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# THE RURAL THINK TANK MEETING REPORT



March 2nd and 3rd, 2009  
The Holiday Inn, Sacramento, California

## **Sponsors**

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## EXECUTIVE SUMMARY

The California Department of Public Health (CDPH)/Center for Infectious Diseases (CID)/Office of AIDS (OA) hosted a “Rural Think Tank” on March 2-3, 2009, to discuss how best to maximize the use of limited HIV/AIDS funds and resources for HIV/AIDS-related activities—education and prevention, care and treatment, and surveillance—in the rural areas of California. The meeting brought together OA staff, staff from local health departments all over California, colleagues from other parts of the State Government, key training partners, and several other collaborating partners.

Included in this report are the key findings and recommendations that came out of this initial Rural Think Tank meeting:

### Key Messages from Meeting Participants

#### 1. *Staffing, Funding, and OA-Relationships*

- a. Rural local health jurisdictions (LHJs) have limited staff so one person tends to perform many functions.
- b. Among the different OA programs there are several overlapping reporting requirements.
- c. Rural LHJs have limited staff to input large amounts of data. In addition, the staff must be familiar with each data collection system—AIDS Regional Information and Evaluation System (ARIES), Local Evaluations Online (LEO), etc.
- d. Lack of adequate funding, as well as restricted small pots of funding, are a limiting factor for rural LHJs.
- e. Information flow between OA and rural LHJs is currently not as smooth as can be. Some LHJs do not regularly check the OA website so this may not be a reliable form of communication. Some LHJs also experience difficulties when contacting OA because they do not know who to contact, especially when there are changes at OA.
- f. OA’s reporting requirements are not always clear to the LHJs.

#### 2. *Prevention*

- a. There is a need for more flexibility in training and continuing education requirements for HIV/AIDS prevention and testing providers in the rural LHJs.

#### 3. *Care*

- a. Lack of specialty HIV care providers and support services for HIV/AIDS patients in rural areas present significant challenges for LHJs.
- b. Many providers are unaware of the Warmline, the Post-Exposure Prophylaxis (PEP) Hotline and the Perinatal hotline, and the services they provide.
- c. Most HIV-positive patients that are released from prisons in rural areas are lost to follow up. As a result, care and treatment of such patients are usually interrupted.

- d. An increase in testing brings additional concerns regarding care. Even one additional HIV-positive person creates resource issues in rural counties.

#### **4. Additional Cross-Cutting Challenges**

- a. Substance abuse in rural areas makes HIV prevention efforts and retention of patients in care especially difficult for LHJs.
- b. Hepatitis C virus (HCV) infection is a major issue for many LHJs. This is partly related to high rates of injection drug use in rural areas.
- c. Stigma and lack of anonymity are especially pronounced in rural areas and are a hindrance to testing, care, and treatment activities carried out by LHJs.
- d. Many LHJs are unaware of the funding available through Alcohol and Drug Programs (ADP). ADP has HIV set-aside funds which can be used to pay for HIV testing within drug treatment programs, as well as some HIV care for positive individuals who are in drug treatment.

**Key Participant Recommendations - (This is not an exhaustive list; Please see report for additional valuable recommendations. Note that these recommendations do not necessarily reflect existing OA priorities, but rather reflect recommendations from meeting participants.)**

#### **1. Staffing, Funding, and OA-Relationships**

- a. OA should as much as possible combine contracts into one master agreement and also review non-HIV models, such as the Emergency Preparedness funding model (one contract with three funding streams, three fiscal years, and two scopes of work).
- b. OA should allow rural LHJs flexibility in the use of funds.
- c. OA should determine which requirements are mandated by funders and which have been developed by OA.
- d. Since rural LHJs have limited staff and funds, they should be provided with training that will officially enable them to perform multiple tasks.
- e. Surveillance staff could be utilized as additional outreach workers especially after the implementation of Enhance HIV/AIDS Reporting System (eHARS).
- f. OA should designate a contact person (plus a phone number and e-mail address) who would serve as the first point of contact for (or as a liaison between) the LHJs and OA.
- g. A summary that coordinates requirements and dates for all reports that are required by OA should be provided to LHJs. OA should provide information about all possible funding sources to the rural LHJs.
- h. OA program staff should coordinate monitoring and site visits to reduce burden on LHJ staff.
- i. OA should reduce the number of discreet programs but maintain the objectives.

#### **2. Prevention**

- a. OA should minimize continuing education requirements.

- b. OA should use all possible (and a combination of different) ways to deliver training to the rural LHJs.
- c. OA should develop a Training of Trainers (TOT) for the HIV Counseling and Testing (C&T) Program.
- d. OA should have more flexible ways to deliver training and technical assistance. These should include distance learning, web casts, face-to-face trainings, TOTs, and other methods.
- e. OA should develop guidance to clarify HIV testing laws.
- f. OA should develop guidance regarding different requirements for HIV testing in HIV C&T sites, non-medical settings and medical settings.
- g. LHJs should increase routine HIV testing in medical settings.

### **3. Care**

- a. OA should officially and regularly provide general HIV training for non-HIV/AIDS physicians in rural areas, especially those who see HIV/AIDS clients.
- b. OA should make information available to LHJs and providers in rural areas about existing Warmline, PEP Hotline and Perinatal Hotline, telemedicine, telephone consultations, web-based consultations, etc. OA should also encourage the use of these resources.
- c. OA should encourage the California Department of Corrections and Rehabilitation (CDCR) to collaborate with HIV/AIDS treatment/care providers in the local communities into which HIV-positive prisoners are released to ensure continuity of care and treatment for such patients (bearing in mind current statutory laws).
- d. OA should encourage enrollment in the AIDS Drug Assistance Program (ADAP), Early Intervention Program (EIP), and other programs for the incarcerated prior to release.
- e. LHJs should increase coordination between Transitional Case Management Program (TCMP) with EIP, Bridge, and Community Based Care programs to identify ways to increase the continuity of care and treatment for clients after release.
- f. LHJs should increase the utilization of other non-OA distance learning opportunities such as telemedicine, warm/hot lines, Web med, etc.
- g. OA should collaborate with the TB Control Branch to regularly provide the LHJs with education about current developments in TB testing and treatment, especially in AIDS patients.

### **4. Additional Cross-Cutting Challenges**

- a. OA should create a networking forum on the OA website that is especially dedicated to the rural areas of California, where LHJs could interact and exchange ideas about successful programs, etc.
- b. LHJs should utilize other training and technical assistance resources outside of OA—Sexually Transmitted Diseases (STD)/HIV Prevention Training Center (PTC), Pacific AIDS Education and Training Center (PAETC).
- c. OA should develop the OA website to become a more effective resource referral site for prevention training and technical assistance.

- d. OA should make information available to HIV/AIDS staff in rural LHJs about HCV testing, treatment, and care. In addition, OA should provide them with testing and treatment guidelines for HCV in HIV/AIDS patients.
- e. OA should work with the relevant organizations to incorporate messages about testing for HCV into the HIV testing campaigns.
- f. OA should collaborate with state and local law enforcement, and local politicians to lay the groundwork for good relationships and possibly facilitate more syringe exchange programs (SEPs).
- g. LHJs should increase collaboration with Title 10 and family planning organizations. These organizations can utilize their funding to pay for testing and prevention activities.
- h. LHJs should learn more about the existence of ADP HIV set-aside funds and investigate which counties are not spending their full allotment of funds. Further, there should be policy changes which encourage collaboration on the local level between the public health department and the local alcohol and other drug program administrators.

## INTRODUCTION

The definition or classification of areas as “rural” varies greatly depending on the purpose (Appendix 1). The United States (US) Census Bureau's classification for the 2000 Census for example, stated that “rural” areas consisted of all territory, population, and housing units located outside of urbanized areas and urban clusters. It defined urbanized areas and urban clusters as core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile<sup>1</sup>.

On the other hand, the US Office of Management and Budget (OMB) classifies as “non-metropolitan” (i.e. rural) regions of the US with a total population of less than 50,000 people<sup>2</sup>. By the OMB classification, which the Centers for Disease Control and Prevention (CDC) also adopts, approximately 20 percent of the US population, some 60 million plus people, are said to be living in rural areas<sup>3,4</sup>.

Delivery of and access to medical care in rural areas is accompanied by many challenges. Despite the fact that 20 percent of the US population lives in rural areas, less than 11 percent of US physicians practice there<sup>3</sup>. Nearly 50 million people in rural US are said to face challenges with accessing health care<sup>5</sup>. Also, about 20 percent of the 46-47 million uninsured Americans are rural residents<sup>6,7</sup>. Nearly one-half of rural residents are said to suffer from a major chronic illness and yet rural residents average fewer medical appointments than residents of urban areas<sup>8,9</sup>. The shortage of health care providers in rural areas extends to most medical specialties, including dentistry<sup>10,11</sup>. Even when services are available, rural dwellers usually face distance, terrain and time-related barriers which make it difficult for them to access these services.

HIV/AIDS service delivery in rural areas is even more challenging due to major HIV/AIDS-specific barriers affecting delivery, access to, and retention in care. Stigma, lack of HIV medical specialists, injection drug use, transportation, and lack of funding are just a few of such barriers. These barriers make it difficult for Local Health Jurisdictions (LHJs) and their partners, in rural areas or urban/metropolitan areas with rural-like areas/issues, to perform HIV surveillance, education, prevention, care and treatment activities and also to deliver HIV/AIDS support services.

Currently, it is estimated that between 1,039,000 and 1,185,000 people in the US are living with HIV/AIDS<sup>6</sup>. As many as 250,000 of them are estimated to know they are HIV positive but are not receiving any regular medical care while another 250,000 are estimated to not know they are HIV positive<sup>12</sup>. According to the CDC, more than 51,000 cumulative AIDS cases among adults and adolescent living in rural areas were reported in 2006<sup>2,13</sup>.

In California, between 132,072 and 170,066 people were estimated to be living with HIV infection in 2008<sup>14</sup>. Of that number, between 27,369 and 33,513 were estimated to be unaware of their infection.

The aforementioned challenges and barriers to HIV/AIDS service delivery in the rural US does not only pose challenges to care and delivery of support services, but also to HIV surveillance, education and prevention activities delivered by rural LHJs and metropolitan LHJs containing rural-like areas/issues.

In view of the challenges and barriers posed to HIV/AIDS service delivery and activities in rural/rural-like areas of California, the California Department of Public Health/Office of AIDS (CDPH/OA) hosted a “Rural Think Tank” on March 2-3, 2009 to consider how to most effectively maximize the use of the limited resources available to accomplish high-quality HIV/AIDS education and prevention, care and treatment, and surveillance activities. This initial Rural Think Tank (RTT) also considered how to best provide technical assistance to low HIV prevalence areas (i.e. rural areas) throughout the state.

Although the 2009 budget proposals for California and its outcome were not known at the time of the RTT meeting, considering the current economic hardships and budget crisis in California, a RTT meeting to discuss how best to maximize the use of limited HIV/AIDS funds and resources could not have come at a more opportune time.

### ***Background***

OA funds HIV/AIDS surveillance, education and prevention, and/or care and support services in all 61 LHJs throughout the state of California. Funds are usually allocated based upon the disease burden in each LHJ. Low prevalence (rural) areas often receive limited funds to carry out HIV/AIDS-related activities.

Rural LHJs and metropolitan LHJs containing rural-like areas or issues face unique obstacles compared to urban/metropolitan-only LHJs. Some, such as distance, unique stigma-related and poverty-related issues are common to both groups. In addition to these however, rural LHJs receive minimal funding, while metropolitan LHJs containing rural-like areas/issues need to make resource allocation decisions taking into account both their urban and rural concerns.

### ***Purpose and goals of the meeting***

The main purpose of the RTT meeting was to identify policy and program changes at OA which are likely to facilitate appropriate and high-quality HIV education and prevention, care and treatment, and surveillance activities in rural LHJs and metropolitan LHJs containing rural-like areas/issues.

Meeting attendees considered successful programs and strategies as well as barriers and obstacles that hinder HIV/AIDS activities in rural LHJs. In addition, attendees brainstormed about potential policy and program changes at OA.

The meeting focused on three main goals:

1. To identify policy and program changes in OA likely to facilitate appropriate and high-quality HIV education and prevention, care and treatment, and surveillance activities in rural LHJs and metropolitan LHJs containing rural-like areas/issues.

2. To facilitate access to relevant non-OA-sponsored training, consultation, and other resources.
3. To facilitate collaboration within and between LHJs.

### ***The process of planning the Rural Think Tank***

The process began by sending letters to local AIDS directors in all 61 LHJs of California through the California Conference of Local AIDS Directors (CCLAD). The letter presented them with the idea of a RTT and surveyed them about their interest in such a meeting. A favorable response was overwhelmingly received from them along with useful specific information regarding what they were interested in discussing.

### ***Defining rural***

For the purposes of this meeting, the classification of counties as rural, or as containing rural areas/issues, was left to the discretion of each individual LHJ. In view of this, all 61 LHJs in California were officially invited to the RTT meeting.

### ***Invitees***

In addition to the LHJ representatives, federal, state, and training partners were also invited. Appendix C shows a complete list of all invitees.

### ***Site visits***

Before the meeting, LHJs in three counties: Shasta, Madera, and Imperial—in Northern, Central, and Southern California, respectively—were visited by OA staff to learn at firsthand about the problems rural LHJs face. LHJs at Shasta and Madera Counties invited representatives from LHJs of neighboring counties to attend their meeting. Representatives from Merced and Fresno Counties attended the meeting at Madera County and the one at Shasta was attended by representatives from Butte, Glenn, Tehama, Plumas, and Del Norte Counties.

The planning committee, which consisted of Dr. Michelle Roland (OA), Amy Kile-Puente (OA), Sabina Laveaga (Imperial County), Heidi Vert (Shasta County), and Anne Harris (Madera County), held several meetings and teleconferences to plan the agenda for the RTT meeting.

### ***The meeting***

This initial RTT was hosted by OA on March 2-3, 2009, at the Sacramento Holiday Inn.

This two-day meeting consisted of a morning and an afternoon session on the first day, plus a morning session on the second day. The first day started with a welcome address from Dr. Michelle Roland, Chief, OA, followed by self introductions of attendees. The group then broke up into small groups to discuss issues identified on the agenda. Each breakout session had a pre-assigned facilitator and note taker. Four sessions (each lasting an hour) were held simultaneously in the morning and another four were held in the afternoon of the first day. Each group discussed just one topic on the agenda during each session. All the small groups got back together before the end

of the morning session (and again for the afternoon session), and the entire group of attendees discussed the key points that emerged during the small group discussions.

There was only a morning session on the second day. During this session, participants prioritized all the key points that emerged during the discussions the previous day's discussions.

The meeting came to a close around noon on the second day with a thank you address from Dr. Roland.

The discussion topics, key issues that emerged during the RTT meeting and participants' recommendations are summarized below under the heading, "Discussion topics and recommendations from participants."

## DISSCUSSION TOPICS AND RECOMMENDATIONS FROM PARTICIPANTS

### 1. Reducing OA-Associated Administrative Burden and Increasing Flexibility at LHJ Level

#### 1.1 *Contractors and monitoring*

##### 1.1.1 *Challenges*

- Too many agreements to deal with:
  - Master agreement for all OA programs.
    - Early Intervention Program (EIP) and AIDS Case Management Program (CMP).
    - Surveillance
    - HIV Counseling and Testing (C&T)
    - Prevention—with Neighborhood Interventions Geared to High-Risk Testing (NIGHT)
  - Non-master agreement
    - Ryan White (RW)
    - AIDS Drug Assistance Program (ADAP) administration – board action?
    - Public health labs – viral load, Therapeutic Monitoring Program
    - Housing Opportunities for Persons with AIDS (HOPWA)
- What are the real requirements from funders, and not just OA policy?
- Can LHJs have program flexibility to achieve goals within the current funding stream requirements?
- How does surveillance fit into the program?

##### 1.1.2 *Best practices*

- Shasta County: “A good non-HIV model is the Emergency Preparedness model—one contract (master agreement) with three funding streams, three fiscal years, and two scopes of work”.

##### 1.1.3 *Participants’ Recommendations*

- Combine more into the master agreement.
- Focus on C&T, ADAP, prevention, and surveillance.
- For small counties, one person that knows the county well can be the main person to deal with if there is a block grant.
- Let rural LHJs have block grants and more flexibility within programs and budgets.
- Clarify federal versus OA requirements.

#### 1.2. *Central Communication*

##### 1.2.1 *Challenges*

- Data entry burden and technology solutions.
- Overlapping reporting requirements.
- Duplicate mailings.
- Information gap between OA and LHJs. There is insufficient notification from OA on policy changes, and on what OA is doing in general. There seems to

be an expectation that LHJ staff will simply go to the website, rather than OA making an effort to reach out to and inform them.

### 1.2.2 *Best practices*

### 1.2.3 *Participants' Recommendations*

- Clarify OA contact.
- Central OA contact/communication person or one consultant.
- Help identifying non-OA monies.
- AIDS Regional Information and Evaluation System (ARIES) should share information between programs (e.g., must sign out from each program screen for the same client).
- Provide a summary of key requirements and dates.
- Adapt the grid from HIV C&T of contact people for other OA areas. Check to make sure this is correct and put it on the website. Keep it updated.
- There is a need for a liaison to help get you started when you contact OA.
- Coordinate reporting requirements.

## 1.3 **Others**

### 1.3.1 *Challenges*

- Continuum of care.
- The local implementation group (LIG).
- The LIG requirement; especially the RW advisory group requirement (only LHJ staff ends up meeting with each other).
- The two parts of the Local Evaluations Online (LEO) system are not “talking to” each other.

### 1.3.2 *Best practices*

### 1.3.3 *Participants' Recommendations*

- Combine monitoring and site visits.
- Reduce discreet programs but keep objectives.
- Reduce board actions; be mindful that each contract amendment requires board approval at the local level.
- Retool CMP and EIP, etc., to enhance continuum of care.
- Coordinate fiscal years.
- Have one report for non-federal programs.
- Clarify the narrative elements needed in reporting (especially new with LEO).
- Revamp RW for continuum of care.
- Messages from various OA programs to care provider should be consistent.

## 2. **Enhancing Training and Technical Assistance and Focusing Training Requirements**

## **2.1 Training**

### **2.1.1 Challenges**

- How long do LHJs need to do continuing education training (CET) as a requirement?
- Basic 1 and Basic 2 (B1/B2) are of real value to the inexperienced; not so much to the experienced health professional.
- The length of training programs is a barrier and limits the ability of rural LHJ staff to attend.
- Rural LHJ staff has a hard time traveling for training.

### **2.1.2 Best practices**

- B1/B2 is very important for counseling skills.
- B1/B2 is great from nurse's point of view, teaches counseling skills.
- B1/B2 helps build up knowledge across all areas of public health and HIV/AIDS.
- B1/B2 is excellent.

### **2.1.3 Participants' Recommendations**

- Bring counselors in to do CETs/Training of Trainers (TOT).
- Expanding capacity to do continued education with HIV C&T coordinators.
- Develop quality indicators to address the expanding capacity to do continued education with HIV C&T coordinators.
- Need to develop relationships in addition to online trainings.
- Use Webex training for parts of some training programs but maintaining face-to-face training for other parts also.
- Training entities could partner with colleges to incentivize continuing training.
- Use TOT manuals for medical providers.
- Client-centered training is very important. If possible, it would be better to shorten it.
- Advocate for training all staff at same time.
- Pre-training before B1/B2 might be helpful.
- B2 is not as necessary as B1.
- Provide clearer guidance about when B1/B2 is required.
- Need for general HIV training for physicians who have clients come in the door and do not recognize it.
- Training of Medical Doctors (MDs) on issues of disclosure as far as HIV/AIDS is concerned.
- Make rural curriculums available and easily accessible.
- How do LHJs train and assess quality of care?
- There is a need for distance learning.
- More online learning is needed.
- Trainings on DVDs would be helpful.
- Send letters that includes menu of Prevention Training Center (PTC) trainings to LHJ consistently.
- More flexible ways to deliver training and technical assistance:

- Distance learning
- Web cast
- Face-to-face training sessions
- TOT (low level experts)
- Others
- Identify context of setting (i.e. adaptations of curriculum for rural areas).
- Develop core competencies with OA and training partners.
- Develop training and technical assistance to improve quality of practice (to achieve core competencies).
- Assess actual practice of HIV/AIDS-related activities by LHJs at the local level.
- Offer more online trainings.
- Offer more CET topics.

## **2.2 Technical Assistance**

### **2.2.1 Challenges**

- Collaborative efforts:
  - To develop collaborations
  - Clinical support
  - Need to make sure that LHJs work with the tuberculosis (TB) program
  - Need to work with medical interpreters training and recruitment
- Need for collaborative effort involving bilingual students to increase translating capacity.
- Laws are unclear about testing.

### **2.2.2 Best practices**

- Fresno County:
  - Utilizes volunteers to train as outreach workers and HIV counselors
  - Works with the University Medical Center
  - Works with county behavior health which includes substance abuse

### **2.2.3 Participants' Recommendations**

- Can LHJs use students and interns as testers?
- Need a combination of tools to enhance training opportunities.
- Need support in face-to-face trainings, followed by ongoing trainings.
- Need to get schools and public health to talk.
- Would like OA to clarify laws about testing.
- Gathering resources and advertise them more widely.
- Need to clarify medical setting versus non-medical setting requirements for providers.

## **Some Training and Technical Assistance Resources**

- PTC provides training and technical assistance services. It is funded by OA and the CDC. Their website is: [www.stdhivtraining.org](http://www.stdhivtraining.org).

- PTC does Diffusion of Effective Behavioral Interventions (DEBIs) and CETs for HIV counselor trainings.
- PAETC
  - Funded by the Health Resources and Services Administration (HRSA).
  - Provides training for clinical care.
  - It has 11 local performance sites that provide services in their community.
  - Warmline.
    - Telephone line.
    - Hotline—PEPline.
    - Perinatal hotline.
- California AIDS Clearinghouse
  - Their website is: [www.hivinfo.org](http://www.hivinfo.org).
  - Carries educational materials for prevention and care.
  - Three ways to get materials:
    - Staff identify gaps to assess need for materials.
    - Staff make materials in-house.
    - OA will direct/list needed materials.
  - Mini grants.
  - Condoms.
- CHOICE HIV website.
  - The CHOICE website is: [www.choicehiv.org](http://www.choicehiv.org).
  - Have DEBIs and other interventions (115).
  - Provide easily accessible information for providers.
- Other potential resources.
  - Medical students.
  - Master of Public Health students.

### **3. Maximizing Prevention with Minimal Resources**

#### **3.1 Collaborating with others**

##### **3.1.1 Challenges**

- Issues surrounding coordination of partner services: surveillance, case management, partner services, linkages, etc.
- In San Luis Obispo County, it is part of the contract for community-based organizations (CBOs) to attend HIV consortium meetings where HOPWA services, syringe exchange, etc., are discussed. OA direction was to focus on interventions but the consortium focuses on advocacy.

##### **3.1.2 Best practices**

- Butte County: “No issues; all programs work together.”
- Lake County: “Fifteen percent of our time is given to HIV. We do great things with our little money. Building relationships with people is good. A lot of time is devoted to filling out forms with illiterate farm workers. I was able to hire peer educators. I feel happy that we can give Hepatitis vaccines. Our work is

not in the health departments, 90 percent is building relationships and staying connected.”

- Sharla Smith of the California Department of Education (DOE): “In rural areas people represent everything, including schools. We are trying to re-train schools to focus on HIV. Public schools have a requirement to teach HIV/AIDS. Public health workers should partner with the schools; schools should not rely on public health to do it all. There are ways to partner. Don’t think DOE thinks public health should do it.”

### *3.1.3 Participants’ Recommendations*

- Increase collaboration with Title 10 and family planning organizations because their funding can be used to pay for testing.
- Needle exchange kiosks look like mail boxes. Partnering with recycling centers that supports placing kiosks at the recycling centers is helpful. At three-fourths full, a phone call is made and the boxes are picked up by a medical waste provider who gets paid.

## **3.2 HIV Testing**

### *3.2.1 Challenges*

### *3.2.2 Best practices*

### *3.2.3 Participants’ Recommendations*

- Publicize the fact that family planning organizations and Title 10 funds can be used to pay for testing in order to free up funds from OA for prevention activities.
- There is a desire from the counties for nurse case managers to have minimum certification requirement for testing. The question is: What is the minimum training and is OA able to back off on some of the training?
- Shasta County: “As an EIP case manager, I have an opportunity to go out and do testing. It is a great opportunity to be able to do testing on the spot, in homes. Some agencies are already funded; they would just need the rapid test training. It may add extra work to CBOs with testing, Counselor Information Forms, and entering the data into LEO. LHJs could provide assistance to CBOs. There would be assurance of the tests being run. It is a good opportunity though, for the client to find out their status.”
- Would it be helpful to have a testing questionnaire with less information? Anything to streamline the process is helpful. There is still a lot of time involved for the provider to administer the test.

## **3.3 Education and Training**

### *3.3.1 Challenges*

- Yolo County: “One hundred thousand dollars came from local monies. Next year it will be \$0. We will need to find volunteers and apply for grants. We have to cross county lines when reaching out to men who have sex with men (MSM); since there is no gay bar in Yolo so we go to Sacramento County”.

- In the rural areas, HIV is related to injection drug use and to MSM who live in urban areas but come home to be taken care of by their families when they get infected with HIV.
- Rural counties have many injection drug users (IDUs).

### 3.3.2 *Best practices*

- Participants discussed the OA website and shared that it has improved and has helpful information. The counties give school nurses and teachers information from the website. “It is a great resource and we utilize what is out there as a referral.”
- Alice Gandelman: “PTC provides training and works with providers to support better interactions among people in smaller areas”.
- Harm Reduction Coalition has a number of free trainings and offer overdose trainings, outreach, and dealing with trauma and sexual abuse.

### 3.3.3 *Participants’ Recommendations*

- Increase TB testing and education.
- Demonstrate OA and TB Control Branch collaboration through periodic mailings to update on current TB and HIV research and best practices to help normalize associating TB and HIV together.
- Increase ease of access to technical assistance to help schools better meet education code by publicizing that the California Teacher’s Association provides free training to teachers and other sources of technical assistance.
- Develop the OA website to become a more effective resource referral site for prevention training and technical assistance.
- Providing referrals to sources of technical assistance and training for TB, Hepatitis C virus (HCV), and school adherence to education code regarding HIV education on the OA website. The link to the California Department of Education (CDE) website is [www.cde.ca.gov/ls/he/se/index.asp](http://www.cde.ca.gov/ls/he/se/index.asp).
- Technical assistance resources should also be included on the OA website for psychologists, dentists, and other health professionals working with HIV-positive clients and communities interested in implementing telemedicine.
- Increase the capacity for case managers and field staff to do testing for partners and social networks by developing a new streamlined B1/B2 and also appropriate regulations to make it easier for persons (possibly students or interns) to become certified HIV counselors and testers.
- More HCV and HIV training resources should be provided on the OA website.

## **3.4 *Programs—Syringe Exchange Program (SEP)/Title 10/TB/Prevention with Positives (PWP)***

### 3.4.1 *Challenges*

- Shasta: “The problem is still with law enforcement. It may take some time for them to realize that it is not a problem. In prevention, when looking at the cost we gain and we lose. Why are we still doing it? How sustainable will it be?”
- Shasta: “Should the funding get proportionately cut for SEPs?”

- Shasta: “How can we integrate syringe exchange to what is already being offered?”
- Shasta: “How do we get SEP out of the silo?”
- Dr. Michelle Clark: “As a psychiatrist there are issues surrounding prevention and the influence of childhood sexual abuse and safe sex practice. What are the resources for providing these services?”
- Prevention or sexual activity among positives having serosorting sex with STDs is going up.
- How active are the prevention counselors in prisons? Are they accessible?
- How prepared are the prevention counselors when it is not a behavioral issue but a biomedical/viral load issue?
- There is an issue surrounding clients knowing each other so they do not come to group meetings.

#### 3.4.2 *Best practices*

- San Luis Obispo County Health Department allows needle exchange in the department’s parking lot.
- In Shasta County, the California AIDS Clearinghouse has allowed them to provide condoms to the community.
- Shasta County has initiated a SEP with augmentation funds and has installed kiosks across the county.
- Shasta County suggests that a county start with a sharps disposal program if they want to get their foot in the door with syringe exchange.
- Shasta County: “We could not have done it without Alessandra. We used information from other counties. If you think your county may implement SEP, talk to Alessandra Ross of OA.”
- Yolo County: “I like combining programs so that you only have to deal with one person. It is helpful if the program coordinator identifies their program in the e-mail, phone message, etc. Some combinations do not work but the idea of combining is good. Would like some consistency”.
- Title 10 integrate family planning and HIV testing.
- Title 10 funds can be used for prevention.
- Title 10 funds a lot of work around family planning.
- Title 10 funds for men are included in the program.
- Recent studies have looked at HIV-infected TB cases. TB program and HIV services combined. It is challenging to integrate HIV into TB. Any advice?
- In San Luis Obispo County, the TB program is located upstairs. A program person sends clients downstairs. This is not an issue in small counties. Having the programs in the same clinic is helpful. A TB nurse walks the patient downstairs but it is a “hand off” approach.
- In Shasta County, if a tester is available they walk the patient down the hall.
- In Lake County, one person is responsible for STDs and TB. That person does home visits and does the rapid testing there.
- Use affordable speakers to do PWP meetings.
- San Luis Obispo County did a PWP retreat where it offered:

- Relaxation
- Cooking
- Learning about “How to tell people you are HIV positive”
- Fun activities

Clients had to pay but some prevention money paid for the speakers.

- Michelle Roland: “There is pressure on OA with limited resources and money. People are struggling with what to do with prevention dollars. There are two major things to do: a) Focus your prevention interventions where you know HIV is (e.g., PWP and prevention services); and b) Use what you know works (evidence-based interventions).”

### 3.4.3 *Participants’ Recommendations*

- With limited funding, risk assessments, social networking, and syringe exchange were suggested as areas to focus on.
- Where are the rural programs finding success with PWP programs?

## 4. Correctional Issues

### 4.1 *Education and Training*

#### 4.1.1 *Challenges*

- There are many challenges to training correctional providers in rural areas.
- Patient educational materials currently available are outdated.

#### 4.1.2 *Best practices*

- One of California Department of Corrections and Rehabilitation’s (CDCR) goals is to provide education immediately upon diagnosis.

#### 4.1.3 *Participants’ Recommendations*

- To ensure continuity of care for inmates and parolees, increase the number of HIV knowledgeable providers in rural settings through training.
- Education is greatly needed for inmates and providers. Most prisons are in rural areas, where stigma around HIV testing and prevention is likely to be more of an issue.

### 4.2 *Testing*

#### 4.2.1 *Challenges*

- Barriers to HIV testing in prisons includes stigma on the inside.
- The possibility of being transferred to another prison is a barrier to HIV testing in prisons.
- Fears that participation in programs will be limited due to being transferred are also barriers to testing in prisons.
- There have been instances where an HIV-positive result was not returned to an inmate prior to their being transferred to another prison or their first scheduled visit with a clinician.

#### 4.2.2 *Best practices*

- A pre-test script has been developed by the CDCR Public Health Unit to standardize the information provided to inmates prior to testing.
- OA is working with CDCR to provide testing and treatment in institutions.

#### 4.2.3 *Participants' Recommendations*

- In addition to information required to be shared with patients who are offered HIV testing in the community, informed consent in correctional settings should include that the warden and parole officer will be notified of a positive result and that testing positive in CDCR may result in transfer to another prison.

### **4.3 Treatment**

#### 4.3.1 *Challenges*

- Major barriers include the lack of an efficient medical record system to identify known HIV positives within each prison and also to track HIV patient care and movement within and between prisons.
- Late or no notification that an HIV-positive patient is arriving.
- Community hospitals not recognizing opportunistic infections.
- Delays in getting non-formulary medications.
- From a meeting participant: "About one-half of unnecessary deaths of prisoners with HIV/AIDS is due to failure to be diagnosed and/or treated correctly while out at a community hospital".
- Medical history (e.g., past vaccinations) are difficult to track down for inmates after release. Is there a registry for this type of information?
- Who can do prevention for positives being released from prisons?
- Can enrollment in ADAP occur prior to release?

#### 4.3.2 *Best practices*

- CDCR goals are to standardize HIV care across all prisons, ensure HIV-positive patients are able to see a specialist very soon after entry, and to provide education immediately upon diagnosis.
- University of California, San Francisco (UCSF) consulting physicians provide care for approximately 1,400 inmates at any given time have been maintaining their own HIV patient database.
- UCSF consulting physicians noted that they are trying to make information about inmates' medical history (e.g., past vaccinations) available via a discharge list.
- UCSF consulting physicians noted that they routinely address prevention for positives during their clinical visits.

#### 4.3.3 *Participants' Recommendations*

- Continuity of care for inmates hospitalized in CDCR and community hospital: providers should co-manage patients to ensure continuity of care.

- UCSF consulting physicians' patient list would be very helpful to LHJ surveillance coordinators for the purpose of distinguishing prevalent from new cases that need to be reported to HIV/AIDS reporting system.
- LHJs need more flexibility when working with parolees. They often have trust issues and will refuse care if they are expected to enroll right away.
- EIP and other LHJ programs need to have more advanced notice of inmates being released to their areas in order to triage them for services.
- CDCR has to come up with an agenda to start meeting with public health departments, LHJs in rural areas, and providers.

#### **4.4 Transitional Case Management**

##### **4.4.1 Challenges**

- TCMP for patients being released. Challenges include prisons being mainly in rural areas while majority of inmates are returned to urban counties.
- Inmates may be released suddenly leaving insufficient time for discharge planning, also TCMP provides only 90-day follow up.
- There was concern that if TCMP is reorganized in June to become more centralized (north and south regions) collaboration between TCMP and LHJs will be more challenging.

##### **4.4.2 Best practices**

- TCMP will be expanding its presence from the current 8 prisons to all 33 prisons.
- TCMP would like to coordinate with EIP, Bridge, and other OA programs. Related to this, OA has been looking at ways to track TCMP referrals in ARIES.

##### **4.4.3 Participants' Recommendations**

- There needs to be more coordination between CDCR and UCSF providers, CDCR Public Health Unit, LHJs, and TCMP. One possibility for increasing collaboration would be to meet at prisons when UCSF physicians are already there doing their on-site clinics.
- TCMP should work with EIP, Bridge, and Community-Based Care programs to identify ways they can coordinate to reduce loss to follow up of released inmates and provide services through OA and other providers.

### **5. Enhancing Specialty HIV/AIDS Medical Care: Utilizing Warmline, PAETC, Telemedicine, and Web-Based Consultants**

#### **5.1 Specialty HIV/AIDS Medical Care**

##### **5.1.1 Challenges**

- Supportable models are not always available in areas needed.
- Some communities have too few non-specialty care providers who accept HIV-positive patients.
- Staff changes can cause decreased use of technical media.

- Rural providers must be comfortable and develop trust with specialist and the system for it to work.
- Providers in rural areas need an ongoing relationship with specialist. This is key to developing comfort and trust.
- The delivery of specialty HIV/AIDS medical care requires commitment from both parties—LHJs and the specialists.

### *5.1.2 Best practices*

- On-site consultation and training by specialists.
- Remote consultation through web-based case conferences.
- Remote access to specialty care through telemedicine.
- PAETC
  - Provides training and clinical support to providers
  - Eleven local sites which cover entire state
  - Provide individual on-site consultation
  - Phone consultations
  - Technical assistance workshops provided on location
  - Preceptorship programs

### *5.1.3 Participants' Recommendations*

- Need to send out ambassadors to improve awareness.
- Explore the possibility of using telemedicine and web-based technology for case management and team meetings.
- Comfort levels can be enhanced by beginning first with face-to-face consultations then working towards using telemedicine format.
- Role of distance-based clinical support: It should be tailor to specific needs.
- Identify and train interested non-HIV medical doctors who provide care for HIV/AIDS patients.
- Investigate various technologies for “distance-based” medicine (telemedicine, warm/hot lines etc).
- Training consultants should first develop face-to-face contacts in rural areas to help build trust and alleviate discomfort of care providers.
- Distance-based clinical support should be multidisciplinary (case managers, registered nurses, mental health specialists, etc.).
- Development of a rural curriculum for outpatient care hospitals.
- Funding for distance care: Use various models.
- Electronic access to medical records.
- Create guides for information required, questionnaires, case manager liaison, and malpractice concerns.

## **5.2 Telephone Consultations**

### *5.2.1 Challenges*

- Many do not know how easy Warmline/PEPLINE/Perinatal lines are to use.

### *5.2.2 Best practices*

- Use of telephone consultation for specialty care.
- National HIV Consultation Service (Warmline/PEPLine/Perinatal line).
  - Warmline provides telephone clinical consultation across the clinical spectrum from basic testing questions to complicated cases.
    - Staffed Monday-Friday 6 a.m. to 5 p.m., with 24-hour voicemail.
    - Hosts a panel discussion once a month.
  - Warmline physicians have developed lasting relationships with providers who call frequently.
  - PEPLine provides consultation on post-exposure questions.
    - Staffed 24 hours a day.
  - Perinatal line provides consultation for questions related to care and treatment of pregnant women and exposed infants.
  - Remote consultations with specialists allow better outcomes for client and provider.

### 5.2.3 Participants' Recommendations

## 5.3 Telemedicine

### 5.3.1 Challenges

- Telemedicine services are not covered by many insurances; Medi-cal covers some services but with restrictions.
- For it to work, patient must also be comfortable with components of the system.

### 5.3.2 Best practices

- The California Telemedicine and eHealth Center (CTEC) is available to assist in development of telemedicine programs.
- Program must meet security and Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations.
- CTEC:
  - Uses video conferencing and a flexible group of electronic technologies to provide remote clinical services.
  - Assisted in developing ten rural networks with 125 site in California.
  - Has a broad spectrum of care and services:
    - Assessments in home, remote clinics, hospitals.
    - Provide patient education and medical interpretation.
- UCSF telemedicine
  - Provides HIV specialty services in HIV, HCV, transgender, and chronic pain health issues.
  - Uses telemedicine and on-site collaboration for assessment and care of complicated cases.
  - Provides peer education and consultation for providers in correctional settings.
  - Currently outreaching to hospitals who care for inmates, and physicians and CBOs who work with inmates after release, for consultation and education (and keeping track of patients) can be difficult. Some

correctional institutions and local hospitals fail to diagnosis or treat appropriately. It is however difficult to connect with these institutions and medical doctors.

### *5.3.3 Participants' Recommendations*

- Use of Ryan White funds for telemedicine equipment and services needs investigation.
- Using telemedicine to provide services across the health care spectrum (instead of using it for HIV only), can increase cost effectiveness.
- Need to use development funds for expansion of remote access model.
- Use of telemedicine as a provider extender: It can be used for assessments, co-management, procedures (i.e. anal colposcopy).
- Use of telemedicine as a provider extender: Primary physicians may be present but it is not required. Only the patient and site coordinator could be present.
- There is a need for a program coordinator or identified champion to keep motivation in telemedicine programs.
- Consider the cost effectiveness of telemedicine versus transportation to a specialist for LHJs with a small number of patients.

## **5.4 Web-Based Consultants**

### *5.4.1 Challenges*

- Some web-based systems may be cost prohibitive.

### *5.4.2 Best practices*

- At the University of California, San Diego (UCSD), physicians could submit cases weekly for consultation/case conference.
- UCSD: "A central location not needed. Only a computer with high-speed Internet access and a telephone line is needed to participate in a web-based consultation. Telephone lines allow verbal conferencing".
- Additional features of the UCSD web-based consultation: Photos, charts, etc., can be imbedded, question and polling, and side chat feature in web presentation.
- UCSD system cost \$7,000 initially at \$2,000 maintenance fee.
- Other system options are available with UCSD.
- University of California, Davis (UCD) provides quarterly tutorials and consultations to rural providers in Quincy and Susanville, California, but it is labor intensive as a UCD physician is required to be out of UCD clinic for two days.

### *5.4.3 Participants' Recommendations*

- UCSD: "Finding the right market and timing for the web-based consultations is important".
- The Kaiser web-based model: "Patient portals" allow lab results to be posted in protected websites and e-mails between physicians and patients.

## **5.5 PAETC - Training, Technical Assistant, and Capacity Building**

### 5.5.1 Challenges

- Not all providers know of the variety of services available.
- Virtually all health departments expressed a need for assistance and resources for clinical capacity.

### 5.5.2 Best practices

### 5.5.3 Participants' Recommendations

## 6. Injection Drug Users, Non-Injection Drug Users and Substance Use

### 6.1 SEPs and HIV Prevention for IDUs

#### 6.1.1 Challenges

- The SEP Request for Applications is competitive. This is a challenge for low-prevalence counties.
- Except for some border counties, most rural counties have no access to sterile syringes and already have challenges with syringe disposal for the local diabetic community (apart from the very rural counties).
- Board approval of syringe access programs is highly unlikely in rural areas given the conservative political make-up of local boards.
- There is a lot of methamphetamine injection use in rural areas and it is difficult to get methamphetamine users to adhere to medication regimens.

#### 6.1.2 Best practices

- A few counties make use of the existing HIV set-aside funds distributed by ADP. These funds pay for HIV testing within drug treatment programs, as well as some HIV care for positive individuals who are in drug treatment.
- Some LHJs pilot SEPs within other programs. Shasta County did it within a syringe disposal initiative and Fresno County did it within a program which emphasizes bridge to drug treatment.
- Working with local law enforcement is important. Local law enforcement should be made aware that it is OA education and prevention funds that are used for SEPs and not local general funds. Also working with local law enforcement to site SEPs is important.
- The Harm Reduction Coalition provides technical assistance in establishing SEPs, as well as overdose prevention. Some counties found that avoiding the term "harm reduction" and using "risk reduction" or "community safety" instead helps.

#### 6.1.3 Participants' Recommendations

- OA should fund a pilot program that links syringe disposal with syringe access, and uses disposal as a method to encourage county approval of either syringe exchange or pharmacy sale of syringes.

- OA should take initiatives that will lay the groundwork for good relationships with law enforcement while anticipating changes in the law that will increase syringe access statewide.
- Health departments can partner with unauthorized SEPs.
- Make more services available for “users”
- OA should disseminate information about DEBIs and possible funding associated with their implementation to rural LHJs.

## **6.2 Drug Treatment and Overdose Prevention**

### **6.2.1 Challenges**

- Only few Methadone Maintenance Treatment (MMT) programs, other drug treatment programs and buprenorphine prescribers are available in rural areas.
- Some LHJs are doing C&T with set-aside funds, but not charging the appropriate entity—OA versus Alcohol and Other Drug (AOD) administrator.
- How is OA considering working with various types of treatment modalities, such as contingency management (“pee for pay”)?
- How many counties have either MMT or buprenorphine programs? What are counties doing about drug use by non-IDUs, apart from mostly providing HIV C&T in drug treatment programs?
- Risk of death from overdose is higher in rural communities due to transportation challenges.
- Overdose due to prescription medications is a huge problem in rural areas, especially opiate overdose.

### **6.2.2 Best practices**

- Naloxone prescriptions can reduce overdose fatalities dramatically in rural communities.

### **6.2.3 Participants’ Recommendations**

OA and ADP should collaborate to:

- Investigate which counties are not spending their full allotment of funds.
  - Remedy this through policy change which encourages collaboration on the local level between the public health department and AOD program administrators.
- Examine reporting requirements and other accountability measures; share data and data forms.
- Disseminate information to LHJs about the existing set-aside funds, opportunities for collaboration on the local level and about how to learn more.
- Include the above information with other communication about alternative sources of funding.
- ADP should provide a template memorandum of understanding (MOU) between public health and local AOD.
- At one point, ADP and OA had an MOU in which ADP paid OA to purchase rapid tests. Is that MOU still in operation?

- AOD staff may be trained for free in HIV testing under certain conditions.
- Information about what other agencies, such as ADP, are doing would also be helpful, especially when it impacts rural LHJs.
- ADP recently sent out a survey on the use of HIV test dollars (set-aside funds). OA should provide data to ADP, or data should be linked so that there is less repetitive data collection.
- Increase communication about use of ADP set-aside funds, by starting at the top and enhancing collaboration between OA and ADP.
- Make more services available for “users.”
- Collaborating with local ADPs for “set aside” funding would be helpful.

## **7. HIV Testing**

### **7.1 Testing in Medical Settings — General**

#### **7.1.1 Challenges**

- There is a need to do more testing than what is been done currently.
- Missed opportunity to test patients with TB. It is in the guidelines but the issue is implementation.
- Who is going to pay for routine testing—Medi-cal, private, out of pocket or refer to health department to do testing?
- A lot of doctors do not have time to do a rapid test because they may have only 15 minutes to see a patient.
- Rapid testing has requirements and barriers, such as, quality assurance, Clinical Laboratory Improvement Amendments (CLIA) requirements, temperature requirements, shelf life, and controls.
- Rapid testing is too expensive and takes too much time.
- Doing more testing in increased prevalence settings is a challenge.
- Lack of counseling.
- Guidance is needed regarding who should be tested. Should everyone be tested?
- Should the standard be rapid testing or conventional?
- Which test should be provided?

#### **7.1.2 Best practices**

- National Medical Association recommends testing African Americans twice every year.
- Some counties, such as Butte and Santa Clara Counties, are providing providers with resource guides for HIV testing and care.
- Is Kaiser doing routine screening?

#### **7.1.3 Participants’ Recommendations**

- Increase testing in medical settings: partner with American Medical Association.
- Include rapid testing in routine screening for other diseases/conditions.

- People assume they are being tested for HIV when they receive other testings, so HIV testing can be included in the routine tests.
- Provide letters recommending best practices to providers, suggesting screening as a way to get through stigma.
- Possible use of surveillance staff, especially after implementation of eHARS. This may provide more outreach providers.
- There is the need to proceed carefully otherwise a lot of precious resources would be wasted by testing “no-risk” individuals. Instead of testing everyone, more professionals (nurses, medical doctor’s, medical assistants, etc.) should be trained to be more aware of signs and cues that would trigger the offer of a test. Shrinking resources make it more vital that resources be targeted.

## **7.2 HIV Testing in Medical Settings — Emergency Departments (EDs)**

### *7.2.1 Challenges*

- EDs will not test you if they cannot give you the results before you leave.
- In EDs it may not be feasible to test everyone.
- Some barriers to rapid testing in EDs are funding, systemic change, staffing, what can they do? Who can do it? How long will it take? HIV exemptions?

### *7.2.2 Best practices*

- Some EDs use a strategy to test everyone admitted.
- Rapid testing in labor and delivery departments: provide technical assistance and training.
- Labor and delivery departments have presumptive eligibility so funding is not a problem for them.
- There are CDC grants available for routine testing in EDs of only three hospitals.
- If a patient tests HIV positive in an ED, they are linked to care.

### *7.2.3 Participants’ Recommendations*

## **7.3 HIV Testing in Medical Settings — Labor and Delivery Department**

### *7.3.1 Challenges*

### *7.3.2 Best practices*

- CDC recommends that HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women and that any woman who presents to the labor and delivery department during labor with an undocumented HIV status should be routinely provided with a rapid HIV test.
- CDC further recommends that any newborn whose mother’s HIV status is unknown should be tested for HIV. When the mother’s HIV status is unknown prior to the onset of labor and rapid HIV testing is not done during labor, CDC recommends that rapid HIV testing of the infant should be done immediately post-partum.
- Based on clinical trial and observational data, when antiretroviral prophylaxis intervention begins on HIV-exposed infants at the intrapartum (during labor or

delivery) or during the neonatal period, 9 to 13 percent HIV transmission rates are achievable. This represents a 50 percent reduction in expected HIV transmission rates without intervention.

### *7.3.3 Participants' Recommendations*

- Need to increase rapid testing in labor and delivery departments

## **7.4 HIV Testing in Medical Settings — Federally Qualified Health Centers (FQHCs)**

### *7.4.1 Challenges*

- Difficult to have FQHCs do HIV testing.
- There has been some resistance to testing; mainly related to the underlying fear of HIV and concerns about the lack of resources for following up a positive test with care.

### *7.4.2 Best practices*

- Some FQHCs are proactive about providing routine HIV testing.

### *7.4.3 Participants' Recommendations*

- FQHCs need to be targeted for rapid testing.
- There is a need to decrease barriers to HIV testing in FQHCs.

## **7.5 Linkages to Care and Demand on Care Systems**

### *7.5.1 Challenges*

- Increasing testing is going to increase the need for care. Care is already stretched.
- Concern of more HIV care needs if testing increases. Even one additional HIV-positive person creates issues in rural counties.

### *7.5.2 Best practices*

### *7.5.3 Participants' Recommendations*

- Need to treat more people with symptoms rather than catching them in the late stage.

## **7.6 Reimbursements**

### *7.6.1 Challenges*

- Reimbursement is a barrier to testing and care.

### *7.6.2 Best practices*

- How are tests paid for in rural counties? (County Medical Services Program, Medically Indigent Service Providers, AIDS Coalition for Education Program in Ventura County).
- Programs are sliding fee scale and usually include lab tests.

### *7.6.3 Participants' Recommendations*

## **8. Hepatitis C Virus**

### **8.1 HCV Testing and Diagnosis**

#### **8.1.1 Challenges**

- In the rural areas HCV is the epidemic blood-borne disease and not HIV.
- There is little access to HCV and hepatitis B virus (HBV) testing in rural areas.
- There is little access to vaccines for hepatitis A virus (HAV) and HBV in rural areas.
- MMT programs will not test for HCV without reimbursement.
- There is a considerable level of HCV stigma.
- Blood draw is a barrier to HCV testing in rural areas. There is a desire to eliminate the need for blood draw for HCV testing. This is currently waiting for US Food and Drug Administration (FDA) approval.
- ADP pays for HCV testing for HIV-positive individuals only.
- Some local health department refused OA HCV testing dollars, believing that since OA does not pay for confirmatory testing, it was unethical to offer the antibody test.
- How many people do AOD programs test with set-aside fund dollars?

#### **8.1.2 Best Practices**

- Siskiyou County participates in a Quest Diagnostics special program that offers low-cost blood draw and processing for participants.
- Health departments can refer clients to their provider for confirmatory HCV testing.

#### **8.1.3 Participants' Recommendations**

- OA should prepare for the anticipated FDA approval of the rapid oral HCV test.
- OA should consider whether they will purchase the HCV test kits or not.
- OA should consider whether the allocations to LHJs for HCV will remain the same or not.
- OA should make sure policies are in place to roll out the rapid oral HCV test once it is approved.
- OA should develop policies around the use of the rapid oral HCV test, including whether or not it should be used in addition to, or instead of conventional tests.
- OA should also develop guidelines for using the oral HCV test.
- OA should examine any relevant regulatory issues regarding the use of oral HCV, including CLIA exemptions.
- OA should re-examine and update the initial policies it created for LHJs doing HCV testing.
- OA should disseminate information on best practices of HCV antibody testing to all LHJs and also information clarifying whether it is valuable or not to test even if confirmatory testing is difficult or impossible to obtain within LHJs.

- OA should allow OA HCV testing dollars to be used to also test sexual partners of HCV-positive individuals and not just the IDUs alone.
- OA should provide guidance for LHJs regarding how HIV/HCV testing programs from both OA and ADP relate to each other. It will not be enough to post answers to these questions on the website.
- Provide HCV testing for sexual partners of those at risk for HCV.
- Add HCV to HIV partner counseling and referral services.
- Develop materials and infrastructure to help facilitate the rollout of rapid HCV testing.

## **8.2 HCV Care**

### **8.2.1 Challenges**

- There are only few HCV treatment services in rural areas.
- Indigent care programs will not pay for HCV screening.
- Local HCV treatment options are nonexistent.

### **8.2.2 Best practices**

- Some counties focus on immunization for HAV/HBV and screening for HIV and HCV for parolees at their mandatory orientation meeting.

### **8.2.3 Participants' Recommendations**

- OA should clarify whether or not Bridge workers can be used for delivering HCV-positive results and for linking mono-infected individuals to care.
- OA should disseminate information about basic care guidelines for HCV-positive individuals.
- OA should pay for nurses to deliver HAV and HBV vaccine.

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## APPENDICES

### Appendix A: Some Definitions of Rural

#### Variations on the Definition of “Rural” for AIDS/HIV Studies

- 1) Geographic areas were classified as rural (nonmetropolitan) if they were located outside metropolitan statistical areas (MSAs). MSAs are counties or groups of counties (with the exception of New England, which includes town boundaries) that represent an area with a central city with more than 50,000 residents included in an urbanized area with a population greater than 100,000. (n = 22).
- 2) Residence in a community with 50,000 residents or fewer (that is, the criteria used by CDC to designate communities as nonmetropolitan).
- 3) Rural counties include counties with populations of <2,500 to 19,999, adjacent and not adjacent to metropolitan areas. About 65 percent of all U.S. counties are rural and 14 percent of the U.S. population lives in these counties.
- 4) Residence in a community of 50,000 residents or fewer that was located at least 20 miles (32 km) from a city of 100,000 or more. The cut-off of 50,000 residents was employed because it is used by CDC to designate communities as ‘nonmetropolitan.’ In the United States, people living in small towns and rural communities have historically accounted for 5-7 percent of AIDS cases (CDC, 2001).
- 5) The present study considered respondents to be ‘urban’ if they reported living in a city with a population of 100,000 or more (n = 77), while respondents were classified as ‘rural’ if they: 1) lived in a town with a population of 10,000 people or less; and 2) reported living at least 15 miles away from a larger city (n = 28). (This paper did not have a good reference or justification for definition of “rural.”)
- 6) Low prevalence areas were defined at a cut-off at (note: these cut-offs are from a few studies, there are not many low prevalence area studies in relation to HIV that have well defined cut-off percentages):
  - a. <1 percent (the specific community chosen for the study had HIV 0.13 percent prevalence).
  - b. <15 percent.
  - c. CDC seems to consider <1 percent prevalence as low prevalence. A 15 percent cut-off may be too high to be considered a low HIV/AIDS prevalent population.

**In summary, the literature predominantly defines “rural” populations as nonmetropolitan communities (or non MSAs) with 50,000 residents or fewer. This definition is used by CDC and defined by the U.S. OMB.**

MSA Breakdown for California:

In depth information located at: <http://www.labormarketinfo.edd.ca.gov/?pageid=156>.

For map on the California breakdown of MSAs, click here:

<http://www.calmis.ca.gov/file/maps/msa2003.pdf>.

**\*Summary of Information from the California Employment Development Department (EDD) (Note: non-MSAs are considered “rural” areas in the literature):**

Using the data from the 2000 census, OMB revised or created new MSAs across the country. These new MSAs become the standard geographic areas for which economic data are produced by cooperative programs of the Bureau of Labor Statistics. OMB<sup>TM</sup>'s 2000 standards provide for the identification of the following types of statistical areas in California:

- **MSA** have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.
- **Metropolitan Divisions (MD)** - If the specified criteria are met, a MSA containing a single core with a population of 2.5 million or more may be subdivided to form smaller groupings of counties referred to as MDs.
- In California, there are four MDs that combine into two MSA, one in Southern California and the other in the Bay Area. EDD will publish data at the MD level to maintain the same geographic configuration for these two MSA that is currently published. Data for the two MSA will be published at the BLS website . The MSA and their MDs are:

Los Angeles-Long Beach-Santa Ana MSA

Los-Angeles-Long Beach-Glendale MD

(Los Angeles County)

Santa Ana-Anaheim-Irvine MD

(Orange County)

San Francisco-Oakland-Fremont MSA

San Francisco-San Mateo-Redwood City MD

(Marin, San Francisco, and San Mateo Counties)

Oakland-Fremont-Hayward MD

(Alameda and Contra Costa Counties)

- **Micropolitan Statistical Areas** – a new set of statistical areas - have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Defined as one or more contiguous counties. Data

for these areas will be identified for the counties rather than for the Micropolitan Statistical Area.

Bishop Micro. SA (Inyo County)  
Clearlake Micro. SA (Lake County)  
Crescent City Micro. SA (Del Norte County)  
Eureka-Arcata-Fortuna Micro. SA (Humboldt County)  
Phoenix Lake-Cedar Ridge Micro. SA (Tuolumne County)  
Red Bluff Micro. SA (Tehama County)  
Truckee-Grass Valley Micro. SA (Nevada County)  
Ukiah Micro. SA (Mendocino County)

#### Determining Rural Areas within MSAs:

It appears that the California Office of Statewide Health and Planning Development has done some work to define rural areas in California. They use a different geographical unit of analysis called Medical Service Study Areas (MSSAs) which describes subcounties and cities that are used to determine medically underserved populations. A more formal definition, explanation of MSSAs can be found at the following: <http://gis.ca.gov/catalog/BrowseRecord.epl?id=23784>.

The following is the definition of rural by the Rural Health Policy Council (RHPC) using MSSAs:

The definition of a Rural Medical Service Study Area is a MSSA, as defined by the California Health Manpower Policy Commission that have a population density of 250 persons or less per square mile and have no incorporated area greater than 50,000 persons.

The definition of a Frontier Medical Service Study Area is an MSSA with population densities equal or less than 11 persons per square mile.

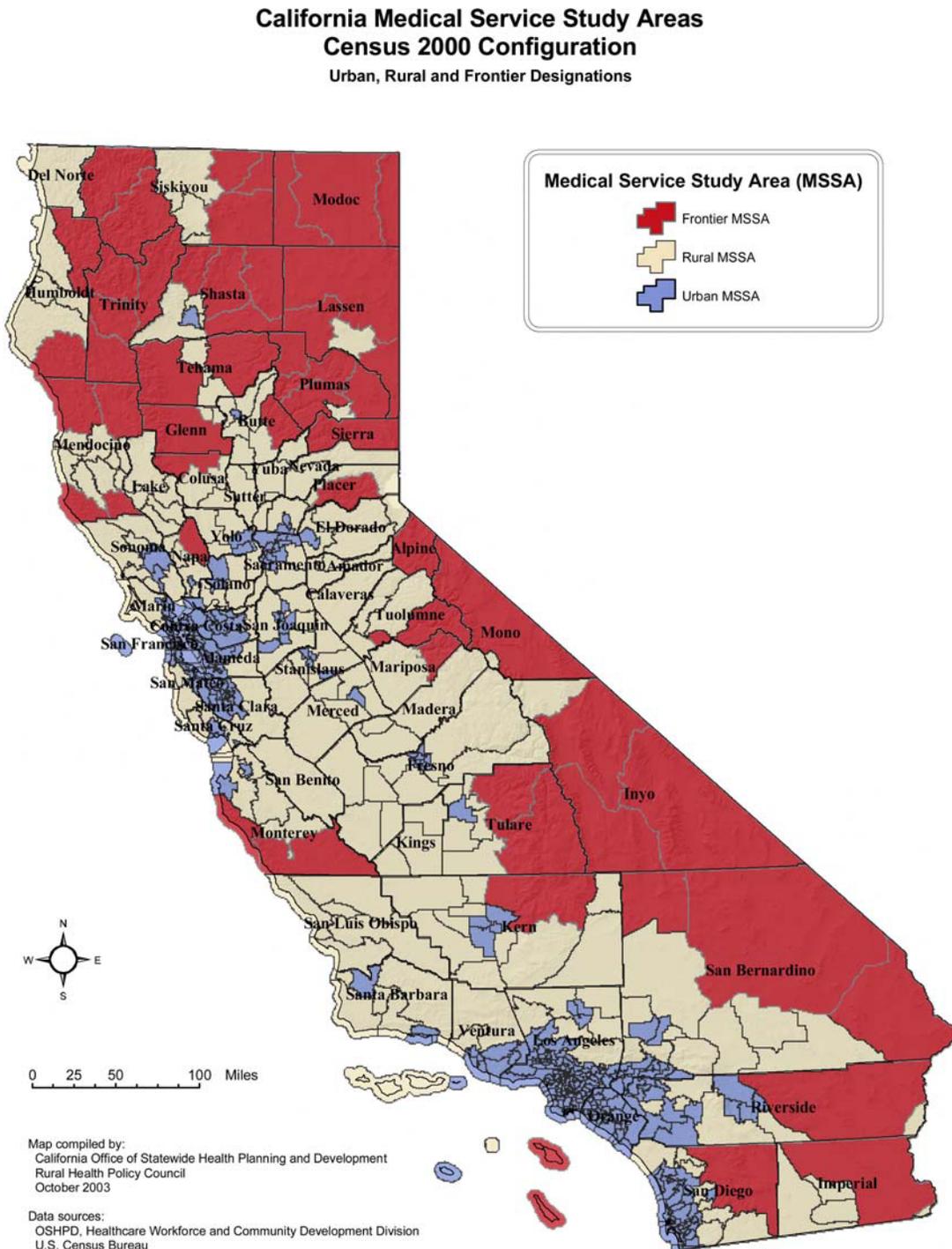
A map of the rural MSSAs in California is located at the following link: <http://www.oshpd.ca.gov/HWDD/pdfs/2000overallMSSAs.pdf>.

As you can see from this map, there are far more divisions within counties that are created compared to an MSA map in order to more accurately determine rural areas.

The more specific, interesting information is located at the following site: [http://www.oshpd.ca.gov/RHPC/Resources/Rural\\_Medical\\_Service\\_Study\\_Areas.html](http://www.oshpd.ca.gov/RHPC/Resources/Rural_Medical_Service_Study_Areas.html).

On this web page, you have the option to click “Northern Region,” “Central Region,” and “Southern Region.” For instance, if you are looking for rural areas within Los Angeles County, by clicking on “Southern Region,” you can directly go to Los Angeles County, and it will list all the rural regions within that county with MSSA numbers and the total population for each rural area.

**Appendix B:** MSSA map showing rural, urban, and frontier designations in California



**Appendix C: List of the initial Rural Think Tank Invitees (did not necessarily attend)**

**Training Partners**

<b>PAETC</b>		
Jason Tokumoto, M.D.	Asst Clinical Professor of Medicine HIV Telephone Consultation Service	UCSF
Mona Bernstein, M.P.H.	Deputy Director	UCSF
Shannon Weber, M.S.W.	Perinatal HV Warmline Coordinator	UCSF
Marshall Kubota, M.D.	Site Director	North Coast
Ivan Gomez, M.D.	Clinical Director	San Joaquin Valley
Greg Melcher, M.D.	Site Director	Sacramento, UCD
Geeta Gupta, M.D.	Associate Clinical Professor	UC Irvine
Tom Donohoe, M.B.A.	Site Director	UCLA
Lesley Carmichael, D.O.	Director of Clinical Training	USC
Kathy Jacobson, M.D.	Clinical Consultation Trainer	USC
Jackie Tulsy, M.D.	Medical Coordinator HIV Care	Positive Health Program, UCSF
<b>STD/HIV Prevention Training Center</b>		
Chris Hall, M.D., M.S.	Deputy Director and Co-Medical Director	STD/HIV PTC
Alice Gandelman, M.P.H.	Director	STD/HIV PTC
<b>UCSF, AIDS Health Project</b>		
Lori Thoemmes	Deputy Director	UCSF AHP
<b>Harm Reduction Coalition</b>		
Hilary McQuie, M.A.	Regional Director	

**Clinical Partners**

<b>Correctional clinical care</b>		
Lori Kohler, M.D.	Director, Correctional Medicine Consultation Network	UCSF Consultant
<b>Web-based clinical care</b>		
Wm. Chris Mathews, M.D.	Director	UCSD
<b>Telemedicine</b>		
Javeed Siddiqui, M.D., M.P.H.	Director HIV Telemedicine	UCD
Christine Martin, M.B.A., P.M.P.	Executive Director	CTEC

**State Partners**

<b><i>STD Control Branch</i></b>	
Gail Bolan, M.D.	Chief
Rachel Mclean, M.P.H.	Adult Viral Hepatitis Prevention Coordinator
<b><i>TB Control Branch</i></b>	
James Watt, M.D.	Chief
<b><i>California Department of Drug and Alcohol Programs</i></b>	
Michael Cunningham	Deputy Director of Prevention Services Division
Ann Michaels	HIV Coordinator
<b><i>California Department of Educations</i></b>	
Sharla Smith	HIV/STD Prevention Education Consultant
<b><i>California Department of Housing and Community Development</i></b>	
Lynn Jacobs	Director
<b><i>California Department of Corrections and Rehabilitation</i></b>	
Joseph Bick, M.D.	Deputy Chief, Clinical Services
Nancy Snyder, R.N.	Nurse Consultant
Rhonda Carr	
Janet Mohle-Boetani, M.D., M.P.H.	Chief Medical Officer
<b><i>Primary and Rural Health Program, Department of Health Care Services</i></b>	
Sam Wilburn	Chief

**Federal Partners**

<b><i>CDC – Capacity Building Branch</i></b>		
Rashad Burgess, M.A.	Acting Branch Chief	
<b><i>CDC Prevention Project Officer</i></b>		
Odessa Du Bois		
Luke Shouse, M.D., M.P.H.		
Jane Kelly, M.D.		
<b><i>HRSA</i></b>		
Karen Ingvoldstad		
Chrissy Abrahms		
Diana Palow		
Marinna Bank-Shields		
Mylander Davis		
Ron Howard		

**Other Partners**

<b><i>International AIDS Society – USA</i></b>		
Donna M. Jacobsen, B.S.	Executive Director	
<b><i>American Academy of HIV Medicine</i></b>		
Stephen O'Brien, M.D.	Medical Director	East Bay AIDS Center
<b><i>HIV Medicine Association</i></b>		
Andrea Weddle, M.S.W.	Executive Director	
<b><i>Association of Nurses in AIDS Care</i></b>		
Clarissa Ospina-Norvell, NP	Nurse Practitioner II	Positive Health Program, UCSF
<b><i>National Medical Association</i></b>		
Robert Scott, M.D.		The Positive Care Center, UCSF
Michelle Clark, M.D.		Westwood Medical Plaza
Wilbert Jordan, M.D.	Medical Director	OASIS Clinic, Drew University

<b><i>Kaiser</i></b>		
Michael Horberg, M.D., M.A.S., F.A.C.P., A.A.H.I.V.S.	Director of HIV/AIDS Policy	Co-Chair, Kaiser's Northern California HIV Provider and Therapeutics Committee
<b><i>Department of Veteran's Affairs</i></b>		
Lisa Backus, M.D., Ph.D.	Clinical Manager	Center for Quality Management in Public Health

**Appendix D: Rural Think Tank Attendee Roster - March 2, 2009**

**Training Partners**

<p><b><i>Pacific AIDS Education and Training Center</i></b>  <a href="http://www.ucsf.edu/paetc">www.ucsf.edu/paetc</a></p>	
<p>Jason Tokumoto, M.D.                  Asst Clinical Professor of Medicine                  HIV Telephone Consultation Service – UCSF</p>	<p>Mona Bernstein, M.P.H.                  Deputy Director – UCSF                  Mona Bernstein, M.P.H.                  Deputy Director</p>
<p>Shannon Weber, M.S.W.                  Perinatal HIV Hotline Coordinator – UCSF  <i>Hotline: 1-888-448-8767</i></p>	<p>Marshall Kubota, M.D.                  Site Director - North Coast Area AETC                  Sonoma County Academic Foundation for                  Excellence in Medicine</p>
<p>Jackie Tulskey, M.D.                  Medical Director, San Francisco AETC                  UC San Francisco                  San Francisco General Hospital</p>	<p>Greg Melcher, M.D.                  Site Director                  UC Davis AETC                  Sacramento, CA</p>
<p>Geeta Gupta, M.D.                  Associate Clinical Professor                  University of California, Irvine AETC</p>	<p>Cristina Gruta, Pharm.D.                  Assistant Clinical Professor                  National HIV/AIDS Clinicians' Consultation Center</p>
<p>Kathleen Jacobsen, M.D. (<i>unable to attend</i>)                  Clinical Consultation Trainer                  USC AETC</p>	<p>Megan Mahoney, M.D.                  Assistant Clinical Professor                  National HIV/AIDS Clinicians' Consultation Center                  Department of Family and Community Medicine</p>
<p><b><i>Pacific AIDS Education and Training Center - Web</i></b></p>	
<p>Wm. Chris Mathews, M.D., Director                  UC San Diego Owen Clinic                  Professor of Clinical Medicine</p>	<p>Lori Kohler, M.D., Director                  Correctional Medicine                  Consultation Network -UCSF Consultant</p>

**PAETC - Telemedicine**

Christine Martin, M.B.A., P.M.P.  
Executive Director  
CA Telemedicine and eHealth Center  
1215 K Street, Suite 2020  
Sacramento, CA 95814

**STD/HIV Prevention Training Center**  
[www.stdhivtraining.org](http://www.stdhivtraining.org)

Alice Gandelman, M.P.H., Director  
300 Frank H. Ogawa Plaza, Suite 520  
Oakland, CA 94612

**Harm Reduction Coalition**  
[www.harmreduction.org](http://www.harmreduction.org)

Hilary McQuie, M.A.  
Regional Director  
1440 Broadway, Suite 510  
Oakland, CA 94612

**California HIV/AIDS Research Project (CHRP)**  
[www.californiaAIDSresearch.org](http://www.californiaAIDSresearch.org)

Judith Fitzpatrick, Ph.D.  
Social Behavioral Research and Dissemination  
California HIV/AIDS Research Program  
University of California Office of the President  
300 Lakeside Drive, Sixth Floor  
Oakland, CA 94612-3550

**State Partners**

<p><b>CDPH STD Control Branch</b>  <a href="http://www.cdph.ca.gov/programs/std">www.cdph.ca.gov/programs/std</a></p>	
<p>Gail Bolan, M.D., Chief (<i>unable to attend</i>)              850 Marina Bay Parkway, Bldg P, 2nd Fl              Richmond, CA 94804</p>	<p>Rachel McLean, M.P.H.              Adult Viral Hepatitis Prevention Coordinator              300 Frank H. Ogawa Plaza, Suite 520              Oakland, CA 94612</p>
<p><b>CDPH TB Control Branch</b>  <a href="http://www.cdph.ca.gov/programs/tb">www.cdph.ca.gov/programs/tb</a></p>	
<p>Jan Young, R.N., M.S.N., Chief              Program Development Section              850 Marina Bay Parkway              Building P, 2nd floor              Richmond, CA 94804-6403</p>	<p>Stephanie Spencer, M.A.              Program Liaison              850 Marina Bay Parkway              Building P, 2nd floor              Richmond, CA 94804-6403</p>
<p><b>California Department of Drug and Alcohol Programs</b>  <a href="http://www.adp.ca.gov">www.adp.ca.gov</a></p>	
<p>Barbara Weiss (<i>unable to attend</i>)              Manager              1700 K Street              Sacramento, CA 95814</p>	<p>Ann Michaels              HIV Coordinator              1700 K Street              Sacramento, CA 95814</p>
<p><b>California Department of Education</b>  <a href="http://www.cde.ca.gov">www.cde.ca.gov</a></p>	
<p>Sharla Smith, M.P.H.              HIV/STD Prevention Education Consultant              1430 N Street, Suite 6408              Sacramento, CA 95814</p>	
<p><b>California Department of Corrections and Rehabilitation</b>  <a href="http://www.cdcr.ca.gov/Parole">www.cdcr.ca.gov/Parole</a></p>	
<p>Janelle Gorman              Public Health Nurse Consultant              Public Health Unit</p>	<p>Rhonda Carr              Public Health Unit              California Prison Health Care Services</p>

California Prison Health Care Services Medical Services Division P.O. Box 4038, Suite 220-08 Sacramento, CA 95812-4038	Division of Adult Parole Operations 1515 S Street, Room 212-N Sacramento, CA 95811
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**Other Partners**

<p><b><i>International AIDS Society – USA</i></b>  <a href="http://www.isausa.org">www.isausa.org</a></p>	
<p>Donna M. Jacobsen, B.S.                  Executive Director                  425 California Street, Suite 1450                  San Francisco, CA 94104-2120</p>	
<p><b><i>National Medical Association</i></b>  <a href="http://www.nmanet.org">www.nmanet.org</a></p>	
<p>Wilbert Jordan, M.D., M.P.H. (<i>unable to attend</i>)                  Medical Director                  OASIS Clinic, Charles Drew University                  1807 E. 120<sup>th</sup> Street                  Los Angeles, CA 90059</p>	<p>Michelle Clark, M.D., D.F.A.P.A.                  President, Golden State Medical Assoc.                  Westwood Medical Plaza, Suite 405                  10921 Wilshire Boulevard                  Los Angeles, CA 90024-4001</p>
<p><b><i>Kaiser Permanente</i></b>  <a href="https://members.kaiserpermanente.org/kpweb/aboutus.do">https://members.kaiserpermanente.org/kpweb/aboutus.do</a></p>	
<p>Michael Horberg, M.D., M.A.S., F.A.C.P., A.A.H.I.V.S. (<i>unable to attend</i>)                  Director of HIV/AIDS Policy                  Co-Chair, Kaiser's Northern California HIV Provider and Therapeutics Committee                  2000 Broadway                  Oakland, CA 94612</p>	
<p><b><i>California Family Health Council, Inc</i></b>  <a href="http://www.cfhc.org">www.cfhc.org</a></p>	
<p>Maryjane Puffer, B.S.N., M.P.A.                  3600 Wilshire Boulevard, Suite 600                  Los Angeles, CA 90010-2648</p>	

### Local Health Departments

Butte County James Gamez CDI	Butte County Sherry Bloker, P.H.N. AIDS Director	CARE Network (Napa) Dale Weide, RN
Colusa County HHS Deborah Yeager, LVN Coordinator	Fresno County David Luchini, P.H.N. AIDS Director	Fresno County Jena Adams, SCDS Coordinator
Humboldt County Michael Weiss AIDS Director	Humboldt County Beth Wells North Coast AIDS Project	Humboldt County Geoff Barrett, R.N., Sr. P.H.N. <i>(unable to attend)</i>
Imperial County Rosendo Gil Case Manager	Kern County Denise Smith, M.P.A. Assistant Director of Disease Control	Kern County Suzanne Chesebrough, P.H.N. EIP/CMP
Kern County Reuben Sosa	Lake County Michele Paulet, R.N. AIDS Director	Los Angeles County Mario Perez <i>(unable to attend)</i> AIDS Director
Madera County Anne Harris AIDS Director	Marin County Deborah Gallagher AIDS Director	Marin County Linda Dobra, R.N. C&T Coordinator
Mariposa County Sharleyne Jarvi, R.N. AIDS Director	Merced County M. Louise Tilston AIDS Director	Mono County Nancy Mahannah, P.H.N. AIDS Director
Mono County Sandra Pearce AIDS Director	Orange County Tamarra Jones, Dr.P.H. AIDS Director	Plumas County Karla Burnworth AIDS Director
Plumas County Dottie Bok, R.N., M.A., P.H.N.	San Bernardino County Susan Strong, N.P. AIDS Director	San Luis Obispo County Marsha Bollinger AIDS Director
San Luis Obispo Department of Public Health Thomas Keifer	San Mateo County Ellen Sweetin AIDS Director	Santa Clara County James McPherson AIDS Director

The Rural Think Tank Meeting Report

<p>Santa Clara Kathleen McQuaid, MFT Health Program Manager</p>	<p>Shasta County Heidi Vert AIDS Director</p>	<p>Siskiyou County Blair Loftus AIDS Director</p>
<p>Solano County/ Napa County Peter Turner AIDS Director</p>	<p>Sonoma County Shari Brenner AIDS Director</p>	<p>Sonoma County Mark Netherda, M.D. Deputy Public Health Officer</p>
<p>Sutter County Alice Williams-Root, P.H.N. AIDS Director</p>	<p>Sutter County Anne Westlake AIDS Director</p>	<p>Ventura County Craig Webb AIDS Director</p>
<p>Yolo County Sheila Allen, P.H.N., Ph.D. AIDS Director</p>		

**Appendix E: Post-meeting evaluation**

**A. Reducing OA-Associated Administrative Burden and Increasing Flexibility at LHJ Level**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:			1	10	6
The information was relevant and useful:			2	7	7

1. So very relevant – looking forward to recommendations.
2. Standard Scope of Work for education and prevention activities for counties funded less than \$25, 000.
3. Just like to reinforce to make only minimal reporting required and simplify process as much as possible for rural counties. How much data, etc., is really required?
4. Great discussion.
5. Lots of great information.
6. Very nice to hear OA will try to help us do our work with less paperwork.
7. The information provided has been previously heard – follow up will be key.
8. I am neutral only because I am an OA employee and am aware of these issues and possible solutions.
9. Could have used more time to discuss. Needed microphones – hard to hear.
10. Was able to get clarification on some issues and useful ideas.

**B. Enhancing Training and Technical Assistance and Focusing Training Requirements**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:		1		8	2
The Information was relevant and useful			1	8	2

1. Good discussion.
2. Training topic too broad. Each category of trainees could be a session in themselves – providers, counselors, students (K-12). Hard to set priorities for rural areas for all of those subcategories of trainees.
3. Good that we are thinking of rolling back some of the “required” training – helps us do more with less resources.
4. One panelist dominated the session. Therefore other topics were not discussed. Required clearer importance of all discussion points. Non-panelists were hung up on a single point.
5. Unfortunately there were few (two) folks from LHJs – therefore recommend future discussions regarding options regarding C&T training and requirements.
6. Many of the same concerns I have had were addressed.
7. Spent too much time with introductions/comments from panel members; this truncated our time available for developing/discussing the deliverable products requested (Recs, Actions Items, etc.).
8. Good sharing of resources in panel comments. Needed more time to discuss collaboration needs.

**C. Maximizing Prevention with minimal resources**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:		1	1	8	6
The information was relevant and useful:		1		8	6

1. Very little “prevention” was covered – we know that in small counties one person wears several hats. It would have been great to hear examples of targeted prevention activities – How to run any kind of prevention/education program on less than \$20,000.
2. Too much discussion focused on what seems to be larger county issues. For counties receiving only \$15,000 education and prevention, etc., discussion did not seem relevant or applicable. Would have liked to see group composed of smallest funded counties to focus on their issues.
3. Little attention was given to primary prevention.
4. We are doing this already by wearing many hats – flexibility from OA will help us.
5. Would have appreciated stronger facilitation. Too much discussion regarding individual programs and not enough regarding breakout topic.
6. Several topics also overlapped other groups.
7. Excellent discussion.
8. Some good ideas.

**D. Correctional Issues**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:				4	4
The information was relevant and useful:			1	3	4

1. Again, discussion seemed to focus on counties with large prisons and not enough focus on smaller county issues with county jails, etc.
2. Panel did a good job.
3. The facilitator did not seem to be very familiar with the issues raised in this session. It would have been helpful to have someone else do it. Also, because of the draw of other sessions, there were very few local health departments (two) present so the provider contingent dominated the discussion. A separate meeting only dealing with corrections issues would be useful.
4. Great to hear that OA is working with CDCR to provide testing and treatment in institutions – the penal institutions are a “reservoir” of HIV that needs to be addressed.
5. CDCR has to come up with an agenda to start meeting with public health departments, rural areas, and providers.

**E. Enhancing Specialty HIV/AIDS Medical Care: Utilizing “the Warmline,” PAETC, Telemedicine, and web-based consultation**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:				10	6
The information was relevant and useful:			2	8	6

1. I was aware of warmline and PEP hotline, but learned today about PAETC. Would have liked to learn more about funding for PAETC and if any charge for using training.
2. Great ideas for me to return with.

3. We rural “folks” have a hard time attracting HIV specialists – we need to expand our accessibility to telemedicine and web-based consultation.
4. Clear information but not enough time given to each topic to expand understanding and usage.
5. This was the first I was introduced to the warmline. It is a wonderful concept.
6. Good information.
7. Again – too much time spent on introductions/statements from panel – left little time for thorough brain-storming and discussion of recommendations, action items, including prioritization.

**F. IDUs, Non-IDUs and Substance Use and HCV**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:				7	6
The information was relevant and useful:				6	6

1. Would love to have more services available for “users” and wish OA could be more directive with county Board of Supervisors.
2. The alcohol and drug state person could have used the entire time to discuss SABT money; example MOUs; how it works in small counties.
3. Great discussion; made day worth while.
4. I thought Alessandra did a particularly good job summarizing our group.
5. Facilitator did a great job presenting this session to the larger group.
6. We need to continue to target our drug using population – studies show there is a link between HIV and drugs – a lot of work to be done.
7. Thanks for the posters
8. Good session for LHJ’s wanting to implement SEP. Good information regarding collaboration with alcohol and drug for “set-aside” funding.
9. More good information.

**G. Increasing appropriate HIV testing: in medical settings and testing partners and social networks of those in care**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The information was presented clearly:			2	6	5
The information was relevant and useful:			1	6	5

1. Again, a lot of focus on larger counties.
2. Good session.
3. Good topic – it is nice to hear what is working in other locations.
4. We need to proceed carefully with this – I think we can waste a lot of precious resources by testing “no-risk” individuals. Instead of testing more we should train the professionals (nurses, medical doctor’s, medical assistants, etc.) to be more aware of signs or cues that would trigger the offer of a test. Shrinking resources make it more vital that we target our resources.
5. Huge issue – thanks for the attention. Will need some more work to take a look at the settings and determine appropriate response and remove barriers.
6. Good discussion on issues.

**Overall Meeting Goals** Total N = 33

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
<b>1. The meeting accomplished its overall goals:</b>		1		12	18	31

1. It was great.
2. Very little related to “rural counties;” how to deliver effective prevention/education services with \$16,000? No EIP, no staff (except for limited time with test counselors), isolated non-English speaking at-risk clients.
3. Ambitious goals but time used productively.
4. This was a great meeting. Hopefully some changes will be forth coming.
5. Rural counties needed a forum without the “urbanites” present to impose their ideas on us.
6. I would like to see more participation of our rural areas – not all were invited. There appeared to be as many PAETC folks as rural representation – all rural areas should have this type of access to this information.

7. Wonderful opportunity to focus on rural HIV issues – greatly appreciate OA willingness to convene this group and listen to expressed needs, opinions, and recommendations.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
<b>2. The length of the meeting was appropriate:</b>		2	2	12	17	33

1. One day only.
2. The meeting was “dense” however a longer meeting is not practical/economical for most.
3. Too much was packed into one day – four sessions at one time was too much. It made some of the session audiences too small for good discussion on a variety of issues within the topic.
4. Perfect length.
5. The second half day was great to sort out the previous day in a smaller group.
6. Thank you for allowing adequate time to travel home (four and one-half hour drive). I would prefer not starting on a Monday, however.
7. With some minor changes, the second day activities could have been enfolded into the first day. Being away for two days is very difficult.
8. Kept everyone focused, knowing that time allotted was a precious resource for all attendees.
9. Even a little longer on the afternoon on first day.
10. Should have had more time for breakouts. It felt rushed.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
<b>3. This meeting was valuable:</b>		1	2	11	19	33

1. Too many OA staff – too few front line county staff; too many issues that I know little about.
2. Some good information – but not all I hoped for.
3. This was really important for us to come together for. We could not do this one regionally or by web.
4. I believe as rural areas our voices were heard – not buried as unimportant by Los Angeles and San Francisco.
5. It will be valuable if we see some good changes come of it.
6. Any meeting or focus group that allows for community input is valuable as long as the input results in positive.
7. Allowed me to meet, listen, share ideas with rural LHJ staff; network with partners involved in HIV care, prevention, training.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
<b>4. The meeting space was sufficient:</b>		1	1	10	17	29

1. The room was very cold.
2. Great location/available small group space and plenary space

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
<b>5. The food and beverage was adequate:</b>			1	13	19	31

1. No vegetarian main dish.
2. Plenty of coffee, nutritious food.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
<b>6. The hotel accommodations were acceptable:</b>			1	6	18	25

1. No hot tub; no Internet connection in the rooms; good location.
2. My favorite motel in Sacramento!

***What did you like best about the meeting?***

1. Interaction with OA and their willingness to listen and to support recommendations.
2. Ability to hear problems and workable solutions.
3. SAPTB6 discussion.
4. The opportunity to dialogue and hear from many partners – I appreciate Michelle’s leadership so much.
5. Open dialogue – sharing of ideas.
6. Networking opportunities.
7. The chance to give feedback and hear others.
8. Networking and meeting with HIV providers.
9. The ‘Brain Storming’
10. Safe environment to state your opinion.
11. Meeting specialists in different fields
12. Hearing about clinical challenges in rural areas.
13. Hearing about enthusiasm among remote providers.
14. We were encouraged to speak frankly.
15. Networking – having the “ear” of OA staff. Great productive process. Inclusive!
16. Hearing from the community – their perspective of changes that could be made at OA to provide better customer service.

17. Chance for rural areas to express opinions and direct policy change.
18. Learning how other (smaller) jurisdictions are approaching how to meet needs with very limited resources.
19. The compassion for the HIV population.
20. ADP, TB, and CDCR present.
21. Discussion, sessions, and networking.
22. Nice to network and share info with other counties who are having similar concerns.
23. Networking with colleagues, meeting LHJ staff, discussions with them.
24. Collaboration among departments, organizations, agencies.
25. Great format. Should do this with other topics.

***What did you like least and/or what would you have done differently?***

1. Room temperature.
2. Would have liked a small group for only minimally funded small LHJ. Seemed like to large a group.
3. An overview of current statistics in HIV state.
4. Nurses would like to get CEUs.
5. All was good and would change nothing.
6. Facilitator/note taker role.
7. Guidance on discussion points.
8. Too much time spent passing the microphone around.
9. Nothing – great job!
10. Bring in a power point presentation regarding the Warmline.
11. Day 2 – Not nearly enough time for discussion/dot exercise. Do not believe recommendations are well discussed or thought out. Discussion should have been at least one hour. Recommendations definitely not well-informed. Implications not eased out. Definite problems especially for administration, contracts, etc. Day 1 very good. Meeting overall was a good opportunity to finally focus on non-urban areas. Thanks.
12. Smaller groups with OA chief and county reps.
13. OA partners with brochures – maybe breakout sessions next time.
14. Shorter intros of panelists for small breakout sessions – more time for brain-storming/prioritizing ideas/recommendations.
15. Minor – the opening exercise was too long on Day 2. Maybe just go with what was impressive, instead of both that and something about my job.
16. I would have allowed more time for the breakouts.

***What suggestions would you have for a follow up meeting?***

1. Progress on request for recommendations.
2. Meeting with rural counties – what does work with high-risk; isolated populations. More specific info on SABB money; what does it cover; how to access the funds locally.
3. Look into how STD Control Branch administers Chlamydia prevention program – very easy to work with. Chlamydia Prevention Program only requires check off list

and has state scope of work and minimal reporting requirements for minimally funded counties. Sharla Smith would have information on this.

4. Targeted discussions on how to reduce admin burden on small counties
5. CDCR issues need a follow-up meeting that can include more local health departments with prisons as well as more CDCR staff.
6. Bring service providers to the table. Many medical providers are sub-contracted, so they were not here. Big deal.
7. Perhaps a follow up at the upcoming CCLAD meeting.
8. Web cast?
9. Since HIV and OA policies evolve with time a rural think tank meeting every other year to discuss ongoing issues would be good.
10. Invite sub-contractors/CBOs.
12. Make sure that information regarding next steps or recommendations progress is communicated to participants – updates on progress as appropriate. Next steps for us on the local level.
13. Refinement or OA's proposed implementation of the suggestions brought forward at the workshop.
14. More focus on rural areas and corrections.
15. Work groups that focus on recommendations to work with OA staff to design improvements.
16. I think some follow-up meeting should be specific to action items. Not sure how or where to pull together again.
17. Follow up definitely needed. More LHJs need to give input for issues – especially administrative, contracts, etc.
18. Breakout sessions or tables with info by OA partners.
19. Develop smaller, focused groups of partners in OA and LHJs/training partners to work on follow-up of issues – continuing the collaborative process through implementation.
20. Need to also evaluate the report back sessions. Great idea to expose the whole group to all issues and recommendations raised in each breakouts.

***Please use the space below to offer general comments and feedback about the meeting or other topics relevant to this meeting:***

1. We are attempting to break down silos within our own health department and breaking down silos at the state level supports this new philosophy. Would like to receive summary notes and recommendations from this meeting.
2. Michelle Roland – what a great leader; thanks for the opportunity to ask questions and to give us direct feedback.
3. Very much appreciate the opportunity to discuss issues and efforts to incorporate and hear issues.
4. Many of the rural concerns also affect the urban, suburban areas. How will the larger areas have a voice?
5. Loved that we came back together and shared info from all breakout groups, where we could give feedback. LOVED IT!
6. This was a great interactive meeting.

7. Enter a synopsis of the meeting to us so we can evaluate and give feedback.
8. Thanks for listening.
9. Thank you so much for valuing the rurals!
10. The overall meeting was extremely productive.
11. Day 1 – Too many physicians commenting (especially AETCs) and not enough from local health departments. Just a bit out of balance. Not enough non-medical expertise. Greatly appreciated AETC presence just needs more non-MD expertise.
12. Good meeting!

**Appendix F:** CDPH support of routine testing in medical settings; information regarding recent relevant changes to California law; available resources to support increased HIV testing in medical settings.



State of California—Health and Human Services Agency  
California Department of Public Health



ARNOLD SCHWARZENEGGER  
Governor

March 3, 2009  
Minor Revisions March 5, 2009

TO: ALL FACILITIES  
CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS  
CALIFORNIA CONFERENCE OF LOCAL AIDS DIRECTORS  
CALIFORNIA MEDICAL ASSOCIATION  
AMERICAN ASSOCIATION OF HIV MEDICINE  
MATERNAL CHILD ADOLESCENT HEALTH DIRECTORS  
CALIFORNIA FAMILY HEALTH COUNCIL  
CALIFORNIA PRIMARY CARE ASSOCIATION  
CALIFORNIA APIC COORDINATING COUNCIL  
CALIFORNIA AMERICAN COLLEGE OF EMERGENCY PHYSICIANS  
CALIFORNIA ASSOCIATION OF HEALTH PLANS

SUBJECT: CALIFORNIA DEPARTMENT OF PUBLIC HEALTH SUPPORT OF  
ROUTINE HIV SCREENING IN MEDICAL SETTINGS; INFORMATION  
REGARDING RECENT RELEVANT CHANGES TO CALIFORNIA LAW;  
AVAILABLE RESOURCES TO SUPPORT INCREASED HIV TESTING IN  
MEDICAL SETTINGS

### Background

HIV infection and AIDS remain among the leading causes of illness and death in the United States. There are an estimated 56,000 new infections annually in the United States and over one-fifth (21 percent) of individuals living with HIV infection are estimated to be unaware of their HIV status. The California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA), estimates that 5,000-7,000 new infections occur in California each year.

As of December 31, 2008, 187,300 HIV and AIDS cases have been reported in California; 86,964 of these individuals have died. While survival rates have increased due to improved treatment, little progress has been made in increasing early diagnosis. Approximately 40 percent of people test late in their HIV infection and progress to AIDS within one year of an HIV diagnosis. Persons who test late in the course of their infection are more likely to be African American or Hispanic. Additionally, 87 percent of

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MS 7700, P.O. Box 997426, Sacramento, CA 95899-7426  
MS 7700, 1616 Capitol Avenue, Suite 616, Sacramento, CA 95814  
Telephone: (916) 449-5900 / Fax: (916) 449-5909  
Internet Address: [www.cdph.ca.gov/programs/AIDS](http://www.cdph.ca.gov/programs/AIDS)

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persons who test late received their first HIV-positive test result at an acute or referral medical care setting, and 65 percent were tested for HIV because of illnesses that led to an AIDS diagnosis.

Perinatal HIV transmission also continues, primarily among women who lack prenatal care or who were not provided the opportunity for an HIV test during pregnancy. A substantial proportion of the perinatal HIV infections in the United States each year can be attributed to the lack of timely HIV testing and treatment of pregnant women. Perinatal transmission rates can be reduced from approximately 25 percent without treatment to below 2 percent with universal screening of pregnant women in combination with prophylactic administration of antiretroviral drugs, scheduled cesarean delivery when indicated, and avoidance of breast feeding.

### **2006 Centers for Disease Control and Prevention (CDC) Guidelines**

In 2006, CDC issued "Revised Recommendations for HIV Testing for Adults, Adolescents, and Pregnant Women in Health Care Settings," recommending routine HIV screening for people 13 to 64 years old who access care in a variety of medical settings. The objectives of these recommendations are: to increase HIV screening of patients, including pregnant women, in health care settings, increase access to care and treatment, and to reduce perinatal, sexual, and injection drug use-associated transmission of HIV in the United States. CDPH supports these recommendations to the extent that resources are available to implement them.

### **California Law**

In California, two recent changes to HIV testing law have supported the effort to bring "opt-out" (routine offering with the option to decline to take an HIV test) HIV testing to the state's health care facilities.

1. As of January 1, 2008, Assembly Bill (AB) 682 (Berg, Chapter 550, Statutes of 2007), added California Health and Safety (H&S) Code Section 120990 which eliminated the requirement for written consent for an HIV test when ordered by a medical care provider.

Medical care providers ordering HIV tests under H&S Code Section 120990(a) are not required to obtain written consent for an HIV test, nor are laboratories processing HIV tests ordered by medical care providers under H&S Code Section 120990(a) required to obtain either written or oral consent to process the ordered test. Furthermore:

Continued requirements for written consent under H&S Code Section 120990(c) refer to HIV testing provided and/or processed in non-medical settings (such as OA-funded confidential HIV test sites).

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Instead of required written consent, H&S Code Section 120990(a) requires medical care providers to do the following before they order an HIV test:

- 1) Inform the patient that an HIV test is planned;
- 2) Provide information about the HIV test;
- 3) Inform the patient that there are numerous treatment options available for a patient who tests positive for HIV and that a person who tests negative for HIV should continue to be routinely tested;
- 5) Advise the patient that he or she has the right to decline the HIV test; and
- 6) If the patient declines the HIV test, document that fact in the patient's medical file.

AB 682 also amended H&S Code Section 125090 which eliminated the requirement for written consent for HIV testing for pregnant women. H&S Code Section 125090 states that if a woman does not have an HIV test documented in her prenatal record during prenatal care or at the time of labor and delivery, the physician and surgeon or other person engaged in the prenatal care or attending the woman shall ensure that the woman is informed about the:

- 1) Intent to perform an HIV test,
- 2) Routine nature of the test,
- 3) Purpose of the test,
- 4) Risks and benefits of the test,
- 5) Risk of transmission of HIV, that approved treatments are known to decrease the risk of perinatal transmission of HIV, and
- 6) Right to decline HIV testing.

If the woman verbally accepts testing, she must then receive an HIV test "by a method that will ensure the earliest possible results." Currently, there are six HIV tests available that can provide preliminary results within 20 minutes; therefore, hospitals should be able to provide rapid HIV testing in labor and delivery. If a woman receives appropriate HIV treatment during labor and delivery, she can decrease the chances of transmitting HIV to her infant by approximately one-half.

2. As of January 1, 2009, AB 1894 (Krekorian, Chapter 631, Statutes of 2008) added H&S Code Section 1367.46 and Insurance Code Section 101023.91 to require individual and group health care service plans and health insurers to provide coverage for testing for HIV in medical care settings regardless of whether the testing is related to the primary diagnosis. Insurance Code Section 10123.91 further states that reimbursement shall be provided according to the respective principles and policies of the health insurer. This statute does not cover reimbursement through all public funding.

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## IMPLEMENTATION RESOURCES

OA has assembled the following tools to assist in the implementation of these recommendations. In addition, OA can help you identify appropriate contacts in your local health department and community for care, treatment, support, and prevention services. For more information, please contact Sandy Simms, Chief, HIV Counseling, Testing, and Training Section, OA, at (916) 449-5538 or by e-mail at: [Sandy.Simms@cdph.ca.gov](mailto:Sandy.Simms@cdph.ca.gov).

### *Training and Technical Assistance*

- The **Pacific AIDS Education and Training Center**, based at the University of California, San Francisco (UCSF), has 11 local implementation sites throughout California that can provide free training and technical assistance to health care facilities on implementation of CDC's HIV testing recommendations and H&S Code Section 120990. Based in medical schools and community-based organizations, the faculty of nurses, physicians, and program managers can help you address implementation challenges, train your staff, and develop necessary policies and procedures. For inquiries regarding training and technical assistance, please contact Michelle Kipper at (415) 597-8197 or [michelle.kipper@ucsf.edu](mailto:michelle.kipper@ucsf.edu).
- The **California STD/HIV Prevention Training Center (CA PTC)** is funded by CDC and is a joint project of CDPH's Sexually Transmitted Disease (STD) Control Branch; University of California, Berkeley, School of Public Health; and UCSF School of Medicine. A new CA PTC training: *Testing for HIV Infection: A Curriculum for Medical Providers in California*, is available free of charge to medical providers and health professionals. The course explains changes in HIV testing as allowed under H&S Code Section 120990, differentiates between "opt-in" and "opt-out" HIV testing, describes pros and cons of traditional and rapid HIV testing, and outlines how to integrate routine HIV testing procedures into current practice. Participants also learn how to conduct a brief HIV risk assessment/risk-reduction session, and deliver HIV-negative and HIV-positive test results to patients. The training can be delivered in one-hour modules or as a single four-hour course. For more information, or to schedule training, please contact CA PTC at (510) 625-6000, or consult the CA PTC Web site at: [www.stdhivtraining.org](http://www.stdhivtraining.org).

### *Telephone Consultation*

- The **National HIV Telephone Consultation Service (Warmline)** at (800) 933-3413 provides free and confidential expert consultation on HIV testing and care, including test interpretation (specializing in rapid testing and indeterminate test results). They can also offer guidance for the initial steps in workup and initial management. The Warmline is available 6 a.m.-5 p.m., Pacific Standard Time, Monday-Friday.

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- The **National Perinatal HIV Consultation and Referral Service (Perinatal HIV Hotline)** at (888) 448-8765 provides around-the-clock advice on indications and interpretations of standard and rapid HIV testing in pregnancy, as well as consultation on antiretroviral use in pregnancy, labor and delivery, and the postpartum period. The Perinatal HIV Consultation and Referral Service also can link HIV-infected pregnant women with appropriate health care.

#### ***Local Health Department Contacts***

The mission of the **California Conference of Local AIDS Directors (CCLAD)** is to improve the quality and scope of health programs for HIV prevention and HIV-positive persons by promoting standards of excellence throughout the state of California. CCLAD achieves this mission by serving as a leader in HIV/AIDS policy development, by enhancing partnerships with the California Conference of Local Health Officers (CCLHO) and OA, and by creating bridges between local health jurisdictions, statewide coalitions, community-based organizations, and other affiliate organizations. A contact list for CCLAD can be found at [www.cclad.org](http://www.cclad.org). Please note that these AIDS directors have agreed to be contacted for local assistance with HIV testing and referrals for prevention as well as care, treatment, and support services. A comprehensive array of services, including life-saving medications, are available for people with and at risk for HIV infection in California (information about many of these is also available at the OA Web site: [www.cdph.ca.gov/programs/AIDS](http://www.cdph.ca.gov/programs/AIDS)).

#### ***Client Education Materials***

The **California HIV/AIDS Clearinghouse (CAC)** is a repository and distribution resource center for culturally appropriate HIV/AIDS/STD/tuberculosis (TB)/hepatitis educational materials. CAC provides access to over 200 HIV/AIDS health education materials. The materials address health education, awareness, knowledge, and behavior change. Additional materials such as DVDs, books, and health publications are available for loan and technical assistance is provided through library services including specialized literature database searches. CAC can be reached toll free at (888) 611-4222 or [www.hivinfo.org](http://www.hivinfo.org).

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***Additional Materials and Comprehensive Guidance Documents***

**Health Research and Educational Trust (HRET), HIV Testing in Emergency Departments (EDs): A Practical Guide** <http://edhivtestguide.org>. HRET has developed this guide for clinicians and administrators seeking to incorporate routine HIV testing in their EDs. This practical guide to different approaches, considerations, and resources for making HIV testing routine in ED care is based on site visits and interviews with leadership and staff in EDs and health departments that have successfully incorporated testing. You may choose to use this guide to navigate program design and resource allocation decisions as well as to inform policies and operational approaches to HIV testing in your ED.



Michelle Roland, MD, Chief  
Office of AIDS

Enclosures

cc: Pacific AIDS Education and Training Center  
California STD/HIV Prevention Training Center  
National HIV Telephone Consultation Service

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**Selected References:**

CDC "Revised Recommendations for HIV Testing for Adults, Adolescents, and Pregnant Women in Health Care Settings"  
[www.cdc.gov/mmwr/pdf/rr/rr5514.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5514.pdf).

CDC: HIV Testing in Healthcare Settings  
[www.cdc.gov/hiv/topics/testing/healthcare](http://www.cdc.gov/hiv/topics/testing/healthcare).

OA's Web site: HIV Testing in Health Care Settings  
[www.cdph.ca.gov/programs/AIDS/Pages/OAHIVTestHCS.aspx](http://www.cdph.ca.gov/programs/AIDS/Pages/OAHIVTestHCS.aspx).

California H&S Code Section including 120990  
<http://leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=96324118285+2+0+0&WAIAction=retrieve>.

AB 682  
[http://leginfo.ca.gov/pub/07-08/bill/asm/ab\\_0651-0700/ab\\_682\\_bill\\_20071012\\_chaptered.pdf](http://leginfo.ca.gov/pub/07-08/bill/asm/ab_0651-0700/ab_682_bill_20071012_chaptered.pdf).

AB 1894  
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OA's Web site: Perinatal HIV Prevention Project  
[www.cdph.ca.gov/programs/AIDS/Pages/OAPerinatal.aspx](http://www.cdph.ca.gov/programs/AIDS/Pages/OAPerinatal.aspx).

CCLAD Web site and Contact List  
[www.cclad.org](http://www.cclad.org)

## **Appendix G:** Some useful websites, web-based materials, and journal articles

### **Websites and web-based materials**

1. National Rural Health Association (HRHA): [www.ruralhealthweb.org](http://www.ruralhealthweb.org).
2. National Prevention Information Network: [www.cdcnpin.org/scripts/index.asp](http://www.cdcnpin.org/scripts/index.asp).
3. Connecting To Care: [www.connectingtocare.net](http://www.connectingtocare.net).
4. National AIDS Education and Training Center: [www.aidsetc.org](http://www.aidsetc.org).
5. Methamphetamine Use and Risk for HIV/AIDS:  
[www.cdc.gov/hiv/resources/factsheets/PDF/meth.pdf](http://www.cdc.gov/hiv/resources/factsheets/PDF/meth.pdf).
6. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America: [www.cdc.gov/mmwr/pdf/rr/rr5804.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5804.pdf).
7. Care and Treatment for HCV and HIV Co-infection:  
[www.cdc.gov/hepatitis/HCV/PDFs/HRSA-HIV-HCV\\_2006.pdf](http://www.cdc.gov/hepatitis/HCV/PDFs/HRSA-HIV-HCV_2006.pdf).
8. Technical Assistance, Resources, Guidance, Education, and Training (TARGET) Center: [www.careacttarget.org](http://www.careacttarget.org).
9. Rural Health, Open Door Forum:  
[www.cms.hhs.gov/OpenDoorForums/24\\_ODF\\_RuralHealth.asp#TopOfPage](http://www.cms.hhs.gov/OpenDoorForums/24_ODF_RuralHealth.asp#TopOfPage).

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