

**Office of AIDS
HIV Prevention Program
Budget Guidance for
July – December 2013
Cooperative Agreement
Contract**

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

A. Base Funding

This budget guidance is for the local health jurisdictions' (LHJs) HIV Prevention Cooperative Agreement Contract that will begin July 1, 2013 and end December 31, 2013.

Base funding allocations are determined via a formula that uses the percentage of people living with HIV/AIDS (PLWH/A) excluding prison cases. Percentages of African Americans, Hispanics, and people living below poverty are also part of the formula. The weight of the criteria is as follows:

- 75% Percentage of PLWH/A, excluding prison cases (2009 Surveillance data);
- 15% Percentage of African Americans (2010 Census Data);
- 5% Percentage of Hispanics (2010 Census Data); and
- 5% Percentage of people living below poverty (2010 Census Data).

B. Partner Services (PS) Funding

The California Department of Public Health, Center for Infectious Diseases, Office of AIDS (OA) will continue to allocate the Centers for Disease Control and Prevention (CDC) funding directly to LHJs to support PS activities using a tiered approach that is based on an LHJ's capacity to deliver PS.

[Click here](#) for detailed information regarding the HIV Prevention Program allocations. Please refer to the *Total Allocation* column for funding amounts. The *Total Allocation* column includes base funding and PS funding.

II. HIV PREVENTION PROGRAM

A. Required Services to be Performed

Services must be consistent with the California HIV Prevention Program funded by CDC's PS12-1201 grant. In response to the National HIV/AIDS Strategy and CDC's PS12-1201 grant, OA aims to support the development and implementation of comprehensive, high impact prevention strategies for HIV-positive individuals and their partners, and high-risk negative populations, as defined in OA's program guidance, [Information for Program Planning](#) (IPP).

All LHJs funded by OA's prevention cooperative agreement contract must meet monitoring and evaluation requirements set by OA and must provide these core services:

- a. Targeted HIV testing to prioritized high-risk populations;
- b. Linkage-to-care (LTC) services for all newly diagnosed HIV-positive individuals; and
- c. Partner Services.

Additionally LHJs must:

- a. Maintain an alternative test site (ATS). ATS testing must be anonymous and provided for free;
- b. Assign a staff member to attend to health care reform issues, for a proportion of time to be determined by the LHJ; and
- c. Meet the subsidiary requirements that support HIV testing, PS, and LTC services. In response to CDC's PS12-1201, OA has designated that these core services be delivered together.

B. California HIV Prevention Program Priority High-Risk Populations:

- a. HIV-positive individuals and their partners;
- b. Men who have sex with men (MSM), including MSM/Injection Drug Users (IDU) with strong emphasis on African-American and Latino MSM;
- c. IDUs;
- d. Transgender Individuals; and
- e. High-risk negative individuals with sexual and/or injection-sharing HIV-positive or MSM partners.

C. California's Two-Tiered System

The California HIV Prevention Program divides prevention services into a two-tiered structure. Activities are prioritized according to both the National HIV/AIDS Strategy and CDC's approach to HIV prevention. The tiers represent OA's priorities in HIV prevention, and correspond closely to the required and recommended services identified in the CDC PS12-1201 grant.

Funded LHJs are required to provide the three core activities of HIV testing (with or without counseling), LTC and PS. LHJs may also elect to implement one or more of the other Tier I activities. The California HIV Prevention Program stipulates that LHJs must ensure that activities designated as Tier I are adequately provided, using any resources available to the LHJ, before using OA prevention funding for Tier II activities (with the exception of Hepatitis C virus [HCV] testing).

Tier I activities include services and initiatives related to HIV testing (with or without counseling); LTC; PS; retention and re-engagement into care; risk assessment, linkage to services and behavioral interventions for HIV-positive individuals/prevention with positives (PWP) interventions; HIV medication treatment adherence; allowable syringe services; integrated HIV, hepatitis, tuberculosis (TB), and sexually transmitted diseases (STD) screening for HIV-positive persons; condom distribution, and health care reform.

Tier II activities include HCV testing; behavioral interventions targeting high-risk HIV-negative individuals; social marketing, media and mobilization; and incorporation of STDs, TB, and HCV screening into HIV testing programs.

All required and allowable service activities are outlined in detail under the HIV Prevention Program Allowable Services, Section IV.

III. REQUIRED DOCUMENTS

In order to prepare for the HIV Prevention Program cooperative agreement contract, OA needs budget documents for the time period of July 1, 2013 through December 31, 2013 from your LHJ. Each LHJ must submit the documents listed below in this section.

*The following budget documents are [available here](#) as a Microsoft Excel file. Budgets must be prepared using this file. Please note: the Excel file has multiple tabs. Additionally, the budget documents all have formulas built in and shaded green; therefore, please **do not delete the formulas** when you are entering information. The formulas automatically do the required computations. Budget documents include:*

- Document Checklist.
- LHJ Contact Information.
- HIV Prevention Program Five-Line Budget for July 1, 2013 – December 31, 2013.
- HIV Prevention Program Budget Detail for July 1, 2013 – December 31, 2013.
- HIV Prevention Program LHJ's Personnel Detail for July 1, 2013 – December 31, 2013.
- HIV Prevention Program Subcontractor Budget Detail for July 1, 2013 – December 31, 2013 *(if applicable)*.
- HIV Prevention Program Subcontractor Personnel Detail for July 1, 2013 – December 31, 2013 *(if applicable)*.
- HIV Prevention Program Service Category Summary for July 1, 2013 – December 31, 2013.

HIV Prevention Program LHJ Contact Information

This form asks you to identify the HIV Prevention Program AIDS Director, HIV Prevention Program Coordinator(s), and the HIV Prevention Program Fiscal Contact. OA uses this information to keep our records up to date so please complete the information for each position and notify us if you have changes. For the HIV Prevention Program Coordinator, please list the individual that our office will work with on a day-to-day basis. The LHJ's Data Universal Numbering Systems (DUNS) number is also required on this page.

HIV Prevention Program Five-Line Budget

In order to prepare the HIV Prevention cooperative agreement contract, OA needs budget information for the five line-item budget. Indirect Expenses are limited to 15 percent of the total Personnel Costs for the contractor.

HIV Prevention Program Budget Detail Form

This form requests detailed information to support the five line-item budget. As with the five line-item budget, the detailed budget includes personnel costs, operating expenses, capital expenditures, other costs, and indirect costs. For personnel benefits, LHJs must indicate a

percent that is the same for all employees. The total in your detailed budget must equal the total in your five line-item budget. OA requests more detail in Operating Expenses, including a brief description of each expense.

HIV Prevention Program Personnel Detail Form

This form identifies the LHJ personnel charged to the HIV Prevention Program cooperative agreement contract. The total in the detailed personnel page(s) must match the amount entered in the total personnel line of the HIV Prevention five line-item budget and the detailed budget. Please include in the description of duties the staff member that will be overseeing the responsibilities of Health Care Reform activities and the full-time equivalent (FTE) associated with these duties.

HIV Prevention Program Subcontractor Budget Detail Form

This form is required for *each* subcontractor and/or consultant funded by the HIV Prevention Program cooperative agreement. It is the same format as the HIV Prevention Program budget detail form but displays the subcontractor costs instead of the LHJs costs. Indirect Expenses are limited to 15 percent of the total Personnel Costs for each subcontractor and the percent applied to benefits must be the same for all employees. Additionally, each subcontractor is required to provide a DUNS number on the *HIV Prevention Program Subcontractor Budget Detail* page.

Sections 1 and 2 must be completed. Section 1 includes subcontractor information. Section 2 includes personnel costs, operating expenses, capital expenditures, other costs (i.e., subcontractor's contract with other community-based organizations) and indirect costs for the subcontractor.

HIV Prevention Program Subcontractor Personnel Detail Form

This form is required for *each* subcontractor and/or consultant funded by the HIV Prevention Program cooperative agreement. This form follows the same format as the HIV Prevention Program personnel detail form, but includes the subcontractor(s) personnel instead of the LHJs personnel.

HIV Prevention Program Service Category Summary

The service category summary form includes direct service costs, non-client service costs and administrative costs. As you complete the Program Service Category Summary tables, **please incorporate direct service costs, non-client service costs and administrative costs into the budget amounts for each category.** Each of these is described below. By incorporating direct service costs, non-client service costs and administrative costs, you will be able to account for your total award amount. **Only include your OA Prevention Grant funding.** Do not include budgeted amounts from other sources such as from Ryan White or county funding.

Section 1 is a summary of services that the health department will provide. For each direct service activity, provide the estimated number of clients to be served for each service category and the budgeted amount for each of these services. HIV testing should not only include HIV testing activities, but should also include LTC activities. Health Education/Risk Reduction (HE/RR) should include the activities that you are planning to do in your LHJ related to prevention with positives and high-risk negative

activities, retention/re-engagement in care, treatment adherence, and social marketing activities. As stated above, there is a section to record non-client service costs and administrative costs. Examples of non-client service costs may include health care reform and STD/HIV integration. Administrative costs may include personnel costs not related to interventions, relevant operating expenses, and indirect costs. These categories are described in detail below.

Section 2 is a summary of services provided by each of your subcontractors. Complete one table for each of your subcontractors; including a list of the direct services they will provide, the estimated number of clients to be served and budgeted amount the subcontractor will spend on each service activity. The subcontractor's Service Category Summary Form should also include administrative cost and non-client service costs. **The total of budgeted amounts for all your subcontractors in Section 2 should match the amount listed under "Other Costs" in the LHJs budget.**

Section 3 summarizes the combined totals from Section 1 and 2. It contains the total for *all* services and costs related to the cooperative agreement contract. **The total for Section 3 must equal your total allocation.** Your allocation is listed below the Section 3 Total.

IV. DETAILED INFORMATION ABOUT SERVICE ACTIVITY CATEGORIES

HIV Testing

HIV testing (with or without counseling) includes HIV testing activities targeting high-risk individuals in non-health care settings and health care settings. It also includes LTC service costs for newly diagnosed HIV-positive individuals. If you are using Ryan White or other funding sources, do not include that funding in this category. Additionally, if your LHJ receives Category B Expanded Routine opt-out HIV Testing funding, do not include these funds in this category. A separate budget is required for that program. Do not list PS funding in the HIV testing category. All PS activities should be recorded in the distinct PS activity line item, including offers made to both newly diagnosed individuals as well as other HIV-positive individuals.

Partner Services

You must include at least the amount that you have been allocated for PS. If you use additional funding from your OA prevention allocation for PS, include that in the budget amount as well. Do not include funding from sources other than your OA prevention award. The estimated number of clients to be served in PS includes offers made to both newly diagnosed individuals as well as other HIV-positive individuals.

HE/RR Activities

In the HE/RR activity line item, include both Tier I (prevention with positives) and Tier II (prevention with high-risk negative clients) clients to be served and the costs associated with providing HE/RR interventions. Costs may include funding staff to conduct risk assessments as well as staff that provide the evidenced-based intervention or approved locally developed interventions. Do not include funding from non-OA prevention funding sources.

Syringe Services Program Activities

Allowable activities with OA prevention funding include supporting syringe disposal for IDUs, providing support for nonprescription sale of syringes in pharmacies and policy work.

HCV Testing

In the HCV activity line item, include the estimated number of individuals planned to be tested and the associated costs being funded with OA prevention funding, such as staff time and HCV tests.

Non-Client Services

In this line item, include the total budgeted amount of OA prevention funding used for activities such as health care reform planning, STD/HIV integration or activities that work toward prevention and care service integration. The estimated number of clients to be served is not applicable (N/A).

Administrative Costs

This category should include costs such as personnel costs not related to interventions, appropriate operating expense costs, training, and indirect costs. The estimated number of clients to be served is N/A. LHJs and their subcontractors must adhere to the current travel and [per diem requirements](#) and rates established by the State of California. Please note, the current mileage reimbursement rate is not indicated in the per diem requirements document due to a recent update. The new mileage reimbursement rate is .0565.

For questions about completing the budget forms, please contact your assigned Prevention Program Operations Advisor, as noted in Section VI.

IV. HIV PREVENTION PROGRAM REQUIRED AND ALLOWABLE SERVICES FOR THE JULY 1, 2013 THROUGH DECEMBER 31, 2013 COOPERATIVE AGREEMENT CONTRACT

Funded LHJs are required to provide the core activities of HIV testing (with or without counseling), LTC and PS. LHJs may also select to implement one or more of the other Tier I activities. If an LHJ intends to implement any Tier II activities (except HCV testing), LHJs must ensure that all activities designated as Tier I are adequately provided, using any resources available to the LHJ, before using OA prevention funding for Tier II activities. HCV testing can be done even if not all Tier I activities are implemented. Tier I and Tier II activities are listed below.

Tier I Activities	
Targeted High-Risk HIV Testing in Non-Health Care Settings (Core Service)	1) LHJs shall administer HIV testing by providing anonymous and/or confidential HIV testing services (with or without counseling) to individuals at high risk for HIV. Testing services may include: assessment of client needs regarding HIV transmission; client-centered prevention counseling; risk-reduction planning; and referral to other services. LHJs funded for testing in non-health care settings are required to: establish

	<p>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 programs.</p> <ol style="list-style-type: none"> 2) Individuals seeking testing services shall be informed about the validity and accuracy of the antibody test before consent to test is obtained. Written consent is required for testing in non-health care settings; oral consent is required for ATS testing; and oral consent is allowed for testing in health care settings. All individuals tested with OA funds in non-health care settings shall be given the results of their test in person. 3) Funded agencies must ensure all HIV counseling interventions are provided by staff members who have successfully completed the Basic Counselor Skills Training. In addition, test kit operators are required to complete an annual competency assessment test to maintain their certification for testing client samples. 4) All funded LHJs must ensure that all contracted testing sites maintain appropriate documentation. This includes the LHJ's written protocols for the local testing program, signed statements of confidentiality by staff, testing forms, invoices, etc. All documentation must be maintained for three years plus the current year. 5) Written quality assurance plans are required by sites conducting point-of-care rapid HIV tests waived under the federal Clinical Laboratory Improvement Act (CLIA). These plans must be submitted to OA for review by the Testing Specialist for comprehensiveness and compliance with State and Federal requirements. 6) LHJs must increase the number of newly identified HIV-positive tests by at least 0.1 percent annually.
<p>HIV Testing in Health Care Settings (not Category B Expanded Testing)</p>	<ol style="list-style-type: none"> 1) LHJs should work with local health care settings on ways they can implement and increase routine, opt-out HIV testing. These settings may include but are not limited to hospital emergency departments and primary care clinics in community health care settings. 2) Funding for routine, opt-out HIV testing cannot be used to pay for HIV testing staff. 3) This funding can only pay for HIV testing (i.e., test kits and other testing costs) when a patient has no other payer for health care

	services (OA is the payer of last resort).
Linkage To Care (Core Service)	<ol style="list-style-type: none"> 1) All LHJs that receive OA prevention funds are required to provide LTC. 2) LTC is the process of assisting newly HIV-diagnosed persons to enter into medical care. LTC is a core activity required of all OA-funded HIV testing sites in both medical and non-medical settings. 3) LTC is considered to be achieved when a newly diagnosed 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. The standard set by Health Resources and Services Administration (HRSA) is that the newly HIV-diagnosed individual attends an HIV medical appointment within 90 days of diagnosis. 4) HIV testing coordinators must establish policies and procedures describing a system for referring individuals with preliminary and confirmed HIV-positive test results to a medical provider for HIV care. In designing this system, coordinators should include identification of HIV care providers, referrals to medical care, and verification of client's attendance at their first appointment. 5) A variety of different mechanism 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 Local Evaluation Online (LEO) data collection system.
PS (Core Service)	<ol style="list-style-type: none"> 1) All LHJs that receive OA prevention funds are required to provide PS. 2) LHJs must offer PS to all people newly diagnosed as HIV positive, as well as those living with HIV who have participated in recent risky behavior and may have exposed others to HIV. LHJ's should assess PS activities and outcomes, and implement provider outreach programs to enhance PS with key community providers. 3) Every LHJ must maintain a staff member to coordinate the PS activities of that LHJ. If an LHJ has the infrastructure to only provide an offer of PS, collaboration with a Disease Intervention Specialist from the State STD Control Branch must be established and maintained for comprehensive PS activities.

	<p>4) 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. PS allocations may not be used to pay for HIV testing, counseling, or other prevention activities.</p> <p>5) All LHJs shall maintain a comprehensive written PS program plan that provides for routine review of PS staff performance with appropriate standards, PS protocols/quality assurance plans, and the availability of and referral to HIV testing, prevention services, STD screening, HCV testing, and HIV medical care as appropriate.</p> <p>6) Local programs should track the number, type and outcomes of PS activities provided by entering data into LEO and review this data routinely.</p>
<p>Retention and Re-engagement into Care</p>	<p>1) Retention and Re-engagement in Care identifies HIV-positive patients vulnerable to not attending HIV medical appointments routinely as well as out-of-treatment HIV-positive individuals, and works with the HIV-positive individual to stay in or return to HIV medical care.</p> <p>2) LHJ's conducting these services are responsible for determining the most effective approaches for achieving active collaboration between local prevention and care providers to provide retention and re-engagement services. In order to decrease duplication of effort and ensure maximum impact of retention and re-engagement interventions, LHJs that fund or provide Retention and Re-engagement in Care services will demonstrate active collaboration and coordination with Care sites.</p> <p>3) OA's LEO or AIDS Regional Information and Evaluation System (ARIES) should be used to document and record Retention and Re-engagement in Care activities.</p>
<p>Risk Assessment, Linkage to Services, and Behavioral Interventions for HIV-Positive Individuals (PWP Services)</p>	<p>1) The goal of Risk Assessment, Linkage to Services and Behavioral Interventions for HIV-Positive Individuals (PWP Services) 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 people, or develop a referral plan for community-based prevention with positives interventions.</p> <p>2) LHJs which elect to fund or conduct PWP Services will select at least one Ryan White-funded clinic or HIV care provider who can</p>

	<p>initiate behavioral risk screening within their medical setting.</p> <ol style="list-style-type: none"> 3) All sites conducting PWP services will administer the LEO Group Self-Administered Questionnaire (GSAQ) and the Substance Abuse and Mental Illness Symptom Screener (SAMISS) to HIV-positive individuals and enter the results in LEO and ARIES. 4) For LHJs that fund HIV behavioral interventions, selected interventions must be evidence-based and designed for HIV-positive people or HIV-positive people and their sexual/needle sharing partners. 5) If a sites choose to refer clients at risk of transmitting HIV to community-based HIV behavioral interventions, those interventions must also be evidence-based and designed to target HIV-positive or serodiscordant relationships. If other evidence-based interventions are adapted to the population, documentation of the adaptation should be submitted to OA for approval. 6) In addition to HIV behavioral interventions, LHJs providing PWP services must identify and refer to culturally appropriate mental health and substance use services as needed. 7) All staff members who facilitate evidence-based interventions must have completed training in the intervention. Supervisors must monitor and ensure that the intervention is administered with fidelity and follow the curriculum and intervention activities as defined by the intervention. 8) OA’s LEO or ARIES should be used to document and record client assessments and referrals. HIV Behavioral Interventions will be recorded and monitored using LEO system. All evaluation required by evidence-based interventions must be completed and be maintained.
<p>HIV Medication Treatment Adherence</p>	<ol style="list-style-type: none"> 1) HIV Medication Treatment Adherence services support the appropriate and consistent use of antiretroviral (ARV) medicines to maximize their benefits in sustaining health and suppressing viral load. 2) OA will fund HIV medication treatment adherence interventions to any patients living with HIV having difficulty taking ARVs as prescribed. 3) LHJs that elect to fund or provide HIV Medication Treatment Adherence should include collaboration with health care

	<p>providers, medical case managers, and others working with HIV-positive individuals. HIV Medication Treatment Adherence activities should include:</p> <ul style="list-style-type: none"> • Regular screening of HIV-infected individuals to determine whether they are on ARV therapy; • Routine assessment of treatment adherence using the adherence questions listed on the LEO HE/RR form or in ARIES, as well as monitoring of viral load suppression to identify individuals who would benefit from treatment adherence interventions; and • 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, consultation with health care providers or referral to HIV medication treatment adherence services. <p>4) OA prevention funds cannot be used to pay for medications or medical services. Purchasing supplies to assist with medication adherence is an acceptable expense when used within treatment adherence intervention programs.</p> <p>5) OA requires LHJs to use ARIES or LEO to track service utilization by clients referred to treatment adherence interventions.</p>
<p>Syringe Services Programs</p>	<p>1) LHJs may use their OA HIV prevention funds to:</p> <ul style="list-style-type: none"> • Support efforts to increase proper syringe disposal among IDUs. • Support local non-prescription syringe sales in pharmacies: this may take the form of working to increase the number of pharmacies providing non-prescription syringe sales and/or encouraging IDUs to purchase sterile equipment in pharmacies which provide non-prescription syringe sales. 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. • 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 ordinances. <p>2) LHJs may not use their OA HIV prevention funds to:</p>

	<ul style="list-style-type: none"> • purchase needles and syringes; • fund staff time used specifically to distribute needles or syringes; • pay for delivery modes such vehicles or rent for fixed sites used specifically for distributing needles and syringes; and/or • conduct any activity designed to influence legislative change at the Local, State, or Federal level.
<p>Integrated HIV, Hepatitis, Tuberculosis (TB), and STD Screening for HIV-Positive Persons</p>	<ol style="list-style-type: none"> 1) 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: <ul style="list-style-type: none"> • 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; and/or • Supporting client education that increases awareness of clinical laboratory monitoring standards and encouraging clients to talk with their health care providers about exposure or transmission risks of Hepatitis, TB, and STDs. 2) OA funding cannot be used to pay for clinical laboratory tests, except for HIV testing and hepatitis screening. 3) LHJs are required to report on their activities in their bi-annual progress reports.
<p>Condom Distribution</p>	<ol style="list-style-type: none"> 1) The condom distribution program requires LHJs to use OA epidemiologic data as well as LHJs local knowledge and resources to enroll venues into the condom distribution program, where they will receive condoms and educational material to distribute to high-risk target populations in locations where HIV/AIDS is most prevalent. 2) 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) have a clientele (whole or partial) that is made up of the targeted population. 3) LHJs will maintain venues previously enrolled in the condom distribution program, add additional venues when possible, and replace venues if former venues stop participating in the program.

	<ol style="list-style-type: none"> 4) To enroll a new venue, the LHJ must fill out the <i>Participating Venue Information</i> (PVI) form. There is no limit to how many eligible venues each LHJ can have participating in the program. 5) Condom orders cannot be placed by an LHJ or another entity on behalf of the participating venue. Condom orders cannot be placed by an LHJ for distribution at a one-time event such as health fairs, workshops, rallies or other presentations unless the events specifically target OA's priority populations and are part of the LHJs HE/RR prevention interventions. 6) LHJs should include information about their condom distribution plans in their bi-annual progress reports.
Health Care Reform	<ol style="list-style-type: none"> 1) Each funded LHJ is required to dedicate a proportion of a specific FTE position to Health Care Reform planning activities. Duties for the local Health Care Reform staff person and the percentage of time spent will be determined by each LHJ and will vary depending on local policies and resources. 2) The Health Care Reform staff position may or may not be from within the LHJ's HIV/AIDS program; however, if it is not, a strong partnership should be maintained between the Health Care Reform staff and the local HIV/AIDS program. 3) LHJs should include information about their Health Care Reform related activities in their bi-annual progress reports to OA.

Tier II Activities	
HCV Testing	<ol style="list-style-type: none"> 1) OA funding may be used to offer HCV testing to clients identified by the assessment process to be at risk for HCV. Although HCV testing is a Tier II activity, LHJs may conduct this activity without implementing all Tier I activities. 2) OA funds may be used for HCV laboratory tests, HCV rapid tests, and Home Access kits. 3) OA will provide training for the rapid CLIA-waived HCV and combination rapid HIV/HCV tests. HIV counselors must be certified prior to administering the new HCV rapid test. Additionally, HIV counselors must take the University of California San Francisco, Alliance Health Project on-line HCV training.

	<p>4) Trained HIV test counselors who are authorized in California to perform rapid CLIA-waived HIV tests may also perform rapid CLIA-waived HCV and combination rapid HIV/HCV tests. HIV test counselors performing rapid CLIA-waived HCV tests or rapid combination HIV/HCV tests, including those tests administered by finger stick, will need to meet the same performance and training requirements as that for rapid CLIA-waived HIV testing.</p> <p>5) HCV test information should be collected on the CIF and entered into LEO.</p>
<p>Behavioral Interventions for High-Risk Negative People</p>	<p>1) The priority high-risk negative populations for the California project area are:</p> <ul style="list-style-type: none"> • MSM, including MSM/IDU with strong emphasis on African-American and Latino MSM; • IDUs; • Transgender Individuals; and • High-Risk Negative Individuals with Sexual and/or Injection-sharing HIV-positive or MSM partners. <p>2) LHJs may provide high-risk HIV-negative populations with evidence-based HIV behavioral interventions to reduce the rate of new HIV infection within identified high-risk target populations. Behavioral interventions may include:</p> <ul style="list-style-type: none"> • Targeted prevention activities for high-risk HIV-negative persons; • Individual level interventions (ILI); • Group level interventions (GLI); and • Comprehensive Risk Counseling and Services for individuals with multiple health needs. <p>3) 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. OA funds should not be used to support interventions for low-risk negatives.</p> <p>3) All OA-funded behavioral interventions must be recorded in LEO.</p>
<p><u>Social Marketing, Media and Mobilization</u></p>	<p>1) OA has chosen the following health messages for social marketing activities, media, and mobilization activities:</p>

	<ul style="list-style-type: none"> • Benefits of early detection of HIV infection; • Need for routine and regular HIV health care; • Benefits of ARV therapy for 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 CDC or OA. <p>2) Messaging must address one or more of the health messages above and be targeted to HIV-positive people, or priority high-risk negative populations as defined by OA.</p> <p>3) Due to limited resources, LHJs should choose campaigns that have already been developed and demonstrated effective. LHJs choosing to conduct social marketing, media, or mobilization activities must submit a plan to OA prior to starting a campaign. The plan should include a definition of the health issue being addressed and the rationale for its selection. The plan should also describe the health messages to promote Testing, HIV Care, ARV therapy, PS, integration of STD, hepatitis, TB screening, and PS into HIV services, as well as the formative work planned to ensure community participation in the campaign development. Monitoring and evaluation activities must also be included in the plan. No LHJ's may create new material until after documentation of a search for pre-existing material and justification for developing new material is submitted to and approved by OA.</p> <p>4) Progress on activities will be clearly documented in bi-annual progress reports submitted to OA, as well as entered into LEO.</p>
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V. LEO FUNDING SET UP

Budget information set up in LEO must be consistent with the budget documents submitted. Specific instructions for doing so are included below. If you have any questions regarding how set-up instructions apply to your specific circumstances, please contact your assigned Prevention Operations Advisor for technical assistance.

Please indicate the correct funding source for each intervention and/or subcontractor set up in LEO. If other funding sources such as local funds, direct funds from CDC, or funds from the California Department of Alcohol and Drug Programs are being used for activities being recorded in LEO, please consult with your assigned HIV Operations Advisor to request that a specific funding stream be established for use with these agencies/interventions. Note that in LEO, agencies may be funded by multiple sources, but interventions may only have a single funding source.

Targeted testing interventions require specific target populations to be entered. In addition to defining target populations, the number intended to be reached and the funding amounts planned to be spent testing each target population must be included.

Include direct, indirect, and other expenses in intervention allocations so the sum of all intervention allocations within a funding stream equals the amount listed on your HIV Prevention Program Service Category Summary tables. When setting up interventions, each target population requires the estimated number of clients you intend to serve and the amount allocated to this target population. The totals for both of these values should match the information on the Program Service Category Summary in the budget documents for all OA-funded interventions. The amount allocated to each population within the intervention should include **all expenses**, including program and administrative costs so that the total of all intervention costs equals the totals for the respective service categories in Section 3 of the Service Category Summary.

PS activities are typically integrated within other interventions, such as within counseling and testing, in HE/RR ILI sessions or as part of a care visit. Do not include the PS funding amounts within interventions. The LEO Contract Annual Review Page will only include your HIV and HCV testing and your HE/RR activity line items. It will not include your PS or Non-Client Services activities amounts listed on your HIV Prevention Program Service Category tables.

Non-client services are not tracked in LEO. These include Healthcare Reform and service activity integration activities.

Activities funded by multiple sources must be set up as distinct interventions, one for each funding source. For example, if you are funding HIV testing for MSM for \$1,000, using 75 percent OA funds and 25 percent from another grant, enter two interventions:

- MSM testing (OA prevention funding), n = 75 MSM, \$750
- MSM testing (funding from another grant), n = 25 MSM, \$250

For simpler identification of various funding sources, it is recommended you note the funding sources in the intervention titles.

Budgeted amounts in LEO should be consistent and reasonable estimates for actual costs. For example, do not enter a budget amount of \$3,000 for the first target population and \$1 for each additional target population. While it may cost more to provide the same service to some target populations compared with others, make sure the cost per encounter does not vary extremely between target populations or interventions of the same type. To assist you, the intervention set-up page in LEO shows the total number of people expected to be served, the total budgeted amount for the intervention and the anticipated cost per encounter for each target population and the overall intervention.

LEO set-up for July 1, 2013 through December 31, 2013 C&T and HE/RR interventions must be completed by June 15, 2013. This is necessary for OA to submit required reports to the CDC.

Data is expected to be entered within five business days of the encounter or activity. Since data is analyzed on a monthly basis, OA requires that data be complete and up-to-date. When OA runs data reports, any data not entered cannot be included. This results in a less accurate picture of your work. Delayed data entry also decreases data quality because the longer length of time between the activity and data entry, the less likely errors or omissions can be accurately corrected.

LEO is designed to make it simple to monitor allocation information during the process of setting up interventions and subcontractor allocation amounts. The Contract Annual View Page in LEO provides a view of the amount of your award that has been allocated and the amount of award that has yet to be allocated for your LHJ and for each of your subcontractors.

VI. REPORTING REQUIREMENTS

Progress Reports

Progress Reports are required on a semi-annual basis, and must be submitted to LHJ's assigned HIV Operations Advisor via e-mail. The progress report for this prevention contract will cover the six months of the contract, from July 1, 2013 to December 31, 2013. The report will be due on February 15, 2014.

The progress reports should address, 1) all applicable services performed in Tier I and/or Tier II, 2) required information as outlined in the IPP guidance (click here for [IPP](#)), and 3) relevant follow-up documentation for items identified in site visits, technical assistance and communication between OA and the LHJ.

Please report on all activities that either the LHJ or subcontracted agencies have implemented.

The progress report should follow the guidance instructions that will be provided in the progress report template.

VII. HIV PREVENTION PROGRAM CONTACTS

HIV Prevention Program		
HIV Prevention Branch Interim Chief	Alessandra.Ross@cdph.ca.gov	(916) 449-5796
HIV Prevention Operations Section Chief	Sandy.Simms@cdph.ca.gov	(916) 449-5538
HIV Prevention Program Section Chief	Amy.Kile-Puente@cdph.ca.gov	(916) 449-5805

Prevention Operations Advisors	Assigned Contracts
Cheryl Austin	<ul style="list-style-type: none"> Monterey Santa Barbara

<p>(916) 449-5810 Cheryl.Austin@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Santa Cruz • Stanislaus • Ventura
<p>Clar Rohde (916) 445-4346 Clar.Rohde@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Contra Costa • Fresno • Kern • Santa Clara • Sonoma
<p>Jill Harden (916) 445-2561 Jill.Harden@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Alameda • Long Beach • Orange • Riverside • San Bernardino • San Diego • San Joaquin • Solano
<p>Yvonne Gaide (916) 650-0573 Yvonne.Gaide@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Sacramento

VII. HOW, WHEN, AND WHERE TO SUBMIT REQUIRED DOCUMENTS

Please e-mail the completed budget documents (*Excel file*) to: Sandy.Simms@cdph.ca.gov by **May 20, 2013.**