



Information for Program Planning **July-December 2013** Prevention Contract

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

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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 emphasis on Prevention with Positives (PWP), in particular, represents a shift in focus, and has required many HIV prevention providers to think differently about how they target their activities and structure their programs. 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 goals of the CDC grant will be achieved by enhancing public health departments' capacities to increase HIV testing, link HIV-positive people to medical care and other essential services and retain them in care, and increase program monitoring and accountability. 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.

LHJ Prevention Grant

OA's HIV Prevention Branch provides funding to local health jurisdictions (LHJs) in the California Project Area (CPA), which consists of the LHJs in the state most highly impacted by HIV/AIDS, excluding the San Francisco and Los Angeles Metropolitan Statistical Areas (MSA), which are directly funded by the CDC. (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, partners of people living with HIV, and other individuals most likely to become infected with HIV. OA's priority populations are listed in [Appendix B](#).

Developing HIV prevention programs requires much work, including analysis of local epidemiology, needs assessments, gap analysis, and other formative activities. OA recognizes the local expertise throughout California and aims to use its prevention funds to support local practitioners response to the directions set by the NHAS with initiatives that build on the success California has had in addressing HIV throughout the state.

Core Services

The cornerstone of OA's Prevention Program is Targeted HIV Testing coupled with both Partner Services (PS) and Linkage to Care (LTC). These are considered the core services. With this new approach, OA aims to more effectively identify cases of HIV and reduce the spread of HIV by ensuring that newly-identified HIV-positive individuals are linked to quality care.

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

- Provide targeted HIV testing;
- 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 healthcare 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.

What's New? Changes in this update of the Information for Program Planning (IPP) document include the following:

- Each LHJ is expected to increase the HIV positivity yield in targeted testing by one-tenth (0.1 %) annually.
- Beginning July 1, 2013, all LHJs conducting HIV-Positive Risk Assessment and Referral services must administer the Local Evaluation Online ([LEO](#)) Group Self-Administered Questionnaire ([GSAQ](#)) and the Substance Abuse and Mental Illness Symptom Survey ([SAMISS](#)) screening tools to clients being assessed for transmission risks and Prevention with Positives (PWP) referrals.
- Due to the complexities related to PrEP, the Office of AIDS will not fund LHJ PrEP-related activities until best practices are established. OA is following multiple PrEP demonstration projects which will contribute to further knowledge on how best to implement PrEP.
- OA requests LHJs send copies of any prevention plans developed by the LHJ.
- Information about non-prescription syringe sale, including educational

materials for pharmacists, and syringe disposal has been updated on the OA website at <http://cdph.ca.gov/SyringeAccess>.

- A complete guidance for rapid HCV testing has been developed and issued by CDPH. *Hepatitis C Testing in Non-Health Care Settings, Guidelines for Site Supervisors and Testing Coordinators* is available at <http://cdph.ca.gov/HCVtest>.
- For Linkage to Care, CDC has issued [*Planning and Implementing HIV Testing and Linkage Programs in Non-Clinical Settings: A Guide for Program Managers*](#). 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.
- The Department of Alcohol and Drug Programs (ADP) has updated its guidance on the use of HIV set-aside funds, which many LHJs use in conjunction with PS12-1201 funds. More information can be found in ADP Bulletin 13-03, at http://www.adp.state.ca.us/ADPLTRS/bulletin_letter.shtml.
- Additional guidance on other Tier I and Tier II activities will be issued on an ongoing basis.

More resources are available on OA's website at <http://cdph.ca.gov/HIVPrevention>

***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 to be delivered together: targeted 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.

Tier I Activities

Core Services	Policy Initiatives
<ul style="list-style-type: none"> • Targeted HIV Testing • Linkage to Care • Partner Services 	<ul style="list-style-type: none"> • Leveraging Substance Abuse and Mental Health Services Administration (SAMHSA) HIV Set-Aside Funds (OA only) • Surveillance Data Use (OA only) • Healthcare Reform Planning • PrEP Planning (OA only)
Other Tier I Activities	
<ul style="list-style-type: none"> • Routine, Opt-out HIV Testing in Healthcare settings • Retention and Re-engagement in Care • HIV Medication Treatment Adherence • Prevention with Positives • Integrated Health Services • Syringe Services Programs • Condom Distribution 	
<ul style="list-style-type: none"> • State Community Planning (OA only) 	

Funded LHJs must implement the three core services. In addition, LHJs may implement one or more additional activities from the Tier I set of activities. Activities labeled “OA only” will not be conducted by LHJs during the July through December 2013 Prevention Contract.

LHJs may choose among these activities in designing their OA-funded prevention portfolio. 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, with the exception of the three core activities.

Tier II Activities

Tier II activities represent lower priority activities for use with OA funds. LHJs must ensure that activities designated as Tier I are 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). 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
<ul style="list-style-type: none">• Hepatitis C Testing• Behavioral Interventions for Prioritized High-Risk Negative People• Social Marketing, Media and Mobilization

In order to conduct Tier II activities, LHJs must document that all Tier I activities are being conducted in the jurisdiction, either by OA-funded initiatives or through other sources. (Note that if an activity is already being implemented using other funding sources, it is not necessary to duplicate the effort.) Documentation will include describing who is doing the activity, the target population(s) served and the number of individuals projected to be served.

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 biannual 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.

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 makes recommendations aimed at facilitating the solicitation of broad 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 ensure stakeholder input for [California's Integrated Surveillance, Prevention, and Care Plan](#), which serves as a practical guide for OA to achieve the vision of the National HIV/AIDS Strategy. 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 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 12.5 million dollars in funds disbursed by the California 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 healthcare 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. OA will fund LHJs to provide targeted HIV testing in non-healthcare settings¹ and will assist LHJs to improve efforts to target testing to individuals at highest risk of HIV.

Definition of Fundable Activities

Agencies will administer HIV testing by providing anonymous and/or confidential 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 testing in non-healthcare settings are required to:

- 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 programs.

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-healthcare settings; oral consent is required for ATS; and oral consent is allowed for testing in medical settings. All individuals tested with OA funds in non-healthcare 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.

OA will work closely with funded LHJs to implement strategies to increase HIV testing which targets specified high-risk populations (see [Appendix B](#) - OA Priority Populations). Targeted testing is a testing strategy that involves testing individuals based on characteristics that increase their likelihood of being infected with HIV. These characteristics can include the presence of sexually transmitted diseases (STDs), behavioral risks, or attendance at venues frequented by high-risk populations.

¹A 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.

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 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.

All sites are also 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 low-risk testing, and assist 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 should maintain a plan for improving yield in lower positivity test sites or closing them in order to shift resources to test sites that effectively reach those populations most likely to test HIV positive.

Additional Requirements

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

- The test site shall maintain signed statements of confidentiality for employees and volunteers who have access to client files of individuals.
- 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, 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 patient information must be in a locked filing cabinet.

HIV Counselor Training

Funded agencies must ensure all HIV counseling interventions are provided by staff members who have successfully completed the three-day Basic Counselor Skills Training (BCST). The BCST has been modified to include 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 funded LHJs. OA will provide HIV test kits based on the number of tests that the LHJ proposes to conduct as indicated the Service Category page of the budget documents and stated in LEO. We will also review the number of tests that a LHJ has conducted by reviewing the data in LEO. As always, it is important that LHJs are up to date in entering data into LEO so that we have accurate information in determining HIV test kit quantities. If a LHJ's test kit order exceeds what is allowed and determined as needed, LHJs may use base funding to purchase test kits directly from OraSure Technologies, Inc. LHJs should ask for the state rate if purchasing directly from OraSure Technologies, Inc. OA conducts a mid-year assessment of test kit usage. To order test kits, LHJ coordinators must complete the HIV Rapid Test kit order form (available from Operations Advisors) and submit the form electronically to testkits@cdph.ca.gov.

Monitoring and Evaluation

Written quality assurance plans² 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 Testing Specialist for comprehensiveness and compliance with State and Federal requirements. **Please submit updated plans anytime there are significant changes, such as adding HCV testing.**

California statute requires CLIA-waived test kit operators to meet specific standards, some more stringent than Federal requirements. For example, test kit operators must either be medical personnel providing direct patient care or HIV counselors who have successfully completed the OA rapid HIV test kit training. The training includes a proficiency exam using five samples from an independent proficiency panel. In addition, test kit operators are required to complete an annual competency assessment test to maintain their certification for testing client samples.

Compliance with these standards and requirements are monitored using data entered into the LEO system and also via TA contacts and in-person site visits. Data are collected for monitoring test kit operation including processing time and temperature ranges, trainings and competency assessments completed by test kit operators, and result delivery rates and time frames, as well as other quality assurance measures. TA contacts with providers occur routinely, prompted either by requests from the provider or

² 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.

by data submitted that requires follow-up. In-person site visits occur as either a routine part of program monitoring or in order 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

LTC is the process of assisting newly HIV-diagnosed individuals to enter into medical care. LTC is a required activity for all OA-funded HIV testing sites in both medical and non-medical settings.

LTC is achieved when a newly diagnosed HIV-positive person is seen by a healthcare 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. The term LTC is used by OA in the context of referral to medical care and not for other types of referrals (to case management, for example).

The Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) and CDC explain the importance of linkage to care in a *Dear Colleague* letter released in February 2013. This letter clarifies that having only one HIV positive test result should not be a barrier to linking a patient to a RWHAP-funded clinic or other HIV care providers for care. 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>.

Models for LTC may vary depending on testing setting (jail, health center, drug treatment center). Each facility is unique – one model or approach does not fit all. 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.

For some LHJs, implementing LTC will involve a shift from the standard model of community testing to more intensive collaborations with other prevention and care providers in the LHJ, and will mean involving Ryan White programs and Early Identification of Individuals with HIV and AIDS (EIIHA) initiatives in designing LTC programs.

Definition of Fundable Activities

In implementing LTC, OA-funded LHJs must:

- Establish a system that refers individuals with preliminary and confirmed HIV-positive test results to a medical provider for follow-up within 90 days, and confirm that the person attended his or her first appointment;
- Identify HIV care providers to which patients will be referred, and develop a means to verify that the patient attended the medical appointment. 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.

Additional Requirements

HIV testing coordinators must:

- Submit to OA any updates to policies and procedures for verifying linkages to medical care,
- Submit to OA any changes to the work flow chart that outlines the steps taken in testing sites from the time client is tested, receives preliminary or confirmatory 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;
- Submit to OA any new linkage verification documents, after review by both the local County Health Officer and by local health department legal counsel. LHJs have the latitude to design their own LTC verification system and forms for linkage verification. OA developed an example verification form that you can request from your Operations Advisor.
- Medical release forms and linkage verification forms should be reviewed by local County Health Officer and legal counsel.

OA recommends using the guide developed by the Centers for Disease Control and Prevention (CDC), [*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 existing and new health departments and community-based organizations to assess and strengthen HIV testing and linkage programs in non-clinical settings. The guide contains several strategies to assist non-clinical HIV testing programs including:

- Defining and targeting high-risk populations that are likely to have an HIV prevalence of 1% or more;
- Identifying effective recruitment strategies linking newly identified clients with positive tests to HIV medical care on the bases of either and initial or confirmatory HIV test result;
- Providing newly-positive clients with a basic needs assessment that would guide decisions on the provision, linkage, and referral to appropriate medical, prevention, and support services.

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.

Health Disparities

Studies show that 35 to 45 percent of people with newly diagnosed HIV infection develop AIDS within one year after diagnosis, representing late entry into care. People with HIV who enter care at this point often have

extremely compromised immune systems and AIDS-related complications. More Black, Hispanic, substance users, and low-income individuals fall into this category. Targeted testing and effective linkage to care can reduce these disparities.

Monitoring and Evaluation

The objective of OA's LTC program is to link a minimum of 84 percent of newly-identified HIV-positive people into medical care within 90 days of receipt of their HIV antibody test results. This rate is currently being exceeded by all LHJs and ongoing monitoring will assist in ensuring sustained success of this critical activity.

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

LHJs should use LEO Indicator Reports to monitor and evaluate their progress with LTC goals. LHJs should contact the OA Testing Specialist for assistance with data reports.

TA Contact

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

PS includes a broad array of services that should be offered to people living with HIV as well as their needle sharing and/or sexual partners. The three major activities include:

- 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 accepting an offer should be referred to the appropriate health department PS official for elicitation and notification follow-up.
- 2) *Partner Elicitation* – 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, offer support, answer questions, provide testing and offer referrals for prevention services to the partner(s). **Only trained PS workers can provide notification of exposure.**

Other functions of PS include coaching HIV-positive people 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.

In California, a venue-based model is used for PS. In this 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.

At a minimum, LHJs should: 1) 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; 2) assess PS activities and outcomes; and 3) implement provider outreach programs to enhance PS with key community providers. Should an LHJ maintain the capacity and trained staff, partner elicitation, and/or partner notification activities may be completed. If an LHJ has the infrastructure to only provide an offer of PS, collaboration with a Disease Intervention Specialist (DIS) from the STD Control Branch must be established and maintained for comprehensive PS activities. An individualized work plan will be developed by each LHJ based on the level of funding allocated and local needs and resources.

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 healthcare providers for improved referral systems, developing collaborations with HIV health clinic staff and embedding PS staff members in healthcare settings with high HIV and/or STD incidence. Additional OA Prevention funds may be added to the PS line item to increase the number of PS activities conducted.

Non-Fundable Activities

PS allocations may not be used to pay for HIV testing, counseling, or other prevention activities or staff.

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 counseling and testing, health education/risk reduction programs (HE/RR), STD programs and care clinics 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. However, if the LHJ has no trained staff, this information should be forwarded to state DIS for notification follow-up.

Health Disparities OA and the STD Control Branch encourage all LHJs to increase the number of venues in which clients receive the offer of PS, especially sites that serve clients from racial or ethnic communities that are disproportionately affected by HIV/AIDS. Expanding PS offers in health clinics, HE/RR programs, testing sites, and private medical practice offices will lead to a more client-centered approach and provide the client more opportunities to accept PS.

Training and Technical Assistance OA and the STD Control Branch have collaborated to develop an HIV PS training program for LHJs, CBO and other staff who are performing 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 sub-contracted CBOs. Three new positions have been created in the STD Control Branch specifically to provide TA on the planning, implementation, expansion and evaluation of PS programs. 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, and the availability of and referral to HIV testing, prevention services, STD screening, HCV testing, and HIV medical care as appropriate. LHJs should submit any updates of their PS program plan to OA.

Local programs should 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. It is important to frequently review PS data in LEO. At minimum, quarterly reviews should be completed which will help identify open cases, trends, and populations served.

LEO currently supports several reports that may assist LHJs in monitoring their PS referrals and activities. Access to these reports is from the *Reports* tab in LEO. Please consult with OA staff before generating these reports, as some may still be in *Beta* form waiting testing and/or further improvements. Other reports will be added as the LEO system matures. LHJs needing additional data analysis or copies of their data to conduct their own analysis may make those requests at:

<http://www.cdph.ca.gov/pubsforms/forms/CtrlForms/cdph8719.pdf>.

The *Partner Services Report* provides counts and percentages of Partner Information Forms (PIFs) and unique clients by venue type; counts of PIFs by partner gender, race, and exposure type; referral outcomes for dual and third-party notifications; and third-party notification quality assurance measures.

The *Partner Services HE/RR Referrals* report provides a count of how many HIV-positive individuals served by the intervention were provided PS activities during a session, or who were referred to PS services, declined PS referrals or were not offered PS referrals during intervention sessions.

OA and the STD Control Branch staff will 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

Amy Kile-Puente, Chief, HIV Prevention Program Section, (916) 449-5805
or amy.kile-puente@cdph.ca.gov.

Routine, Opt-out HIV Testing in Healthcare Settings

The CDC encourages the integration of HIV testing into routine healthcare, and has created a number of initiatives to encourage healthcare 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 healthcare 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 healthcare settings, gynecological services, and jail healthcare settings to assist them in integrating routine, opt-out HIV testing into their healthcare services.

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 healthcare services (i.e., payer of last resort).

Health Disparities

Research shows that people from racial and ethnic minorities are more likely to receive an AIDS diagnosis at the same time as or within one year of an HIV diagnosis. This late diagnosis often means that people are not able to take full advantage of life-enhancing HIV care and treatment. Routine, opt-out testing in health care settings has been shown to identify HIV among people from racial and ethnic minorities earlier in their disease progression, which leads to better health outcomes and can diminish the likelihood of transmitting HIV.

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 biannual progress report. In addition, if funding is given directly to an health care setting to increase or implement routine, opt-out HIV testing, those sites must provide client level data as described in the OA HCS routine testing data dictionaries. 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 Healthcare HIV Testing Form which is similar to the HIV Counseling and Testing CIF. Healthcare HIV Testing forms are available from OA, and can be found on the [OA website](#) and ordered on-line at LEOSreq@cdph.ca.gov.

TA Contact

Clark Marshall, HIV Expanded Testing Coordinator,, (916) 650-6752 or clark.marshall@cdph.ca.gov.

Retention and Re-Engagement in Care

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 that are retained in HIV primary care, and to re-engage people who have been lost to care (not seen their healthcare provider for more than six months). The Health Resources and Services Administration (HRSA) recommends HIV clinical visits at least once every six months for HIV-positive patients.

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 Linkage to Care Plus, Ryan White Part A and Part B-funded programs, EIIHA initiatives, and/or the Minority AIDS Initiative.

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.

Additional Requirements

In order to decrease duplication of effort and ensure maximum impact of LTC interventions, all LHJs that fund or provide *Retention and Re-Engagement in Care* services will demonstrate active collaboration and coordination with care sites.

Monitoring and Evaluation

OA's LEO system or AIDS Regional Information and Evaluation System ([ARIES](#)) is 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 Minority AIDS Initiative (MAI) activities can be documented.

TA Contact

Carol Crump, Behavioral Health Specialist, (916) 449-5965 or carol.crump@cdph.ca.gov.

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 Healthcare 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 people, 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 which 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 abuse treatment services are also important part of PWP services.

OA has selected two assessment instruments to be used 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 behavioral risks that can transmit HIV, 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 using OA prevention funding for PWP services must use both the [GSAQ](#) and SAMISS in the screening of HIV-positive individuals. 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. The SAMISS Score Key is available. LHJs must also provide a summary of screening activity in the bi-annual reports to OA.

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 approval.

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, and the number of sessions completed compared with the total number of sessions included in

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.

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.

Health Disparities

In selecting medical settings for HIV-positive risk assessment and behavioral interventions, health disparities within the LHJ should be considered. LHJs are encouraged to select clinics that serve clients from racial or ethnic communities that are disproportionately impacted by HIV and AIDS.

Monitoring and Evaluation

OA's LEO system or ARIES will be used to document and record client assessments. 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 difficulty 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 healthcare 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 2011 [Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents](#) recommend monitoring viral load every three to six months.

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 encouraged 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.

Health Disparities

In addressing treatment adherence, it is important to consider cultural factors that may contribute to resistance to starting ARV treatment and challenges to maintaining successful adherence. The [California Statewide Training and Education Program](#) offers a free treatment certification program that can provide representatives from various racial and ethnic communities with skills to promote treatment adherence within their communities.

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

Integrated Hepatitis, Tuberculosis and STD Screening, and PS for HIV-Positive Persons

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 can be offered 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
- 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.

Non-Fundable Activities

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

Health Disparities

Monitoring client rates of clinical laboratory monitoring of STDs, hepatitis, and TB should be part of standard quality assurance activities for OA-funded sites. Sites should work to ensure that there are no disparities in clinical monitoring based on race, ethnicity, age, gender, or other community attributes of HIV-positive patients. If disparities are identified, corrective work to eliminate the disparities should be taken. This work may include provider education on the standards for ongoing clinical monitoring and identified health disparities, patient education to increase receptivity to clinical monitoring, and analysis of medical reimbursement policies for the clinical tests.

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 has 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 July - December 2013 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.

Health Disparities

Health disparities among IDUs are similar to those for HIV/AIDS in general, and equally impactful. For example, African American injectors in the U.S. are ten times more likely to be diagnosed with HIV/AIDS than white injectors.³ LHJs may respond to these types of disparities in a number of ways. In soliciting pharmacy provision of NPSS, for example, LHJ may encourage participation by pharmacies that serve clients from racial or ethnic communities that are disproportionately impacted by HIV. Practical suggestions for community-based organizations seeking to better serve their IDU clients may be found in the [Framework for Injection Drug User Health and Wellness](#), which was developed by the Substance Use/IDU Task Force of the CPG in 2009 and endorsed by the CPG as a set of recommendations to OA and its funded partners.

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>.

³ Burris, Scott, Evan D. Anderson, Ave Craig, Corey S. Davis, and Patricia Case. "Racial Disparities in Injection-Related HIV: A Case Study of Toxic Law." Temple Law Review 82.5 (2010): 1263-307. Print.

Health Care Reform Planning

The Affordable Care Act (ACA), which goes into full effect in 2014, provides greater health security by putting in place comprehensive health insurance reforms that hold insurance companies accountable, lower health care costs, guarantee more choice, and enhance the quality of healthcare for all Americans. Due to the complexity of implementing this monumental reform, OA has begun considering the HIV-specific issues associated with the ACA and will require 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 <http://www.hivhealthreform.org/> and <http://www.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; and
- Determine TA and training needs.

OA will keep LHJs abreast of Federal and State health care reform policy developments, provide TA to LHJs, and seek feedback on ideas to further guide the direction of HIV-related health care reform in California.

Additional Requirements

The health care reform lead 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 lead and the local HIV/AIDS program.

Health Disparities

Since many populations infected with or at risk for acquiring HIV lack access to medical care and preventative services, local epidemiology should be used to target appropriate populations when planning for health care reform and later when promoting and delivering healthcare services in the community.

Monitoring and Evaluation

LHJs should include information about their HCR-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 for LHJs in the CPA

In response to the NHAS, the California AIDS Clearinghouse's (CAC) condom distribution program specifically targets HIV-positive people and those people 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, lesbian, gay, bisexual and transgender 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 19 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 people at highest risk of acquiring HIV infection in communities where HIV/AIDS is most prevalent. They are able to utilize the HIV/AIDS cases by ZIP code map provided to them by OA as a resource.

Each LHJ is required to recruit and maintain a minimum number of venues in the condom distribution program. The minimum amounts 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 continue to seek and enroll appropriate venues serving priority target populations throughout the contract period.

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

Each LHJ is encouraged to increase their amount of participating venues by 30% each year.

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 that is made up mostly of one or more of OA's priority populations (see [Appendix B](#)).

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. LHJs should have their minimum number of venues (listed above) recruited by September 31, 2013.

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

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 such as festivals, health fairs, concerts, etc., unless the events themselves specifically target one or more of OA’s priority populations.

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

Hepatitis C Testing

OA funding may be used to offer Hepatitis C Virus (HCV) testing to clients identified by the assessment process to be at risk for HCV, and 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.
- 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 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 Health and Safety Code 120917 and 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 has been modified to include proficiency in HCV rapid testing. 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.

Health Disparities

HCV is transmissible through the sharing of contaminated injection equipment, and the majority of IDUs infected with HIV are dually infected with HCV. HCV infection is the number one cause of death among people with HIV and the leading reason for liver transplantation nationwide. Yet an estimated 75 percent of people with HCV are unaware of their infection. Early detection of HCV is essential to reducing the likelihood of HCV-related liver disease and other complications, and to preventing further disease transmission.

The CDC recommends testing all individuals living with HIV for HCV and also

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](#).

recommends integrating HCV testing into HIV testing sites which target high-risk groups.

**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-Healthcare Settings* is available on the OA website at: <http://cdph.ca.gov/HCVtest>.

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 persons 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, it is critical to target HIV behavioral interventions to HIV-negative individuals at most risk for acquiring HIV. 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:

- Sexual and needle-sharing partners of HIV-positive Individuals;
- Transgender individuals, with an emphasis on African Americans and Latinos;
- Gay men and MSM, with an emphasis on African American and Latino men;
- IDUs;
- Sexual and needle-sharing partners of gay men, MSM, and IDUs;
- 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.

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.

Health Disparities Latinos and African Americans have greater HIV disease burden than non-Hispanic Whites in California. MSM also continue to be the largest population among people living with HIV in California. It is critical to prioritize these populations to reduce health disparities within these communities.

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

According to the CDC, Social Marketing is the application of commercial technologies to the planning and implementation of prevention programs. Social marketing for HIV prevention aims to bring about behavior change that improves health by promoting specific HIV prevention messages. 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 healthcare;
- 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.

Messaging should address one or more of the health messages above be targeted to HIV-positive people, or priority populations defined by OA (see [Appendix B](#)) and local epidemiology.

LHJs which conduct social marketing, media, or mobilization 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 to promote 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. 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.

All social marketing, media, and mobilization activities will have a plan submitted to OA for approval prior to starting any campaign.

Due to limited resources, LHJs should select campaigns that have already been developed and demonstrated effective. Such 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.

No original social marketing activities may be developed without prior written approval from OA.

***Health
Disparities***

Social Marketing, Media, and Mobilization activities must be directed to priority populations and communities that experience HIV health disparities. Culturally literate material should be selected to effectively address different communities. Location of placement of social marketing material should be in geographic areas with high-density of HIV-positive people or priority high-risk negative populations.

***Monitoring and
Evaluation***

Progress on activities are required and need to be clearly documented in bi-annual progress reports submitted to OA, as well as entered into the LEO system.

The LEO system accommodates Health Communication/Public Information (HC/PI) activities, and other activities that are combined to create social marketing, media, or mobilization campaigns. This includes the number of ad placements, estimated size of listening audiences for radio Public Service Announcements, or estimated hits on a website, among other measures.

TA Contact

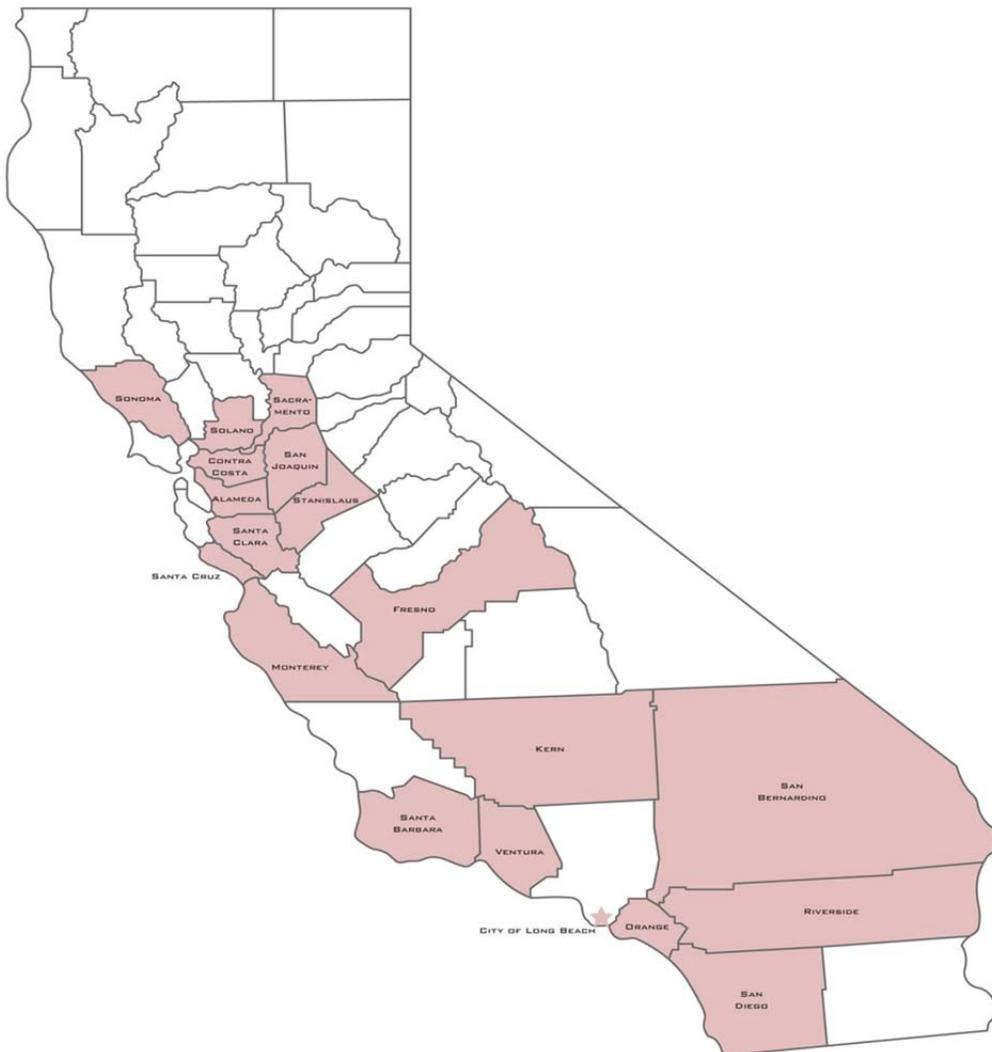
Kevin Sitter, Intervention Specialist, (916) 449-5814 or kevin.sitter@cdph.ca.gov.

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 PWPs, 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 and focuses on populations which have high HIV prevalence. OA priority populations include both people living with HIV, and those at highest risk of acquiring HIV. The priority populations are:

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

Targeting Services towards Adolescents

Young people within the OA priority populations listed above may be targeted for prevention services. Adolescents *in general* are not an OA priority population and OA funds should not be used to target interventions to this population. 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.

The California Department of Alcohol and Drug Programs (ADP) is responsible for providing HIV care and prevention for individuals in substance use treatment programs. ADP 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 in ADP Bulletin 13-03, at http://www.adp.state.ca.us/ADPLTRS/bulletin_letter.shtml.

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 at: www.effectiveinterventions.org, in the *Compendium of Evidence-Based HIV Behavioral Interventions*, or at www.choiceHIV.org.

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. They must also submit the goals of the intervention, curriculum for each session, and the evaluation tools used by the intervention.

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;
- Comprehensive risk counseling and services;
- PS; and
- Limited HC/PI 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: *It is important that participants in the BCST read the pre-training learning packet thoroughly, as much of the material in the packet will not be covered in the training, and the training relies upon the participant already having read, retained the material contained in the learning packet and passing an online quiz.*

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	AIDS 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
FY	Fiscal Year
EIIHA	Early Identification of Individuals with HIV and AIDS
HCS	Healthcare Settings
HCV	Hepatitis C Virus
HC/PI	Health Communication/Public Information
HE/RR	Health Education/Risk Reduction
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration

IDU	Injection Drug User
LEO	Local Evaluations 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

The Office of AIDS has selected two risk assessment tools that all LHJs conducting *HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Healthcare Settings* must use to assess clients at risk of transmitting HIV or acquiring other sexually transmitted infections. Both tools should be administered to clients prior to referral to services and behavioral interventions. Results of the assessment must 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 abuse, 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 either 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, it 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 requiring use of 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;
- 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.