Type: Existing (provide name) or new (to be hired)	Roles and Responsibilities	Estimated % of Time to be Spent on This Program*	Annual Salary	Amount Requested**
Part A – HIV Screening and HIV Counseling, Testing, and Referral					
1. Epidemiologist 2	To be hired	This person is assigned to the DPH STD Control Program. He/She will be assigned to several of the clinical sites to provide assistance with follow-up on positive patients. This includes partner notification services as well as referrals to medical care, STD, TB and HCV screening and social support. This staff person will also continue to work with HIV clients who do not continue in care for HIV.	100%	\$73,834	Including fringe & indirect= \$147,439
2. Epidemiologist 2	To be hired	This person is assigned to the DPH STD Control Program. He/She will be assigned to several of the clinical sites to provide assistance with follow-up on positive patients. This includes partner notification services as well as referrals to medical care, STD, TB and HCV screening and social support. This staff person will also continue to work with HIV clients who do not continue in care for HIV.	100%	\$54,472	Including fringe & indirect= \$108,775
3. Health Program Associate	Dulce Dones-Mendez	This person will be the Project Coordinator will manage the daily project activities. This person will have oversight of the clinical sites and will be responsible for quality assurance and will monitor the progress of the project. She will develop and conduct a Request for Proposal process that results in contracts being established with Community Health Centers. She will oversee and provide technical assistance to these contractors. She will identify and work to address barriers to the implementation of opt-out testing such as reimbursement issues, lack of buy-in, lack of training, etc.. She will oversee the development of a website and other resources for Health Care Providers that enhances their ability to conduct routine HIV screening in their practices.	100%	\$67,434	Including fringe & indirect= \$134,659
4. Health Program Assistant 2	To be hired	This one year durational position will assist the Project Coordinator with responsibilities such as researching insurance reimbursement and working with sites individually to provide technical assistance to the clinical sites around full implementation of opt-out testing and developing plans for sustainability of routine HIV screening beyond the end of the funding cycle. This person will also assist with the development of resources for Health care providers around the area of routine HIV screening and on maintaining the website that is developed for this purpose. In addition, this position will assist with the Request for Proposal Process that will be conducted during the first year of the grant and with the development of contracts with the selected Community Health Centers. At the end of the first year of the grant this position will be eliminated and the money will be used to help fund the selected Community Health Centers.	50%	\$36,917	Including fringe & indirect= \$73,720

Part B – Enhanced Linkage to Medical Care and Partner Services

<p>1. Health Program Assistant 2</p>	<p>To be hired</p>	<p>This position will be assigned to participating routine screening providers throughout the state and will be responsible for overseeing HIV routine screening of clients seen in the designated sites, working with the designated data staff from these sites to assure the reporting of all test results and other required data elements to the Department of Public Health, AIDS Division. Any individual testing positive will be overseen by this staff to assure screening and follow up for other STDs, TB and hepatitis C, vaccination for hepatitis A&B and HPV (if applicable), PNS and providing care for HIV. This person will continue to monitor these HIV infected persons, reviewing the status of care every three months. Anyone who does not receive appropriate screening or maintain care for HIV will be referred to DIS by this staff. All data will be maintained and analyzed by this staff in collaboration with staff from the AIDS Division.</p>	<p>100%</p>	<p>\$50,623</p>	<p>Including fringe & indirect= \$101,089</p>
<p>2. Health Program Assistant 2</p>	<p>To be hired</p>	<p>This position will be assigned to participating routine screening providers throughout the state and will be responsible for overseeing HIV routine screening of clients seen in the designated sites, working with the designated data staff from these sites to assure the reporting of all test results and other required data elements to the Department of Public Health, AIDS Division. Any individual testing positive will be overseen by this staff to assure screening and follow up for other STDs, TB and hepatitis C, vaccination for hepatitis A&B and HPV (if applicable), PNS and providing care for HIV. This person will continue to monitor these HIV infected persons, reviewing the status of care every three months. Anyone who does not receive appropriate screening or maintain care for HIV will be referred to DIS by this staff. All data will be maintained and analyzed by this staff in collaboration with staff from the AIDS Division.</p>	<p>100%</p>	<p>\$50,623</p>	<p>Including fringe & indirect= \$101,089</p>

87

88 * % of FTE (for example, 0.5 FTE)

89 ** Amount requested under this FOA, only. If the position is being paid for from other funding sources (e.g., other CDC cooperative
 90 agreement, state or local funds, in-kind) this should be entered as "0." If the position is being paid for in part from other funding
 91 sources, only the amount being requested under this FOA should be entered.
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 93

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DEPARTMENT OF PUBLIC HEALTH

From: Mary P. Fuller, Chief Fiscal Officer
Subject: Fringe & Indirect Rate for State Fiscal Year 2011
Date: July 14, 2010

FISCAL MEMORANDUM

No. 11-01

Below please find the calculations for Fringe Projections for grants for the State Fiscal Year 2011.

Department of Public Health
Fringe Benefit Rate Estimate
For Fiscal Year July 1, 2010 – June 30, 2011

50430 Unemployment Compensation	.16%
50471 Regular Employee Retirement	37.19%
50441 FICA	6.20%
50442 Medicare	1.45%
50420 Medical Insurance	15.94%
50430 Life Insurance	<u>.12%</u>
<u>Estimated Fringe Benefit Rate</u>	<u>61.06%</u>

The Indirect Rate will remain at 36.2%