Prevention Program Guidance
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Prevention Contract

The California Department of Public Health, Center for Infectious Diseases, Office of AIDS, Prevention Grant to Local Health Jurisdictions

California Department of PublicHealth

OFFICE OF AIDS
California Department of Public Health

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Introduction

Background

The National HIV/AIDS Strategy (NHAS) delineates three broad goals: to reduce new HIV infections, to increase access to care and improve health outcomes for people living with HIV, and to reduce HIV-related health disparities.

In support of the NHAS, the Centers for Disease Control and Prevention (CDC) Prevention Grant PS12-1201 for 2012-2017 places emphasis on identifying individuals unaware of their HIV-positive status and on HIV care and treatment as an effective prevention strategy. The CDC's booklet *High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States* provides a quick and readable overview of this new approach.

The CDC provides guidance for the state and territorial health departments it funds by designating "Required" and "Recommended" activities for the HIV prevention funds it disperses through PS12-1201. This provides a framework within which state health departments may design their CDC-funded prevention programs. The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) has developed a two-tiered system based on the CDC's activities (see "The Tier I and Tier II System," below).

OA's Prevention Grant to LHJs

The California Project Area (CPA) consists of the California local health jurisdictions (LHJs) outside of the San Francisco and Los Angeles metropolitan statistical areas (MSA), which are directly funded by the CDC. OA provides local assistance funding to the 18 LHJs within the CPA which represent 95% of living HIV/AIDS cases outside of the San Francisco and Los Angeles MSAs. Through agreement with Los Angeles County and the City of Long Beach, OA also administers the funds for the Long Beach prevention program. (See Appendix A for a list of OA Prevention Branch-funded LHJs.) With this funding, OA aims to support the development and implementation of comprehensive, high-impact prevention strategies for people living with HIV and individuals most at risk for HIV infection. OA's priority populations are listed in Appendix B.

Developing HIV prevention programs requires much considered work, including analysis of local epidemiology, needs assessments, gap analysis, and other formative activities. OA uses most of its prevention funds to support local practitioners who have the local expertise to respond to the NHAS strategies through initiatives that build on the success California has had in addressing HIV throughout the state.

Core Services

The core services of OA's Prevention Program are HIV testing coupled with both Partner Services (PS) and Linkage to Care (LTC). With this approach, OA aims to reduce the spread of HIV by ensuring that new cases of HIV are identified, and newly-identified HIV-positive individuals are linked to quality care. In jurisdictions where few newly-identified confirmed positive cases are anticipated, LTC and PS activities will take priority.

All LHJs funded under OA's Prevention Grant to LHJs must:

- Provide targeted HIV testing when positivity yield is sufficient to warrant it;
- Provide PS;
- Provide LTC services; and
- Meet monitoring and evaluation requirements set by OA.

Additionally they must:

- Offer HIV testing through an alternative test site (ATS);
- Assign a staff member to attend to health care reform issues;
- Meet the subsidiary requirements that support HIV testing, PS and LTC services.

In addition to the three core services, LHJs may choose to provide other evidence-based HIV prevention services. OA's Tier I and Tier II system is designed to allow LHJs the flexibility to choose among the activities that best meet the needs of their local communities, while ensuring that the CDC requirements are met by the CPA's efforts.

Health Disparities

Health disparities reflect differences in access to prevention and care services and differences in health outcomes across communities and populations. These disparities tend to be related to social determinants -- complex social, economic, and environmental conditions that influence the health of individuals and communities.

Health disparities are seen when populations and communities experience excessively high rates of HIV infection, late entry into HIV care or are not receiving comprehensive and consistent HIV care. The NHAS's health disparities goals are to: 1) increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%; 2) increase the proportion of HIV-diagnosed Blacks with undetectable viral load by 20%; and 3) increase the proportion of HIV-diagnosed Latinos with undetectable viral load by 20%.

HIV incidence, both nationally and in California, is associated with socioeconomic status, race/ethnicity, poverty, and substance use. Addressing HIV-related health disparities requires that LHJs monitor local conditions, including epidemiologic trends and barriers to access and service utilization. Because no single agency can intervene in the entire range of social and structural health determinants, it is also important for LHJs to establish robust partnerships between prevention and care providers as well as other agencies within the constellation of HIV-related services.

More information regarding health disparities can be found in *California's Integrated HIV Surveillance, Prevention, and Care Plan*.

How to Use this Document

The purpose of this document is to provide information on all activities required under OA's Prevention Grant to LHJs, and to assist LHJs to plan their local prevention portfolios.

When read online, this document provides hyperlinks between the table of contents, the tables describing the Tier I and Tier II activities, and the text, and includes hyperlinks within the document to make navigation simpler. The document also includes technical assistance (TA) contact information for each activity. OA encourages LHJs to make liberal use of the services provided by OA staff to assist in developing new initiatives.

Several appendices support this document, including a list of acronyms in Appendix E.

The Tier I and Tier II System

OA has designated three core services: HIV testing, PS, and LTC. OA has developed the Tier I and Tier II system to help LHJs prioritize among the many other evidenced-based approaches to HIV prevention currently required or recommended by the CDC.

The Tier I and Tier II system is designed to provide flexibility for LHJs to make decisions that work at the local level, at the same time it prioritizes the evidence-based interventions that can best meet the goals of the NHAS. In accordance with CDC guidelines, Tier II activities cannot exceed 25% of the total prevention budget award.

Tier I Activities

Core Services	Policy Initiatives
• HIV Testing • Linkage to Care • Partner Services	• Leveraging Substance Abuse and Mental Health Services Administration (SAMHSA) HIV Set-Aside Funds (OA only) • Surveillance Data Use (OA only) • Health Care Reform Planning • PrEP Planning (OA only)
Other Tier I Activities	
• Routine, Opt-out HIV Testing in Health Care Settings • Retention and Re-engagement in Care • HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings • HIV Medication Treatment Adherence • Integrated Health Services for HIV Positive People • Syringe Services Programs • Condom Distribution	
• State Community Planning (OA only)	

Funded LHJs must implement the three core services, with the exception of the lowest prevalence LHJs, which may choose to use their resources to

work with local health care providers to support linkage to care and Partner Services for newly-diagnosed HIV-positive individuals.

LHJs may choose among the additional Tier I activities in designing their OA-funded prevention portfolios. LHJs may also choose not to fund any additional Tier I activity that does not correspond to the HIV prevention needs identified in the LHJ.

Tier II Activities

Tier II activities are lower priority activities within the NHAS, CDC Prevention Grant and the OA Prevention Plan for the CPA. No more than 25% of the OA Prevention allocation may be used for Tier II activities.

LHJs using OA prevention funds for Tier II activities must document that all Tier I activities are being conducted in the jurisdiction, either by OA-funded initiatives or through other sources. If an activity is already being implemented using other funding sources, it is not necessary to duplicate the effort. Documentation for each Tier I activity should include a description of the activity, who is providing the activity, the target population(s) served and the number of individuals projected to be served. Hepatitis C virus (HCV) antibody testing, while designated a Tier II activity, may be conducted by the LHJ without first ensuring that all Tier I activities are being conducted within the LHJ.

Tier II Activities
• Hepatitis C Testing • Behavioral Interventions for Prioritized High-Risk Negative People • Social Marketing, Media and Mobilization

LHJs using OA funds to conduct Tier II activities must provide brief updates on the progress of Tier I activities funded by other sources in their bi-annual progress reports. OA would welcome similar reports from LHJs that will not be conducting Tier II activities; however, they are not required.

If selected, Tier II activities must be provided to the highest risk populations as reflected in local surveillance data and OA priority populations (see Appendix B).

Community Planning

Community input plays a significant role in developing comprehensive local HIV prevention plans. Although OA no longer requires LHJs to maintain Local Implementation Groups (LIGs), OA remains supportive of this process, and community planning can be supported with OA funds. LHJs that do not have LIGs are encouraged to obtain community input by other means, such as focus groups and surveys, and OA funds may be used to support these efforts. Technical assistance is available to assist in eliciting community input.

State CPG

At the state level, the California Planning Group (CPG) is an important facet of OA's approach to obtaining statewide community input. The membership of CPG facilitates community feedback on statewide planning documents, implementation plans, policy development, emerging issues, and other matters that are relevant to the providers and stakeholders who partner with OA. Information about CPG is available at http://www.cdph.ca.gov/programs/aids/Pages/OACPG.aspx

One of CPG's primary responsibilities is to help develop *California's Integrated Surveillance, Prevention, and Care Plan*, which serves as a practical guide for OA to achieve the vision of the NHAS. CPG members also partner with OA in reviewing and updating or revising the Integrated Plan based on shifts in the epidemic, updated data, emerging risk populations or newly-identified community priorities.

LHJ Planning

LHJs should submit a copy of any prevention plans, or integrated prevention and care plans, developed by the LHJ.

Policy Initiatives and other OA Activities

OA Prevention Branch is focused on four key policy initiatives: 1) encouraging state and local coordination of the funds disbursed by the California Department of Health Care Services (DHCS) (formerly by the Department of Alcohol and Drug Programs [ADP]) as the HIV Set-Aside portion of the federal Substance Abuse Prevention and Treatment Block Grant; 2) addressing procedural barriers to using HIV surveillance data to assist in identifying HIV-positive individuals not receiving HIV care and linking them into needed services; 3) examining and defining the HIV-related issues, resources and unanswered questions associated with health care reform; and 4) Pre-Exposure Prophylaxis (PrEP) planning and program development.

Tier I Activities

Targeted HIV Testing

In response to the NHAS, OA's HIV testing initiative has changed to specifically target efforts towards those at highest risk of acquiring HIV infection (See Appendix B for the Priority Populations), and to ensure that newly-identified HIV-positive individuals are linked to HIV care and offered PS.

Targeted HIV testing in non-health care settings[1] can be effective in reaching high-risk individuals who are unlikely to be reached in medical settings. It is also a highly resource-intensive activity that is challenging to conduct in areas that have no recognized venues that serve gay men and other MSM. By working with medical providers to provide Partner Services and ensure that patients are linked to care, begin antiretroviral medication and achieve an undetectable viral load, health departments in lower-HIV-prevalence jurisdictions may impact the spread of HIV more effectively than by running their own HIV testing programs, if their own testing programs are not identifying many new infections.

For the five lower-prevalence LHJs (Monterey, Santa Barbara, Santa Cruz, Stanislaus, and Ventura), OA has removed the requirement that they provide targeted testing, and instead allows them the option of using their resources to work with local health care providers to support linkage to care and Partner Services for newly-diagnosed HIV-positive individuals.

OA will consult with each of the five lower-prevalence LHJs to help them determine the most effective prevention plan.

Definition of Fundable Activities

Funded agencies will administer HIV testing by providing anonymous and/or confidential targeted HIV testing services (with or without counseling) to individuals at highest risk for HIV. Testing services may include: assessment of client risks of HIV exposure; client-focused prevention counseling, where appropriate; risk-reduction planning; and referral to other services. LHJs funded for targeted testing in non-health care settings are required to:

- Assess their ability to identify new positives through targeted testing, and examine their testing sites and funded HIV testing providers that either (a) do not target the majority of their testing efforts to high-risk populations, or (b) did not identify any new cases of HIV in 2013 or in the first half of 2014. If the LHJ wants to continue funding these sites or subcontractors for targeted HIV testing in 2015 they must submit a plan to OA for improving the site's ability to identify new cases of HIV;

[1] A non-healthcare setting is defined by CDC as a setting where neither medical diagnostic nor treatment services are provided. An example is an HIV testing site at a community-based organization.

- Establish systems for linking newly diagnosed HIV-positive or preliminarily positive clients into medical care with a verified medical visit;

- Ensure that clients are offered PS; and

- Establish a plan for referring clients to other prevention services. These services may include but not be limited to STD testing and treatment, syringe services programs and/or HIV education and prevention services.

Requirements to Conduct HIV Testing

LHJs and their testing sites must provide services in accordance with California Health & Safety (H&S) Code 120917, which sets out requirements for both medical and non-medical HIV test operators. A test kit operator must either be a medical provider engaged in direct patient care, or an HIV test counselor who has received the Basic Counselor Skills Training (BCST) from OA or its training partners using OA-approved training curriculum. As of January 1, 2014, Assembly Bill (AB) 446 (Mitchell, Chapter 589, Statutes of 2013) [2] makes additional changes to H&S Code 120917. OA is developing a policy memo to delineate the changes AB 446 makes to California code regarding obtaining client consent for HIV testing, which will be issued prior to January 1, 2014.

All individuals tested with OA funds in non-health care settings shall be given the results of their test in person.

All 19 LHJs are required to have an ATS. The number of hours and location(s) dedicated to anonymous testing are not specified and can be determined by assessing local needs. ATS testing must still be anonymous and provided for free.

LHJs must target high-risk individuals for HIV testing. LHJs should increase the proportion of testing provided to high-risk individuals by 10% each year. The Counseling and Testing (C&T) Indicators report and the Companion Interactive Worksheet for the Evaluation Section of the Progress Report are useful tools that provide information related to LHJ progress in targeting HIV testing.

Written quality assurance plans[3] are required by sites conducting point-of-care rapid HIV tests waived under the Federal Clinical Laboratory Improvement Act (CLIA). These plans are submitted to OA for review by the Targeted HIV Testing Specialist for comprehensiveness and compliance with State and Federal requirements. Please submit updated plans anytime there are significant changes, such as the addition of HCV testing.

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[3] The template for the Quality Assurance Plan is available online at http://www.cdph.ca.gov/programs/aids/Documents/HCVHIVTestingQAPlanTemplate.docx The OraQuick Rapid HIV Testing Guidelines (2003) is also available on the OA website.

Additional Requirements

All funded LHJs must ensure that all contracted testing sites maintain appropriate documentation. Additionally:

- The test site must maintain signed statements of confidentiality for employees and volunteers who have access to individual client files.
- Client records containing personally identifying information developed or acquired by the agency relating to any program activity or services are confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.
- Information collected during HIV testing, such as the Client Assessment Questionnaire (CAQ), Client Information Form (CIF), invoices, etc., must be retained by the test site for three years in addition to the current year. All confidential client information must be stored in a locked filing cabinet.

HIV Counselor Training

Funded agencies must ensure all HIV testing services are provided by staff members who have successfully completed the BCST.The BCST includes certification for finger-stick and HCV rapid test proficiency.

OA contracts with the University of California, San Francisco, Alliance Health Project (UCSF/AHP) to provide this training to funded LHJs. A schedule of classes is located under UCSF/AHP's website at www.ucsf-ahp.org. See Appendix D for information on how to register a candidate for the BCST.

Supplies

OA will continue to provide OraSure sample collection devices, OraQuick Advance Rapid HIV Test kits and external controls to all Prevention-funded LHJs. The number of HIV test kits provided is based on the number of tests that the LHJ proposes to conduct, as indicated the Service Category page of the budget documents and in the LEO database. The quantity of tests entered into LEO is also used to determine the number of HIV test kits OA will provide. Therefore LHJs must enter data into LEO promptly to ensure accurate supply inventory. OA utilizes LEO data to determine the overall budget for HIV test kits as well, so delay in data entry can result in inaccurate inventory. If an LHJ exceeds the allotted quantity of test kits, the LHJ may use OA prevention or other funding to purchase additional test kits directly from OraSure Technologies, Inc. LHJs are eligible to receive the California public health pricing rate when purchasing HIV test kits and control devices directly from OraSure Technologies, Inc.

Test kits may be ordered by the LHJ coordinators using the HIV test kit order form (available from OA Operations Advisors). The form should be submitted electronically to OAtestkits@cdph.ca.gov. Allow 15 business days to process an order. While only the LHJ staff can place an order, test kits can be shipped directly to an LHJ's subcontractor.

The process outlined above is also used to determine the number of rapid HIV testing lab slips and conventional HIV lab slips that an LHJ may order. Lab slips may be ordered by sending a request to LEOSreq@cdph.ca.gov. Include the quantity for each specific lab slip and/or form(s) needed, the contact person, a street address (not a P.O. box) and a telephone number. The order will be processed by OA within 15 business days.

In order to decrease the need to request and process orders on an ongoing basis, OA will contact each LHJ prior to the beginning of the next contract year to determine how many rapid HIV lab slips will be needed during the first six months of the contract period.

Monitoring and Evaluation

All sites are expected to increase the number of newly identified HIV-positive tests annually by at least one-tenth of a percent, so that by year five, the state positivity yield is at least one percent.

LHJs should use the OA LEO database to generate testing indicator reports. These reports provide information on the degree to which the LHJ currently conducts high-risk versus moderate- and low-risk testing, and assist LHJs to adjust efforts to better target testing programs. They can be reviewed for specific sites, allowing monitoring and prioritizing high-positivity test sites over lower-positivity test sites. HIV Testing Coordinators should use these indicator reports and other data reports to assist in identifying those areas in their counties that maximize use of their resources (staffing, time, and materials) to identify newly-diagnosed HIV-positive individuals.

LHJs must submit a plan for improving yield in lower-positivity test sites or for closing them in order to shift resources to test sites that effectively reach those populations most likely to test HIV positive.

Compliance with the targeted HIV program standards and requirements is monitored using data entered into the LEO system and also via TA contacts and in-person site visits. Site visits occur as a routine part of program monitoring or to provide more intensive TA.

TA Contact

Matthew Willis, Targeted HIV Testing Specialist, (916) 449-5797 or Matthew.Willis@cdph.ca.gov.

Linkage to Care

Linkage to Care (LTC) is the process of assisting individuals who are newly HIV-diagnosed to enter into HIV medical care. LTC is a required activity for all OA-funded HIV testing sites in both medical and non-medical settings. LTC may also be provided to individuals who receive HIV diagnosis from non-OA-funded medical providers.

LTC is accomplished when the HIV-positive person is seen by a health care provider (e.g., physician, physician assistant, nurse practitioner) to receive medical care for his or her HIV infection within 90 days and the initial visit is verified.

In 2013, the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) and the CDC explained the importance of LTC in a *Dear Colleague* letter. This letter clarified that having only one HIV positive test result should not be a barrier to linking a patient to care to a RWHAP-funded clinic or other HIV care provider. It is important that HIV testing sites establish relationships with medical providers to facilitate follow-up HIV testing and medical care. The complete letter can be found at: http://hab.hrsa.gov/files/hrsacdchivtestingletter2013.pdf.

For some LHJs, implementing LTC involves a shift from the standard model of community testing to more intensive collaborations with other prevention and care providers in the LHJ, means involving Ryan White programs and Early Identification of Individuals with HIV and AIDS (EIIHA) initiatives in designing LTC programs. Many LHJs have expanded the role of HIV test counselors, who maintain contact with the client beyond disclosure of results to ensure the client is effectively linked and engaged in care. There are a variety of factors to be considered in designing an LTC program, including patient population, facility capacity, organizational and logistical features of the facility, staff skills and resources. Sometimes a mix of models and approaches will best facilitate implementation. Models for LTC may vary depending on testing setting (e.g. jail, health center, drug treatment center).

LHJs are encouraged to routinely monitor their HIV surveillance data to identify newly-diagnosed or previously-diagnosed individuals who do not have subsequent t-cell or viral load laboratory results reported, as these may be individuals who were not linked to care or have been lost to care.

Definition of Fundable Activities

LHJs have the latitude to design their own LTC verification system and forms for linkage verification that will work best within their HIV programs. By now, OA-funded LHJs should have:

- Established a LTC system with written protocols that refers individuals with preliminary and confirmed HIV-positive test results to a medical provider for follow-up within 90 days, and confirms that the person attended his or her first appointment;

- Identified HIV care providers to which patients will be referred, and developed a means to verify that the patient attended the medical appointment. A variety of different mechanisms may be used to verify, including but not limited to verified medical visit forms, kickback cards, and/or client self-report. All verified visits must be entered on the HIV Counselor Information Form (CIF) and entered into LEO. For clients identified as never having been in HIV medical care within Health Education Risk Reduction (HE/RR) activities, LTC is documented on the HE/RR form, and is also entered into LEO.

HIV testing coordinators should submit to OA:

- Any updates to policies and procedures for verifying linkages to medical care;
- An LTC work flow chart that outlines the steps taken in testing sites from the time client is tested, receives preliminary or confirmatory HIV results, is referred to a medical provider, attends their first medical visit, verification is conducted and the client is referred to partner and other prevention services;
- Any new linkage verification documents, after review by both the local county Health Officer and by local health department legal counsel.

Monitoring and Evaluation

The objective of OA's LTC program is to link at least 85 percent of newly-identified HIV-positive people into medical care within 90 days of receipt of their HIV antibody test results. This rate is consistent with the goals of the NHAS and ongoing monitoring will assist in ensuring sustained success of this critical activity.

LHJs will use the LEO data system to document and record LTC activities. All verified visits must be entered on the HIV CIF and entered into LEO.

Improvements in LEO data system allow LHJs to track their progress in linking HIV-positive individuals to care and verifying medical visits. LHJs should use LEO Indicator Reports to monitor and evaluate their progress towards LTC goals. LHJs may contact the OA Testing Specialist for assistance with data reports.

Resources

OA has a variety of resources and assistance for LHJs and HIV testing coordinators with their LTC programs. There are examples of verification forms, work flow charts, and LTC protocols that you can request from the OA TA contacts listed below.

OA recommends the CDC guide *Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers.* This is a tool to be used by health departments and community-based organizations to assess and strengthen HIV testing and linkage programs in non-health care settings.

Included within the guide are a glossary, resources, toolkit, and templates. The templates include examples of an Authorization for Release of Information, Memorandum of Agreement, Client Referral form, and HIV Testing and Linkage Policies and Procedures**.**

OA endorses the Anti-Retroviral Treatment and Access to Services (ARTAS) behavioral intervention as a strategy for linking recently diagnosed positive individuals to care. Information about training and the benefits of this strategy can be found at: http://www.effectiveinterventions.org/en/HighImpactPrevention/PublicHealthStrategies/ARTAS.aspx.

TA Contact

Matthew Willis, Targeted HIV Testing Specialist, (916) 449-5797 or Matthew.Willis@cdph.ca.gov and Dennese Neal, Intervention Specialist, (916) 440-7744 or Dennese.Neal@cdph.ca.gov.

Partner Services

PS is a program that supports HIV-positive people in notifying their sexual and/or needle sharing partners of possible exposure to HIV. In the CPA, the initiative is a collaborative effort with CDPH's STD Control Branch to provide program support, training and TA to LHJs based on each agency's individual infrastructure and need. OA has designated PS as a core service. All LHJs that receive OA Prevention funds are required to provide PS.

Definition of Fundable Activities

The three major activities of PS are:

1) *Offer* – The PS program is explained to the client, including the process, options for notification and benefits of disclosure. If the staff member making the offer is not trained in PS, any client who accepts an offer should be referred to the appropriate health department PS staff for elicitation and notification follow-up.
2) *Partner Elicitation* – Newly-diagnosed as well as previously diagnosed HIV-positive people who report risky behavior are interviewed by trained PS staff to elicit partner names and other locating information.
3) *Partner Notification* – Identified partners are located and confidentially notified of their possible exposure or potential risk of acquiring HIV, offered support, have questions answered, provided testing and offered referrals for prevention services. Only trained PS workers can provide notification of exposure.

Other functions of PS include coaching HIV-positive clients on self-disclosure, testing for HIV and other STDs, hepatitis screening and vaccination, referral to educational and prevention programs, referral to support/social services and, if applicable, LTC and treatment.

OA uses a venue-based model for PS, in accordance with the California H&S Code that governs how and to whom confidential HIV information in the State HIV surveillance system may be disclosed. In the venue-based model, HIV-positive clients who are at risk for transmitting HIV are offered PS in a variety of venues, including testing sites, PWP programs and both public and private medical care sites. With partner notification at the core of PS, HIV-positive clients are offered three methods of disclosure:

Self-disclosure – an HIV-positive client chooses to disclose his/her HIV status to partners. The PS staff member may offer support and coach the client on effective methods for disclosing HIV status to partners, as well as provide information to the HIV-positive client on testing and offer referrals for prevention services that are available to the partner(s).

Dual-disclosure – an HIV-positive client discloses his/her HIV-positive status to partners in the presence of a PS staff member. While responsibility for actually disclosing is with the HIV-positive client, the PS staff member may

offer support, answer questions, provide testing, and offer referrals for prevention services to the partner(s).

Anonymous third-party notification – a trained PS staff member locates and informs identified partners of their possible exposure to HIV, offers support, answers questions, provides testing, and offers referrals for prevention services to the partner(s). This may be done when a client lacks either the desire or the resources to locate and self-disclose to partners.

LHJs should: 1) offer PS to all people newly diagnosed as HIV-positive, as well as those living with HIV who may have exposed others to HIV through recent risk behavior; 2) assess PS activities and outcomes; 3) implement provider outreach programs to enhance PS with key community providers; and 4) identify appropriate staff to conduct partner elicitation and/or partner notification activities.

Funds allocated for PS may be used for any activities supporting PS including staff salaries and benefits, travel, training, and resources for third-party notification. Funds may also be used to enhance or expand an LHJ's PS program. Examples include planning for, hiring and training staff to improve offer, referral process and/or elicitation of partners, surveying health care providers for improved referral systems, developing collaborations with HIV health clinic staff and embedding PS staff members in health care settings with high HIV and/or STD incidence.

Additional Requirements

Every LHJ should maintain a staff member to coordinate the PS activities of that jurisdiction. The amount of time and the duties of this person depend on the structure and capacity of each individual program. Staff members from HIV care clinics and testing, HE/RR, and STD programs should be trained and work as a team to provide PS education and referral to HIV-positive clients at risk for transmitting HIV to others. Experienced HIV prevention, testing, and care program staff, with training in PS, can conduct the PS offer, including coaching for self-referral, dual notification, and elicitation of identifying and locating information for third-party anonymous notification. Partner information may be used by LHJ PS staff if those staff members have been trained to locate partners and provide anonymous third-party notification.

Training and Technical Assistance

CDPH's HIV PS training program is available for LHJs, CBOs and other staff who perform or wish to perform PS activities. The goal of this one-day training is to develop and/or enhance the skills needed by staff to perform PS activities specifically in California. OA and STD Control Branch staff will travel to jurisdictions requesting this training, and the program is free of charge.

OA and the STD Control Branch are also available to provide TA and capacity building assistance to funded LHJs and subcontracted CBOs. TA may be provided using a number of methods including face-to-face meetings, conference calls, and topic-specific webinars.

Monitoring and Evaluation

All LHJs should maintain their written PS program plan that provides for routine review of PS staff performance with appropriate standards, PS protocols/quality assurance plans. LHJs should submit any updates of their PS program plan to OA.

Local programs must track the number, type, and outcomes of PS activities in LEO. It is critical to enter the information in a timely manner, especially when referring clients to DIS staff. LHJs should frequently review PS data in LEO. Local programs must also complete quarterly reviews to identify open cases, trends, and populations served.

LEO PS reports are being re-designed. The current HE/RR PS Report #6 available through LEO does not calculate the data accurately and should not be used. Confidentiality and issues related to exchanging PS outcomes between LHJs requires particular consideration in developing these reports. Please consult with OA staff regarding your PS data summary needs.

OA has two request forms for LHJs that need additional data analysis or copies of their data to conduct their own analyses:

- To request OA to provide additional data reports, submit a *Request for HIV Prevention Program Reports* form;
- To request copies of your LEO data, submit a *LEO Data File Request* form.

OA and the STD Control Branch staff also review LEO data and generate reports to monitor progress, assess data entry and maintain quality assurance for the PS program. Programs experiencing difficulties will be offered TA and capacity building assistance by both OA and the STD Control Branch staff. This assistance may be provided via site visits, webinars, or teleconference calls.

TA Contact

Manny Rios, Partner Services Program Specialist, HIV Prevention Program Section, (916) 449-5824 or manny.rios@cdph.ca.gov.

Routine, Opt-out HIV Testing in Health Care Settings

The CDC encourages the integration of HIV testing into routine health care, and has created a number of initiatives to encourage health care providers, with the assistance of health departments, to routinize HIV screening. OA has participated in these initiatives since 2007.

California law permits routine, opt-out HIV testing, and requires private insurers to pay for such testing.

Definition of Fundable Activities

Under OA's Prevention Grant, LHJs are encouraged to explore with local health care settings ways they can implement and increase routine, opt-out HIV testing. LHJs which choose to fund the integration of HIV testing into health care settings may design a program which meets the needs of their local epidemic. Program activities center on providing TA to venues such as hospital emergency departments, primary care clinics in community health care settings, gynecological services, and jail health care settings to assist them in integrating routine, opt-out HIV testing into their health care services.

LHJs are encouraged to also collaborate with these health care settings in ensuring LTC and PS services are available.

Non-Fundable Activities

In order to encourage full integration and sustainability of routine, opt-out HIV testing this funding cannot be used for HIV testing staff. In addition, this funding can only pay for HIV testing (i.e., test kits and other testing costs) in so far as a patient has no other payer for health care services (OA is the payer of last resort).

Monitoring and Evaluation

LHJs committing funding to HIV testing in health care settings must report their successes, challenges and lessons learned at the site level in the format provided in the bi-annual progress report. In addition, if funding is given directly to a health care setting to increase or implement routine, opt-out HIV testing, those sites must provide client-level data. The data requirements for patients testing HIV negative are minimal and can usually be obtained from the electronic health records of the health care setting. Data requirements for patients testing HIV positive are obtained after HIV testing using the Health Care HIV Testing Form which is similar to the CIF. Health Care HIV Testing forms are available from OA, and can be found on the OA website and ordered on-line at LEOSreq@cdph.ca.gov. Monitoring CDC indicators can be done by reviewing the C&T Indicators report within LEO.

TA Contact

Clark Marshall, HIV Expanded Testing Coordinator, (916) 650-6752 or clark.marshall@cdph.ca.gov or Jenny Olson, Medical Testing Specialist, (916) 449-5940 or Jennifer.Olson@cdph.ca.gov

Retention and Re-Engagement in Care

The Health Resources and Services Administration (HRSA) recommends HIV clinical visits at least twice in a 12-month period, at least three months apart for HIV-positive patients. OA's goal for *Retention and Re-engagement in Care* activities is to support collaborative work between HIV prevention and care providers in order to increase the percentage of HIV-positive individuals retained in HIV primary care, and to re-engage people who have been lost to care (not seen their health care provider for more than six months).

LHJs are encouraged to routinely monitor their HIV surveillance data to identify individuals who have gaps in their reported t-cell or viral load laboratory results, as these may be individuals who have not been retained in care.

Definition of Fundable Activities

LHJs that fund or provide *Retention and Re-Engagement in Care* will work to develop a comprehensive model to identify out-of-treatment HIV-positive individuals, and engage and retain HIV-positive people in treatment, especially those who are hard to reach, experience social, cultural, or economic barriers to care, or are at risk of "falling through the cracks" and failing to access and fully use health care.

Areas of collaboration between prevention and care providers may include involvement with Ryan White Part C (Early Intervention) programs, testing and LTC, Ryan White Part A and Part B-funded programs, EIIHA initiatives, and/or the Minority AIDS Initiative (MAI).

Each jurisdiction is responsible for determining the most effective approaches for achieving active collaboration between local prevention and care providers with the goal of achieving LTC and continued engagement in care for HIV-positive individuals. Examples of collaboration between prevention and care providers may include activities such as:

- Educating HIV-positive clients about recommended frequency of HIV medical care, care eligibility criteria and available resources to access medical care;
- Offering assistance in negotiating care systems;
- Identifying potential barriers to care and providing assistance in overcoming them;
- Assessing individuals for their risk of being lost to care and helping them remain engaged;
- Providing initial and ongoing HIV treatment education and adherence support; and
- Following up on referrals outside of the care setting in order to monitor client progress, offer support, and address barriers as needed.

Monitoring and Evaluation	OA's LEO system or AIDS Regional Information and Evaluation System (ARIES) are used to document and record *Retention and Re-Engagement in Care* activities. In LEO, the date of last medical visit and specific activities to re-engage clients in care can be documented. In ARIES, date of last medical visit and MAI activities can be documented.
TA Contact	Carol Crump, Behavioral Health Specialist, (916) 449-5965 or carol.crump@cdph.ca.gov.

Prevention with Positives (PWP)

HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings

The goal of *HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings* is to increase the number of Ryan White-funded clinics or HIV care providers providing a comprehensive risk screening program and, to the extent that resources are available, initiate behavioral, structural or biomedical interventions for HIV-positive individuals, or develop a referral plan to community-based PWP interventions.

Definition of Fundable Activities

LHJs which elect to fund or conduct *HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings* will select at least one Ryan White-funded clinic or HIV care provider that can initiate behavioral risk screening within their medical setting. Health care settings that conduct behavioral risk screening will either 1) provide an evidence-based risk reduction intervention to clients identified through screening as potentially benefitting from such an intervention, or 2) develop a referral plan to community-based agencies that provide evidence-based risk reduction interventions. Linkages to mental health and substance use disorder treatment services are also an important part of PWP services.

OA has selected two assessment instruments for this activity. These two assessment tools, the Group Self-Administered Questionnaire (GSAQ) and the Substance Abuse and Mental Illness Symptoms Screener (SAMISS) can identify behaviors that can increase risk of HIV transmission, as well as identify factors that may increase risk behaviors, such as substance use or mental health issues. Both of these assessment tools are already used in other OA activities and can be entered into LEO and ARIES. (See Appendix F for more detail on the use of these two assessment tools). All LHJs and/or their contractors that use OA prevention funding for *HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings* should use either the GSAQ or SAMISS in screening HIV-positive individuals.

Selected interventions that are offered to clients after the screening must be evidence-based and designed for HIV-positive people, or for serodiscordant couples when appropriate. (See Appendix C - Evidence-Based Interventions, for further information.) If other evidence-based interventions are adapted to the population, documentation of the adaptation should be submitted to OA for written approval prior to implementation.

If a medical setting chooses to refer clients at risk of transmitting HIV to community-based interventions, those interventions must also be evidence-based and designed to target HIV-positive people or serodiscordant relationships. The referral process must include a means to follow-up and report whether the client attended the intervention.

Referrals to mental health and substance use disorder services should be recorded on LEO HE/RR forms and entered into the LEO system.

Additional Requirements

All staff members who administer the assessment should be trained on the instrument(s) used, including the purpose and meaning of each question, methodology to administer the assessment, appropriate documentation, interpretation of results, and process for referring clients identified at risk of transmitting HIV to others to appropriate evidence-based behavioral interventions or other services. Documentation that staff has completed the training should be maintained and reported to OA via LEO.

All staff members who facilitate the evidence-based interventions must have completed training in the intervention, if it is offered. At minimum, staff should have training in behavior change or community health education and individual counseling techniques if it is an individual-level intervention or group facilitation if it is a group-level intervention. See Appendix C for further information on individual-level interventions and group-level interventions. CDC EBI intervention training can be requested through the www.effectiveinterventions.org website.

Supervisors must monitor and ensure that all staff administer the intervention with fidelity and follow the curriculum and intervention activities as defined by the intervention. Documentation of each intervention session must be maintained to describe session activities and compliance with intervention requirements.

Monitoring and Evaluation

OA's LEO system or ARIES will be used to document and record client assessments. GSAQ data must be entered into LEO. SAMISS information may be entered into ARIES. If a provider does not have access to ARIES, SAMISS results can be easily scored by hand using the SAMISS Score Key. LHJs must also provide a summary of screening activity in the bi-annual reports to OA.

Behavioral interventions will be recorded and monitored using the LEO system. All evaluation required by evidence-based interventions must be completed and be maintained according to standard OA contract language. OA will assist each LHJ in using their monitoring systems or creating a summary database to submit evaluation information specific to each intervention.

TA Contact

Kevin Sitter, Intervention Specialist, (916) 449-5814 or kevin.sitter@cdph.ca.gov, and Carol Crump, Behavioral Health Specialist, (916) 449-5965 or carol.crump@cdph.ca.gov.

HIV Medication Treatment Adherence

To promote treatment adherence interventions in every LHJ, OA will fund LHJ's efforts to support the appropriate and consistent use of antiretroviral (ARV) medicines to maximize their benefits in sustaining health and suppressing viral load. Medication Treatment Adherence should be accessible to all patients having difficultly taking ARVs as prescribed.

Definition of Fundable Activities

LHJs that elect to fund or provide *HIV Medication Treatment Adherence* are responsible for determining the most effective approaches to designing a program. The activity should include collaboration with health care providers, medical case managers, and others working with people living with HIV/AIDS to:

- Regularly screen HIV-infected individuals to determine whether they are on ARV therapy;
- Routinely assess treatment adherence and monitor viral suppression of those on ARV therapy to identify individuals who would benefit from treatment adherence interventions; and
- Develop appropriate referrals for those not on ARV therapies and for those identified as having challenges in maintaining adherence to their HIV medication requirements. This may include delivering treatment adherence interventions.

For those on ARV therapy, OA recommends that screening for treatment adherence be done on a similar schedule to viral load testing. U.S. Department of Health and Human Services 2013 *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents* recommend monitoring viral load every three to six months. A summary of recommendations from an International Association of Physicians in AIDS Care panel provides additional suggestions for effective adherence support in the *Annals of Internal Medicine, June 2012*.

The CDC is developing e-learning trainings for five medication adherence interventions. Resources for treatment adherence interventions may be found in Appendix C - Evidence-Based Interventions. Some staff may have treatment adherence training as part of their professional development (e.g., physicians, nurses and pharmacists). If these staff members are conducting adherence interventions, continuing medical education related to ARV and treatment adherence is encourage and is available through the AIDS Education Training Centers.

For staff whose professional training does not typically include ARV and treatment adherence, a treatment education certificate is strongly encouraged, and is offered free through the California Statewide Training and Education Program.

Non-Fundable Activities	OA prevention funds cannot be used to pay for medications or medical services. Purchasing supplies to assist with medication adherence, such as pill organizers, alarm watches or software to send text reminders is an acceptable expense when used within treatment adherence intervention programs.
Additional Requirements	Whichever treatment adherence interventions(s) are selected, outcome monitoring is critical, with the goal of seeing an increase in taking all doses as prescribed and in most cases seeing the resulting increase in viral suppression through a decrease of viral load laboratory measures. ARIES and LEO have the ability to document adherence information.
Monitoring and Evaluation	OA requires LHJs to use ARIES or LEO to track service utilization by clients referred to treatment adherence interventions. OA staff will assist in developing appropriate set-up in the monitoring systems.
TA Contact	Kevin Sitter, Intervention Specialist, (916) 449-5814 or kevin.sitter@cdph.ca.gov.

Integrated Health Services

All HIV-positive patients should receive ongoing laboratory monitoring for STDs, hepatitis, and tuberculosis (TB), as outlined in the HRSA clinical guidelines for HIV-positive patients. Medical Case Managers and Prevention staff can assist in ensuring clients achieve the HRSA clinical guideline recommendations within their prevention activities, since co-infections challenge individual health and increase the likelihood of HIV transmission.

Definition of Fundable Activities

Activities for integration of screening for and monitoring of hepatitis, TB, and STDs for HIV-positive individuals will be determined by each LHJ and will vary depending on the needs and opportunities within each LHJ. Activities may include, but are not limited to:

- Providing continuing medical education highlighting the benefits of compliance with recommended clinical monitoring to increase staff integration of screening;
- Using ARIES or electronic health records to document clinical testing of medical case management clients and Ryan White clinic patients as appropriate;
- Supporting client education that increases awareness of clinical laboratory monitoring standards and encourages clients to talk with their health care providers about exposure or transmission risks of hepatitis, TB, and STDs; and
- Referring those who are diagnosed with an STD to treatment and behavioral interventions to assist in avoiding future infections.

Non-Fundable Activities

OA funding cannot be used to pay for clinical laboratory tests, except as noted for HIV testing and hepatitis screening.

Monitoring and Evaluation

In addition to recording recent diagnosis of STDs, hepatitis, or TB, health care providers and other staff working with HIV-positive individuals should record clinical screening dates and dates of assessing the need for PS, with indicators developed based on HRSA and CDC recommendations. LHJs will be required to report on their activities supporting the integration of this screening and monitoring in their bi-annual progress reports.

TA Contact

Kama Brockmann, HIV Testing in Health Care Settings Specialist, (916) 449-5964 or kama.brockmann@cdph.ca.gov.

Syringe Services Programs

OA's *Syringe Services Program* (SSP) initiative aims to expand injection drug users' (IDUs) access to sterile injection equipment, improve efforts to properly dispose of sharps waste, and link IDUs to relevant prevention services, medical care, and social services.

The Federal Fiscal Year (FY) 2012 Omnibus Appropriations bill reinstated the ban on Federal funding for syringe exchange programs (SEPs) that was lifted in FY 2010. The CDC notified its funded partners that its funds may not be used to support syringe exchange. OA relies on Federal funds for all HIV prevention and care programs funded by OA, including SSPs.

Definition of Fundable Activities

SSPs are defined by the CDC and OA as including: 1) SEPs; 2) support for nonprescription sale of syringes (NPSS) in pharmacies; 3) sharps disposal for IDUs; and 4) policy work related to access to sterile syringes.

Pursuant to the changes in Federal law, OA and its LHJ partners may not fund syringe exchange with Federal HIV monies. LHJs may, however, use any non-federal funds that are available to support syringe exchange.

Additionally, LHJs may use Prevention contract funds to support the other SSP activities listed above. For example, LHJs may use their OA HIV prevention funds to:

1) Support local NPSS in pharmacies

This may take the form of working to increase the number of pharmacies providing NPSS and/or encouraging IDUs to purchase sterile equipment in pharmacies which provide NPSS. Alternately or additionally, LHJs may provide educational literature or training about recent changes in pharmacy practice to law enforcement, pharmacy staff, IDUs and health and social service professionals who work with IDUs. Educational materials for pharmacists have been updated and are available at http://cdph.ca.gov/SyringeAccess. The same page includes a Patient Information Sheet that can be customized with local referrals.

2) Support efforts to increase proper syringe disposal among IDUs

These efforts may include, but not be limited to providing personal sharps containers to IDUs, either through pharmacies, SEPs or other programs which serve IDUs; establishing and servicing sharps disposal kiosks in areas frequented by IDUs; or funding the sharps disposal costs for SEPs and other agencies which serve IDUs.

3) Support policy work necessary to facilitate structural change to expand access to sterile syringes and/or improve sharps disposal among IDUs, as long as the work does not include efforts to influence local ordinances.

Non-Fundable Activities	The U.S. Department of Health and Human Services has notified its funded partners that its funds may not be used to 1) purchase needles and syringes; 2) fund staff time used specifically to distribute needles or syringes; and/or 3) pay for delivery modes such vehicles or rent for fixed sites used specifically for distributing needles and syringes. Additionally, these funds may not be used for any activity designed to influence legislative change at the local, State, or Federal level.
Monitoring and Evaluation	LHJs should include information about their SSP-related activities in their bi-annual progress reports to OA.
TA Contact	Alessandra Ross, IDU Specialist, (916) 449-5796 or alessandra.ross@cdph.ca.gov. Web page: http://cdph.ca.gov/CAsyringeaccess.

Health Care Reform Planning

The Affordable Care Act (ACA) provides greater health security by putting in place comprehensive health insurance reforms. OA is considering the HIV-specific issues associated with the ACA and requires involvement from funded LHJs in the form of a Tier I activity.

Definition of Fundable Activities

OA asks each funded LHJ to dedicate a proportion of a specific position to health care reform activities. The percentage of time spent and duties for each local health care reform staff person will be determined by each LHJ and will vary depending on local policies and resources. Some suggested activities are:

- Participate in health care reform-related meetings and webinars, in particular those that impact HIV prevention such as routinizing and coverage of HIV testing;
- Monitor relevant websites, such as the "Obamacare & You" web portal explaining the ACA for people with HIV, as well as HIV Health Care Reform and Healthcare.gov.
- Conduct an inventory of health care reform activities in the LHJ;
- Develop HIV prevention (both LHJ and community-based organizations) collaborations with health clinics, hospitals and insurance providers;
- Collaborate with Ryan White Providers to ensure clients moved to other health care programs continue to have access to HIV specialty care; and
- Determine TA and training needs.

Additional Requirements

The health care reform lead staff position may or may not be from within the LHJ's HIV/AIDS program; however, if he or she is not, a strong partnership should be maintained between the health care reform staff lead and the local HIV/AIDS program.

Monitoring and Evaluation

LHJs should include information about their health care reform-related activities in their bi-annual progress reports to OA.

TA Contact

Maria Sevilla, Health Care Reform Specialist, (916) 449-5790 or maria.sevill@cdph.ca.gov.

Condom Distribution

In response to the NHAS, the California AIDS Clearinghouse's (CAC) condom distribution program specifically targets HIV-positive people and those at highest risk of acquiring HIV infection in the CPA. The program is a partnership with local venues (e.g., community-based organizations, community health centers/clinics, LGBT centers, bars, dance clubs, sex clubs, bathhouses, local business partners, etc.) to distribute free condoms to their respective target populations.

Definition of Fundable Activities

Each of the OA-funded LHJs in the CPA will use their unique local knowledge and resources to identify venues in their jurisdiction that serve HIV-positive people and those at highest risk of acquiring HIV infection in communities where HIV/AIDS is most prevalent. OA provides LHJs with an HIV/AIDS Cases by ZIP Code map for planning purposes.

Each LHJ is required to recruit and maintain a set minimum number of venues in the condom distribution program. The suggested numbers (shown in the table below) are based on the number of documented living adult (13 years of age and older) HIV/AIDS cases in each LHJ. LHJs are encouraged to seek and enroll appropriate venues serving priority target populations throughout the contract period. It is more important to enroll venues that explicitly serve the priority target populations than to achieve the set minimum number of venues quickly.

Minimum Number of Condom Distribution Venues, based on 2008-2010 Living Adult HIV/AIDS Cases	
0 – 150 HIV+ people	10 Venues
151 – 300 HIV+ people	12 Venues
301 – 600 HIV+ people	14 Venues
601 – 900 HIV+ people	16 Venues
≥901 HIV+ people	20 Venues

In order for a venue to be eligible for participation in the condom distribution program, they must: 1) provide their services in a ZIP code that has identified HIV/AIDS cases; and 2) specifically serve one or more of OA's priority populations (see Appendix B).

It's important to note that youth are not considered at high risk for HIV infection unless they specifically fall into one or more of OA's priority population categories. If a venue's clientele is made up mostly of youth who are not part of the priority populations the venue is not eligible for participation in the program. Those venues should be able to find free condoms for their clients at: www.teensource.org/ts/condoms/free or at www.condomfinder.org.

Once the LHJ has recruited a venue, the LHJ must fill out the *Participating Venue Information* (PVI) form (available at CACOrders@cdph.ca.gov) for each participating venue, keep a copy and send a copy to OA via e-mail at CACOrders@cdph.ca.gov or FAX at (916) 449-5800. OA staff will review the

PVI form to ensure eligibility and register the venue into the program. Once registered, a condom order sheet will be e-mailed to the venue's contact, copying the LHJ's contact.

Participating venues can choose from two male condoms (lubricated latex and large-size lubricated latex), the FC2 female condom, and personal lubricant packets. The condom order sheet provides directions for filling it out. Participating venues can place their orders by e-mailing the order sheet to CACOrders@cdph.ca.gov, or faxing it to (916) 449-5800. The venues are asked to place their orders on an "as-needed" basis.

There currently is no limit to how many eligible venues each LHJ can have participating in the program.

LHJs are encouraged to maintain collaborative relationships with their venues in order to provide their patrons additional services (e.g. HIV testing, HIV/AIDS/STD information, Partner Services, risk-reduction counseling, etc.).

Non-Fundable Activities

Since the condom distribution program is venue-based, condom orders cannot be placed by an LHJ for distribution at a one-time event unless the event specifically targets one or more of OA's priority populations (e.g. Gay Pride Festival, etc.).

Additional Requirements

OA will conduct evaluations of the condom-order data to generate bi-annual reports on condom distribution numbers that will be shared with each LHJ to assist in identifying where they might be able to expand their venue recruiting for condom distribution.

Monitoring and Evaluation

LHJs should include information about their condom distribution plans in their bi-annual progress reports.

TA Contact

CACOrders@cdph.ca.gov.

Tier II Activities

A maximum of 25% of OA prevention funding may be used to provide Tier II activities.

Hepatitis C Testing

OA funding may be used to offer Hepatitis C virus (HCV) antibody testing (herein referred to as "HCV testing") to clients identified by the assessment process to be at risk for HCV. HCV testing may be offered with or without HIV testing, as appropriate. Although HCV testing is a Tier II activity, LHJs may choose this activity prior to completion of all Tier I activities.

Guidance for rapid HCV testing that includes policies and protocols, training requirements, State and Federal legal requirements and Quality Assurance guidelines is on the OA website at http://cdph.ca.gov/HCVtest.

Definition of Fundable Activities

HCV testing services include assessment of client risk, testing and results disclosure, and referral to additional services. Services may also include client-focused prevention counseling and risk-reduction planning. OA funds may be used for HCV laboratory tests, HCV rapid tests, and Home Access test kits, as well as staff.

H&S Code 120917 requires that HCV testing clients be given the following information:

- A reactive test result means that the client has had HCV infection in the past and may or may not have HCV infection now; and
- Additional testing is needed to know if the client has HCV infection now.

The law also requires that:

- Clients with a reactive HCV antibody test result must be referred to a licensed health care provider whose scope of practice includes the authority to refer patients for laboratory testing for further evaluation.

Detailed guidance on these and other requirements for HCV antibody testing is available at: http://cdph.ca.gov/HCVtest.

For more information on H&S Code 120917 see:
http://www.cdph.ca.gov/programs/aids/Documents/AB1382StakeholderLetter.pdf

Personnel Requirements

California Business and Professions (B&P) Code 1206.5 allows certain medical personnel to perform CLIA-waived HIV and HCV tests. Some examples of personnel authorized by B&P Code 1206.5 to conduct CLIA-waived testing include licensed physicians, physician assistants, registered nurses and licensed vocational nurses.

As of January 1, 2012, H&S Code 120917 allows non-medical personnel that have been trained as HIV test counselors to perform CLIA-waived HCV tests if

they:

1. Have been trained in HIV test counseling by OA or its agents;
2. Work in a HIV testing site that is funded by OA or that uses staff trained by OA or its agents **and** has a QA plan approved by the local health department **and** has HIV testing staff that complies with state regulatory QA requirements.[4]
3. Have been trained by OA or its agents in both HIV and HCV test kit proficiency for finger-stick blood tests and in universal infection control precautions, consistent with best infection control practices.

Training to be an HIV test counselor comprises successful completion of the OA BCST, which will include proficiency in HCV rapid testing beginning in March 2014. Staff not currently trained as HIV test counselors who wish to provide rapid HCV testing should contact the OA Training Coordinator in order to enroll in a BCST provided by an OA training agent. (See TA Contact below for information on how to enroll in the OA BCST.) Medical personnel listed in B&P Code 1206.5 do not need to complete this training.

HIV test counselors who completed the OA BCST prior to the inclusion of HCV rapid testing proficiency in the curriculum must be trained by OA or its agents in HCV rapid testing proficiency in order to be in compliance with H&S Code 120917.

For existing HIV test counselors who wish to perform CLIA-waived HCV testing in addition to HIV testing, training by OA or its agents comprises:

1. Successful completion of the Integrated HCV/HIV Counseling Training, which is available online from OA training agents at the Alliance Health Project; and
2. Proficiency training provided by OA-trained HIV/HCV testing site supervisors.[5]

OA training agents will provide HCV rapid test proficiency training for site supervisors: see TA Contact to schedule training.

Monitoring and Evaluation

HCV test information will be collected on the CIF and entered into LEO. The *Quality Assurance Guidelines for OraQuick HCV Antibody Testing in Non-Health Care Settings* is available on the OA website at: http://cdph.ca.gov/HCVtest.

[4] Title 17 CCR 1230. For more information on California regulations, visit the website of the California Office of Administrative Law at http://www.oal.ca.gov/.

[5] Title 17 CCR Section 1036.3(a) requires that HIV testing site supervisors have a Baccalaureate Degree; be an HIV test counselor (H&S 120917) or other healthcare professional allowed to perform CLIA-waived HIV testing (B&P Code 1206.5); and, if not a medical professional listed in B&P Code 1206.5, meet the training qualifications for HIV testing personnel in nonmedical settings. More information on the training qualifications for HIV testing sites supervisors is available in the *OraQuick HCV Antibody Testing Quality Assurance Guidelines for Non-Healthcare Settings*.

TA Contact

For more information about HCV training, contact Karin Hill, OA Training Coordinator, (916) 319-9461 or karen.hill@cdph.ca.gov.

For questions about the HCV rapid testing guidelines outlined here, contact Rachel McLean, Viral Hepatitis Coordinator, (510) 620-3403 or rachel.mclean@cdph.ca.gov

Behavioral Interventions for High-Risk HIV-Negative Persons

Behavioral interventions for high-risk HIV-negative individuals are a recommended, not required component of the CDC Prevention Grant and are an OA Tier II optional activity.

Definition of Fundable Activities

LHJs may provide high-risk HIV-negative populations with evidence-based HIV behavioral interventions to reduce the rate of new HIV infection within the identified high-risk target populations. (See Appendix B for a list of OA's priority populations; and Appendix C - Evidence-based Interventions for more details about selecting interventions.) All core elements of selected interventions should be adhered to and interventions should be delivered with fidelity.

For greatest effectiveness, LHJs which elect to provide or fund these services must target interventions specifically and use epidemiological data to select the highest risk populations in their LHJ. OA priority high-risk negative populations are:

- Gay men and other MSM, with an emphasis on African American and Latino men;
- Transgender individuals, with an emphasis on African Americans and Latinos;
- IDUs;
- Sexual and needle-sharing partners of HIV-positive individuals; and
- Women at high risk of acquiring HIV via their sexual partners, injection drug use, and/or sex work.

Intervention providers must screen potential participants prior to starting the intervention to ensure participants are part of intended target population, and divert lower risk and non-target population individuals to alternative resources. Documentation of risk is done through completion of the appropriate LEO forms, and the Intervention Progress Report tracks services provided to targeted populations as well as those who do not fit the target population definitions. LHJs should routinely monitor this report to ensure that services are being provided to the intended target populations.

Non-Fundable Activities

OA funds should not be used to support interventions for low-risk HIV-negative individuals. LEO data from FY 2011-2012 indicate that while MSM represent 73 percent of the California epidemic, only 25% percent of all HE/RR prevention encounters were provided to MSM. At the same time, one out of five prevention encounters were provided to people who report "other risk" or "low-risk" behaviors.

Monitoring and Evaluation	All OA-funded behavioral interventions should be recorded in LEO. LEO has the ability to add additional fields to measure additional elements. It can often accommodate additional monitoring and evaluation requirements of evidence-based interventions. The OA Intervention Specialist can assist in using LEO special fields to record additional data.
TA Contact	Kevin Sitter, Intervention Specialist, (916) 449-5814 or kevin.sitter@cdph.ca.gov.

Social Marketing, Media, and Mobilization

The goal of *Social Marketing, Media and Mobilization* activities under the OA Prevention Grant to LHJs is to improve linkage to and retention in care, promote medication adherence and promote care as prevention.

Definition of Fundable Activities

OA has chosen health messages for social marketing activities, media, and mobilization activities which include the following:

- Benefits of early detection of HIV infection;
- Need for routine and regular HIV health care;
- Benefits of ARV therapy for the health of people living with HIV;
- Role of suppressed viral load in reducing HIV transmission;
- Benefits of integrated screening for HIV, TB, STDs, and hepatitis;
- Value of initial and ongoing PS;
- Information about community viral load; and
- Emerging messages from the CDC or OA.

These messages must target HIV-positive people, or priority populations defined by OA (see Appendix B) and identified through local epidemiology. Several CDC social marketing campaigns that have been demonstrated effective are available that convey some of these health messages. LHJs are encouraged to use these campaigns rather than develop new campaigns. These campaigns can be found at: http://www.cdph.ca.gov/programs/aids/Pages/OACAC.aspx, http://www.cdc.gov/actagainstaids/ and http://www.cdcnpin.org/CRP/Public/search.aspx, among others.

LHJs that conduct these activities must submit a plan to OA which includes a definition of the health issue being addressed and the rationale for its selection. The plan should describe both the health messages as well as the formative work planned to ensure program review panel approval of the campaign. Monitoring and evaluation activities must also be included in the plan. A summary of the LHJ's search for pre-existing material and justification for creating any new material must be submitted prior to commencing any social marketing, media or mobilization activities. No social marketing, media, and mobilization activities can begin until after the submitted plan has been approval by OA.

Monitoring and Evaluation

Social Marketing, media and mobilization activities must be documented in LEO and described in bi-annual progress reports submitted to OA, as well as entered into the LEO system.

TA Contact

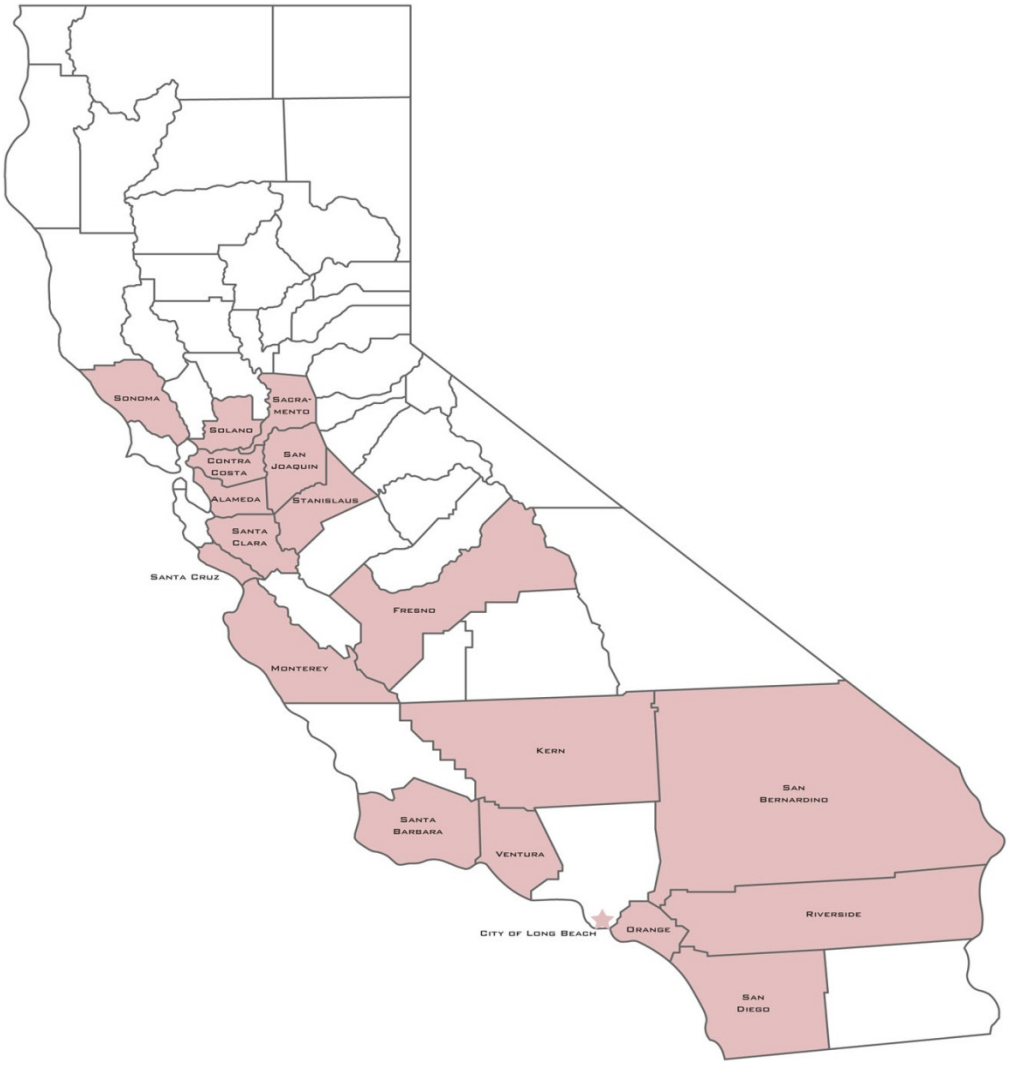
Kevin Sitter, Intervention Specialist, (916) 449-5814 or kevin.sitter@ cdph.ca.gov.

Appendix A - OA Prevention-Funded LHJs

There are 18 funded LHJs within the CPA:

Alameda	Riverside	Santa Clara
Contra Costa	Sacramento	Santa Cruz
Fresno	San Bernardino	Solano
Kern	San Diego	Sonoma
Monterey	San Joaquin	Stanislaus
Orange	Santa Barbara	Ventura

By agreement with Los Angeles and Long Beach, the City of Long Beach will also participate in the CPA, but the funding is from the CDC's award to the Los Angeles MSA.



Appendix B - OA Priority Populations

The NHAS, the CDC and the OA Prevention Grant to LHJs all place greater emphasis than previously on PWP, and on effectively targeting activities to populations at highest risk. Most Tier I activities are targeted to people living with HIV and their sexual and needle-sharing partners.

OA's list of priority populations is based on epidemiological and surveillance trends in HIV infection rates among Californians. OA priority populations include both people living with HIV and those at highest risk of acquiring HIV. The priority populations are:

- HIV-positive individuals;
- Gay men and MSM, with an emphasis on African American and Latino men;
- Transgender individuals, with an emphasis on African Americans and Latinos;
- IDUs;
- Sexual and needle-sharing partners of HIV-positive individuals;
- Women at high risk of acquiring HIV via their sexual partners, injection drug use, and/or sex work.

Targeting Services towards Adolescents

Adolescents in general are not an OA priority population and OA funds should not be used to target interventions to this population. Young people within the OA priority populations listed above may be targeted for prevention services. The California Department of Education (CDE) is responsible for school-based HIV prevention and has funds to support school-based HIV prevention. CDE's website addressing health education is: http://www.cde.ca.gov/ls/he/se/.

Targeting Services towards People in Substance Use Disorder Treatment Centers

Provision of services for IDUs and MSM who use drugs and alcohol and who are not enrolled in substance disorder treatment programs is an appropriate use of OA funds. However, because other funds are available to do so, OA funding should not be used to provide HIV testing and other prevention services in alcohol and drug treatment programs. LHJs should work with their local drug and alcohol program to assess and coordinate the funding of activities.

DHCS is responsible for providing HIV care and prevention for individuals in substance use treatment programs. DHCS provides funds through the HIV Set-Aside portion of SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant for testing in treatment centers and also in vans as long as testing is conducted at the treatment center. In addition, HIV Set-Aside funds can be used for medical care for people living with HIV while receiving drug treatment, and for outreach to out-of-treatment IDUs. They can also be used for testing for HCV and for sexually transmitted infection for people who are receiving substance use disorder treatment services. More information can be found here: http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_13-03.pdf.

Appendix C - Evidence-Based Interventions

The selection of a set of interventions for each target population should be based on local epidemiology, intervention effectiveness, and cultural/ethnic appropriateness necessary to reduce HIV transmission, increase access to care and improve health outcomes for people living with HIV, and reduce HIV-related health disparities in the prioritized populations. Tier I interventions must be delivered before selecting and delivering Tier II activities, with the exception of HCV testing.

Approved behavioral interventions can be found in the table below. More specific information and request for training on the interventions can be found at: www.effectiveinterventions.org .

CDC Supported EBIs by population

- **PLWH**
  - CLEAR
  - Healthy Relationships
  - Partnership for Health
  - WILLOW
- **Adapted for PLWH**
  - CONNECT
  - START
- **IDU**
  - PROMISE
- **Women**
  - PROMISE
  - Sister to Sister
- **MSM**
  - d-up!
  - Mpowerment
  - 3MV
  - POL
  - PCC
  - PROMISE
  - VOICES/VOCES
- **General**
  - Safe in the City
  - RESPECT
- **High-risk youth**
  - PROMISE

Medication Adherence interventions include Project Heart, Partnership for Health, Peer Support, Text Messaging and SMART Couples. More information can be found on the CDC Effective Interventions website.

While use of CDC supported EBIs is strongly encouraged, if a locally developed intervention is selected, the LHJ must submit documentation of its effectiveness by citing the behavioral theory the intervention was based on. In addition, goals of the intervention, curriculum for each session, and the evaluation tools used by the intervention must be submitted. Written approval by OA is required before locally developed interventions may be implemented.

If an evidence-based intervention is adapted, LHJs must maintain all core elements of the intervention. Adaptations must be discussed with one of OA's Intervention Specialists prior to implementation.

Training and Staff

Staff who will implement the intervention should be trained in the specific intervention prior to implementation. If specific training is not available, staff is expected to have sufficient skills to implement the intervention, such as conducting risk assessments, taking sexual histories, facilitating groups, and developing individualized behavioral treatment plans.

OA supports implementation of the following HE/RR interventions for HIV-positive people and if selected, high-risk negative populations:

- Limited targeted prevention activities, with the goal of referring high-risk negative people to HIV testing and linking or re-engaging out-of-care HIV-positive persons to HIV medical care;
- Individual level interventions;
- Group level interventions;
- PS; and
- Limited, pre-approved health communication/public information programs.

Appendix D - Registering Applicants for the Basic Counseling Skills Training (BCST)

LHJ HIV testing coordinators may register an applicant for the BCST through the UCSF/AHP website at www.ucsf-ahp.org. The applicant will be sent an e-mail with the link to the pre-BCST training learning packet (which is in portable document format) and instructions for taking the online pre-training quiz; the questions are based upon the material in the learning packet.

Note: *Participants in the BCST are required to read the pre-training learning packet and pass the BCST online quiz prior to attending the training. Successful completion of the online quiz is a prerequisite to being scheduled into a BCST.*

Once the applicant has been signed up to receive the pre-training learning packet and completed the online pre-training quiz, the LHJ HIV testing coordinator may then begin the rest of the process of registering the applicant for the BCST. The three-day BCST must be completed within 60 days of being employed as, or volunteering as, an HIV test counselor. Before an HIV test counselor can provide single session counseling, they must complete the OA-approved training.

There are a limited number of trainings and spaces (16) in each BCST class and participants will be registered in the order in which complete applications (including passing quiz results) are received. Please submit completed applications for the training as early as possible (and at least 30 days in advance of the training). Applications received less than 30 days prior to the training may be too late to be considered for that training.

OA strongly encourages supervisors to be active participants in their new counselors' orientation process through providing individual supervision, observing counseling sessions (with client consent), having new counselors "shadow" experienced HIV counselors and offering additional training.

Appendix E - Acronyms

ACA	Affordable Care Act
AHP	Alliance Health Project
AIDS	Acquired Immune Deficiency Syndrome
ARIES	AIDS Regional Information and Evaluation System
ARV	Antiretroviral
ATS	Alternative Test Site
BCST	Basic Counselor Skills Training
CAC	California AIDS Clearinghouse
CDC	Centers for Disease Control and Prevention
CDE	California Department of Education
CDPH	California Department of Public Health
CIF	Client Information Form
CLIA	Clinical Laboratory Improvement Act
CPA	California Project Area
DHCS	California Department of Health Care Services
DIS	Disease Intervention Specialist
FDA	U.S. Food and Drug Administration
FTE	Full-Time Equivalent
EIIHA	Early Identification of Individuals with HIV and AIDS
HCV	Hepatitis C Virus
HE/RR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IDU	Injection Drug User
LEO	Local Evaluation Online
LHJ	Local Health Jurisdiction

LIG	Local Implementation Group
LTC	Linkage to Care
MSA	Metropolitan Statistical Area
MSM	Men who have Sex with Men
NHAS	National HIV/AIDS Strategy
NPSS	Nonprescription Sale of Syringes
OA	Office of AIDS
PIF	Partner Information Form
PrEP	Pre-Exposure Prophylaxis
PS	Partner Services
PVI	Participating Venue Information Form
PWP	Prevention with Positives
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SEP	Syringe Exchange Program
SSP	Syringe Services Program
STD	Sexually Transmitted Disease
TA	Technical Assistance
TB	Tuberculosis
UCSF	University of California San Francisco
VMV	Verified Medical Visit

Appendix F - Assessment Tools for Use in PWP Interventions

OA has selected two risk assessment tools that all LHJs conducting *HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings* should use to assess clients' need for mental health or substance use disorder services, their risk of transmitting HIV, and/or their risk of acquiring other STDs. Both tools should be administered to clients prior to referral to services and behavioral interventions. Results of the assessment should be entered into OA databases within one week of the date of service.

The Substance Abuse and Mental Illness Symptoms Screener (SAMISS)
This brief assessment tool assesses for mental illness and substance use disorders, both of which are known drivers of the epidemic. The SAMISS was developed explicitly for screening people living with HIV/AIDS. It was tested and validated within HIV health care settings and can be completed by the client or administered by the staff working with the client. No special training is required to administer the SAMISS. After the SAMISS is completed, staff can enter the results into ARIES and be provided an immediate interpretation and recommendation if referrals are needed. If you do not have access to ARIES, the tool can quickly be scored using the SAMISS Key. Please record the results of the SAMISS in the "Administration Use Only" section, page 4 of the GSAQ.

The Group Self-Administered Questionnaire (GSAQ)
This assessment tool identifies possible sexual and substance use behavioral risks. The GSAQ can be completed by the client or administered by the staff working with the client. No special training is needed to administer the GSAQ.

The first three pages of the GSAQ should be completed by client or staff and client, and the "Administrative Use Only" portion on page 4 should be completed by staff. Note the risk reduction/behavioral outcome questions at the bottom of page 4 can be used for comparison over time. The survey can be administered without client identifying information. The Agency Client number in the "Administrative Use Only" section on page 1 should not include client identifying information.

The following responses would indicate referral(s) to service(s) and/or a behavioral intervention is warranted:

- Reporting vaginal and/or anal sex without using a condom with a partner/partners of HIV-negative or HIV-unknown status;
- Reporting drinking more than 4 alcoholic drinks on a typical day of drinking;
- Reporting use of stimulants or poppers;
- Having shared a needle in the last 12 months;
- Reporting a sexually transmitted infection (STI) in the last 12 months;
- Reporting not being in medical care or not having seen an HIV provider in more than a year;
- Missing two or more days of HIV medication in the last 3 days;
- Requesting assistance in informing partners about their HIV status; or
- Being a pregnant female not in prenatal care.

Appendix G – Capacity Building Assistance and Technical Assistance

OA Resources

Several program specialists at OA are available to provide you with technical assistance and connect you to further resources.

Injection Drug Using Target Population, Syringe Services Programs	Alessandra Ross Alessandra.Ross@cdph.ca.gov 916-449-5796
Partner Services	Manny Rois Manny.Rios@cdph.ca.gov 916-449-5824
Comprehensive Prevention with Positives, Re-engagement in Care	Carol Crump Carol.Crump@cdph.ca.gov 916-449-5965
Routine Opt-Out Testing in Medical Settings	Jenny Olson Jennnifer.Olson@cdph.ca.gov 916- 449-5940 Clark Marshall Clark.Marshall@cdph.ca.gov 650-6752
Linkage to Care, Comprehensive Prevention with Positives	Dennese Neal Dennese.Neal@cdph.ca.gov 916-440-7744
HIV Test Counselor Training	Karin Hill Karin.Hill@cdph.ca.gov 916-319-9461
Use of Surveillance Data in High-Impact HIV Prevention Programming	Kama Brockmann Kama.Brockmann@cdph.ca.gov 916-449-5964
Comprehensive Prevention with Positives, HE/RR Interventions, Social Marketing	Kevin Sitter Kevin.Sitter@cdph.ca.gov 916-449-5814
Targeted Testing	Matthew Willis Matthew.Willis@cdph.ca.gov 916-449-5797

CDC Resources

To view a list of CDC-funded CBA providers who can provide trainings and technical assistance at no charge, as well as a schedule of upcoming trainings, refer to the CDC website at http://www.cdc.gov/hiv/dhap/cbb/providers.html. To request capacity building assistance (CBA) and technical assistance from CDC funded CBA providers, contact Kevin.Sitter@cdph.ca.gov .