

**Office of AIDS
HIV Prevention Program
Budget Guidance for
Fiscal Year 2012–13**

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

A. Base Funding

Your local health jurisdiction's (LHJ) Master Agreement contract began on July 1, 2010 and will end on June 30, 2013. This document will address requirements for fiscal year (FY) 2012-13.

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

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

B. Partner Services Funding

The Office of AIDS (OA) will continue to allocate the Centers for Disease Control and Prevention (CDC) funding directly to LHJs to support Partner Services (PS) activities. LHJs will receive PS funding using a new formula. The formula was determined and based on a tiered approach that addressed each LHJ's need for technical assistance in the continuation and enhancement of a PS program that is currently in place, or for assistance in establishing a new PS program.

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

II. HIV PREVENTION PROGRAM

A. Required Services to be Performed

The new services must be consistent with the new California HIV Prevention Program funded by CDC's PS12-1201 grant. The primary focus of CDC's new grant funding is to address the national HIV epidemic through programs that focus on reducing new infections, increasing access to care, and improving health outcomes for PLWH/A.

All LHJs funded by OA's Prevention grant to LHJs must:

- a. Provide targeted HIV testing;
- b. Provide Linkage-to-Care (LTC) services;
- c. Provide PS; and
- d. Meet monitoring and evaluation requirements set by OA.

Additionally LHJs must:

- a. Offer HIV testing through an alternative test site (ATS). ATS testing must still remain free and anonymous.
- b. Assign a staff member to attend to health care reform (HCR) issues;
- c. Meet the subsidiary requirements that support HIV testing, PS, and LTC services. In response to CDC's Prevention Grant PS12-1201, OA has designated that these core services be delivered together.

B. California's Two-Tiered System

The new California HIV Prevention Program is a two-tiered system of prioritized activities. In prioritizing activities, OA is participating in the significant shifts represented by both the National HIV/AIDS Strategy and CDC's approach to HIV prevention. The tiers represent OA's priorities in HIV prevention, and correspond closely to the required and recommended services identified by CDC's PS12-1201 grant. The new California HIV Prevention Program stipulates that LHJs must ensure that activities designated as Tier I are adequately provided, using any resources available to the LHJ, before funding Tier II activities with their Prevention allocation from OA (with the exception of Hepatitis C virus (HCV) testing). Tier I activities include services and initiatives related to HIV testing (with or without counseling); LTC; PS; Retention and Re-engagement into Care; risk assessment, linkage to services and behavioral interventions for PLWH/A; treatment adherence; allowable syringe services; integrated HIV, hepatitis, tuberculosis (TB), and sexually transmitted diseases (STD) screening for HIV-positive persons; condom distribution, and HCR. Tier II activities include HCV testing; behavioral interventions targeting high-risk HIV-negative individuals; social marketing; pre-exposure prophylaxis (PreP) program planning and/or delivery; and incorporation of STDs, TB, and HCV screening into HIV screening programs.

All required and allowable services for FY 2012-13 activities are outlined in detail under the HIV Prevention Program Allowable Services, Section IV.

III. REQUIRED DOCUMENTS

In order to prepare the amendment for the HIV Prevention Program Memorandum of Understanding (MOU), OA needs revised budget documents for FY 2012-13 from your LHJ. Each LHJ must submit the documents listed below in this section.

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

- Document Checklist.
- LHJ Contact Information.
- HIV Prevention Program Five-Line Budget for FY 2012-13.
- HIV Prevention Program Budget Detail for FY 2012-13.
- HIV Prevention Program Personnel Detail for FY 2012-13.
- HIV Prevention Program Subcontractor Budget Detail for FY 2012-13 (*if applicable*).
- HIV Prevention Program Subcontractor Personnel Detail for FY 2012-13 (*if applicable*).
- HIV Prevention Program Service Category Summary for FY 2012-13.

HIV Prevention Program LHJ Contact Information

This includes a place for the HIV Prevention Program AIDS Director, HIV Prevention Program Coordinator, and the HIV Prevention Program Fiscal Contact. OA uses this information to keep our records up to date so please complete the information for each position and notify us if you have changes during the FY. For the HIV Prevention Program Coordinator, please list the individual that our office will work with on a day to day basis. This FY, OA is asking for your LHJs DUNS number on this page.

HIV Prevention Program Five-Line Budget for FY 2012-13

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

HIV Prevention Program Budget Detail Form for FY 2012-13

This form includes detailed information to support the five line-item budget. As with the five line-item budget the detailed budget includes personnel costs, operating expenses, capital expenditures, other costs, and indirect costs. The total in your detailed budget must equal the total in your five line-item budget. This FY, OA is asking for your LHJ to provide more detail in Operating Expenses which includes a brief description of each expense.

HIV Prevention Program Personnel Detail Form for FY 2012-13

This form identifies the LHJ personnel charged to the HIV Prevention Program MOU. The total of all of the detailed personnel pages (if more than one) must match the amount entered in the total personnel line of the HIV Prevention five line-item budget and the detailed budget. Please indicate in the description of your personnel the staff member that will be overseeing the responsibilities of HCR activities and the full-time equivalent (FTE) associated with this duty.

HIV Prevention Program Subcontractor Budget Detail Form for FY 2012-13

This form is required for each subcontractor and/or consultant for the HIV Prevention program MOU. It is the same format as the HIV Prevention Program budget detail form but displays the subcontractor costs instead of the LHJs costs. Indirect Expenses are limited to 15 percent of the total Personnel Costs for each subcontractor.

Please complete Sections 1 and 2. Section 1 includes subcontractor information. Section 2

includes personnel costs, operating expenses, capital expenditures, other costs (i.e., subcontractor's contract with other community-based organizations) and indirect costs for the subcontractor.

HIV Prevention Program Subcontractor Personnel Detail Form for FY 2012-13

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

HIV Prevention Program Service Category Summary for FY 2012-13

In FY 2012-13, the service category summary form has been changed to include administrative costs, non-client service costs and direct service costs. As you complete the Program Service Category Summary tables, **please incorporate administrative costs, non-client service costs, and direct service costs into the budget amounts for each category.** Each of these are described below. By incorporating administrative costs, non-client service costs, and direct service costs, you will be able to account for your total award amount. **Only include your OA Prevention Grant funding.** Do not include budgeted amounts from other sources such as from Ryan White or county funding.

Section 1 is a summary of services that the LHJ will provide. For each direct service activity, provide the estimated number of clients to be served for each service category and the budgeted amount for each of these services. HIV testing should not only include HIV testing activities, it should also include LTC activities. Health Education/Risk Reduction (HE/RR) should include the activities that you are planning to do in your LHJ as it relates to prevention with positives and high-risk negative activities, retention/re-engagement in care, treatment adherence, social marketing activities, and PrEP planning and/or delivery. As stated above, non-client service costs and administrative costs have been added for FY 2012-13. Examples of non-client service costs may include HCR and STD/HIV integration. Administrative costs may include personnel costs not related to interventions, relevant operating expenses, and indirect costs. These categories are described in detail below.

Section 2 is a summary of services provided by each of your subcontractors. Section 2 will include one table for each of your subcontractors where you will list the direct services they will provide, the estimated number of clients to be served and budgeted amount the subcontractor will spend on each service activity. If a subcontractor has subcontractors, there is not a separate table for them. All activities provided by the subcontractor and those they hire are to be included within the subcontractor's information. The subcontractor's Service Category Summary Form should also include administrative cost and non-client service costs. **All of the subcontractor's information that you enter in Section 2 should total the budgeted amounts for all your subcontractors combined which is listed under Other Costs in the LHJs budget.**

Section 3 summarizes the combined totals from Section 1 and 2. It contains the total for *all* services and costs related to the contract. **The total for Section 3 must equal your total allocation.** For your assistance, we have incorporated a check point listed below the total budgeted amount. This way you will see if you have over- or under-estimated your

totals compared to your total award amount.

Detailed information about service activity categories:

HIV Testing: HIV testing (with or without counseling) includes HIV testing activities in non-health care settings and health care settings, but should also include LTC activities and costs for newly diagnosed HIV-positive individuals, if you are using OA prevention funding for the LTC activity. If you are using Ryan White or other funding sources, do not include this funding in this category. Additionally, if your LHJ receives Prevention Expanded Testing funding, do not include these funds in this category being that it is a separate program. While PS activities occur within HIV testing for newly diagnosed individuals, do not list PS funding in the HIV testing category. All PS activities should be recorded within the PS activity line item, including offers provided to newly diagnosed individuals as well as individuals who have been living with HIV and may be at risk of having transmitted HIV to others.

Partner Services: You must include at least the amount that you have been allocated for PS. You may include additional OA prevention funding, if you choose. In the budget amount, do not include funding from sources other than your OA prevention award. The estimated number of clients to be served in PS includes offers made to newly diagnosed individuals and to PLWH/A.

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

Syringe Services Program Activities: In FY 2012-13, allowable activities with OA prevention funding include supporting syringe disposal for injection drug users (IDUs), to provide support for nonprescription sale of syringes in pharmacies and policy work.

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

Non-Client Services: In this line item, include the total budgeted amount of OA prevention funding used for such activities as HCR, STD/HIV integration or activities that work toward prevention and care service integration. Leave the estimated number of clients to be served blank.

Administrative Costs: This category should include costs such as personnel costs not related to interventions, appropriate operating expense costs, training, indirect costs. Leave the estimated number of clients to be served blank. LHJs and their subcontractors must adhere to the travel and per diem requirements and rates as established by the State of California.

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

IV. FY 2012-2013 HIV PREVENTION PROGRAM REQUIRED AND ALLOWABLE SERVICES

Funded LHJs may select to implement one or more activities from the Tier I set of activities. If an LHJ intends to implement any Tier II activities, all Tier I activities must be implemented first. Activities can be implemented with OA funding or from other funding sources. An exception is made for HCV testing. While this is a Tier II activity, it may be implemented even if not all Tier I activities are implemented. The following is a descriptive list of Tier I and Tier II activities:

Service Categories	
<p>HIV Testing in Non-Health Care Settings</p> <p>Tier I</p>	<ol style="list-style-type: none"> 1) LHJs shall administer HIV testing by providing anonymous and/or confidential HIV testing services (with or without counseling) to individuals at high risk for HIV. Testing services may include: assessment of client needs regarding HIV transmission; client-focused prevention counseling, where appropriate; risk-reduction planning; and referral to other services. LHJs funded for testing in non-health care settings are required to: establish systems for linking newly diagnosed HIV-positive or preliminarily positive clients into medical care with a verified medical visit; ensure that clients are offered PS; and establish a plan for referring clients to other prevention programs. 2) Individuals seeking testing services shall be informed about the validity and accuracy of the antibody test before consent to test is obtained. Written consent is required for testing in non-health care settings; oral consent is required for ATS; and oral consent is allowed for testing in health care settings. All individuals tested with OA funds in non-health care settings shall be given the results of their test in person. 3) Funded agencies must ensure all HIV counseling interventions are provided by staff members who have successfully completed the three-day Basic Counselor Skills Training. In addition, test kit operators are required to complete an annual competency assessment test to maintain their certification for testing client samples. 4) All funded LHJs must ensure that all contracted testing sites maintain appropriate documentation. This includes the LHJs written protocols for the local testing program, signed statements of confidentiality by staff, testing forms, invoices, etc. All documentation should be maintained for three years plus the current year. 5) Written quality assurance plans are required by sites conducting point-of-care rapid HIV tests waived under the federal Clinical Laboratory Improvement Act (CLIA). These plans must be submitted to OA for review by the Testing Specialist for

	<p>comprehensiveness and compliance with state and federal requirements.</p> <p>6) LHJs must increase the number of newly identified HIV-positive tests annually by at least 10 percent.</p>
<p>HIV Testing in Health Care Settings (not Expanded Testing)</p> <p>Tier I</p>	<p>1) LHJs must adhere to the relevant aforementioned requirements as outlined in the Testing in Non-Health care Settings, Section IV.</p> <p>2) LHJs should work with local health care settings on ways they can implement and increase routine, opt-out HIV testing. These settings may include but are not limited to hospital emergency departments and primary care clinics in community health care settings.</p> <p>3) All LHJs will be required to survey the larger health care settings in their LHJ to determine to what extent the health care settings are providing any HIV testing in their settings and what their capacity for routine, opt-out HIV testing is. The survey questions will be available in the beginning of the FY and the LHJs answers should be included in the semi-annual progress report due February 15, 2013.</p> <p>4) Funding for routine, opt-out HIV testing cannot be used to pay for HIV testing staff.</p> <p>5) This funding can only pay for HIV testing (i.e., test kits and other testing costs) in so far as a patient has no other payer for health care services (i.e., payer of last resort).</p>
<p>LTC</p> <p>Tier I</p>	<p>1) LTC is the process of assisting newly HIV-diagnosed persons to enter into medical care. LTC is not a new approach but is now considered a priority activity for all OA-funded HIV testing sites in both medical and non-medical settings.</p> <p>2) LTC is considered to be achieved when a newly diagnosed HIV-positive person is seen by a health care provider (e.g., physician, physician assistant, nurse practitioner) to receive medical care for his or her HIV infection</p> <p>3) HIV testing coordinators will need to establish a system that refers individuals with preliminary and confirmed HIV-positive test results to a medical provider for follow-up. In designing this system, coordinators should include identification of HIV care providers, referrals to medical care, and verification of linkage to first appointment.</p> <p>4) CDC defines an LTC visit as one which occurs within 90 days and the first visit verified. The linkage verification should include confirmation that the person attended his or her first appointment. A variety of different mechanism may be used to verify, including but not limited to verified medical visit form, kickback card, and/or client self-report.</p> <p>5) HIV testing coordinators will need to draft policies and</p>

	<p>procedures for verifying linkages to medical care, and outline the steps in testing sites from the time client receives preliminary or confirmatory results to first medical visit.</p> <p>6) LHJs should also use a linkage verification document. The verified medical visit (VMV) guidance, which includes a sample VMV form, is being updated by OA and will be available during the beginning of the FY. All verified visits must be entered on the HIV Counselor Information Form (CIF) and entered into Local Evaluation Online (LEO) data collection system.</p>
<p>PS Tier I</p>	<ol style="list-style-type: none"> 1) All LHJs that receive OA prevention funds are required to provide PS. 2) At a minimum, LHJs should: 1) offer PS to all people newly diagnosed as HIV positive, as well as those living with HIV who have participated in recent risky behavior and may have exposed others to HIV; 2) assess PS activities and outcomes; and 3) implement provider outreach programs to enhance PS with key community providers. Every LHJ should maintain a staff member to coordinate the PS activities of that LHJ. If an LHJ has the infrastructure to only provide an offer of PS, collaboration with a Disease Intervention Specialist from the STD Control Branch must be established and maintained for comprehensive PS activities. 3) Funds allocated for PS may be used for any activities supporting PS including staff salaries and benefits, travel, training, and resources for third-party notification. PS allocations may not be used to pay for HIV testing, counseling, or other prevention activities. 4) All LHJs should develop a comprehensive, written PS program plan that provides for routine review of PS staff performance with appropriate standards, PS protocols/quality assurance plans, and the availability of and referral to HIV testing, prevention services, STD screening, HCV testing, and HIV medical care as appropriate. 5) Local programs should track the number, type, and outcomes of PS activities provided by entering data into LEO and frequently reviewing this data.
<p>Retention and Re-engagement into Care Tier I</p>	<ol style="list-style-type: none"> 1) LHJs that fund or provide Retention and Re-Engagement in Care will be required to develop a comprehensive plan to identify out-of-treatment HIV-positive individuals, and engage and retain HIV-positive people in treatment. 2) The LHJ is responsible for determining the most effective approaches for achieving active collaboration between local prevention and care providers with the goal of achieving LTC and continued engagement in care for HIV-positive individuals. In order to decrease duplication of effort and ensure maximum

	<p>impact of LTC interventions, LHJs that fund or provide Retention and Re-Engagement in Care services will demonstrate active collaboration and coordination with care sites.</p> <p>3) OA's LEO or AIDS Regional Information and Evaluation System (ARIES) should be utilized to document and record Retention and Re-Engagement in Care activities.</p>
<p>Risk Assessment, Linkage to Services, and Behavioral Interventions for PLWH/A</p> <p>Tier I</p>	<p>1) The goal of Risk Assessment, Linkage to Services and Behavioral Interventions for PLWH/A is to increase the number of Ryan White-funded clinics or HIV care providers providing a comprehensive risk screening program and, to the extent that resources are available, initiate behavioral, structural or biomedical interventions for HIV-positive people, or develop a referral plan to community-based prevention with positives interventions.</p> <p>2) LHJs which elect to fund or conduct HIV-Positive Risk Assessment, Linkage to Services and Behavioral Interventions in Health Care Settings will select at least one Ryan White-funded clinic or HIV care provider who can initiate behavioral risk screening within their medical setting.</p> <p>3) Selected interventions must be evidence-based and designed for people living with HIV. LHJs may also choose interventions that target services to both to people living with HIV and their partners. In that case, evidence-based interventions designed for serodiscordant relationships should be used.</p> <p>4) If a medical setting chooses to refer clients at risk of transmitting HIV to community-based interventions, those interventions must also be evidence-based and designed to target people living with HIV or serodiscordant relationships. If other evidence-based interventions are adapted to the population, documentation of the adaptation should be submitted to OA for approval.</p> <p>5) All staff members who facilitate the evidence-based interventions must have completed training in the intervention. Supervisors must monitor and ensure that all staff administer the intervention with fidelity and follow the curriculum and intervention activities as defined by the intervention. Documentation of each intervention session must be maintained to describe session activities and compliance with intervention requirements.</p> <p>6) OA's LEO or ARIES should be used to document and record client assessments. Behavioral interventions will be recorded and monitored using LEO system. All evaluation required by evidence-based interventions must be completed and be maintained.</p>
<p>HIV Treatment Adherence</p>	<p>1) OA will fund LHJs' efforts to support the appropriate and consistent use of antiretroviral (ARV) medicines to maximize</p>

<p>Tier I</p>	<p>their benefits in sustaining health and suppressing viral load, and to ensure that treatment adherence interventions are available in every LHJ and accessible to all patients living with HIV having difficulty taking ARVs as prescribed.</p> <p>2) LHJs that elect to fund or provide HIV Medication Treatment Adherence are responsible for determining the most effective approaches to designing a program. The activity should include collaboration with health care providers, medical case managers, and others working with PLWH/A to:</p> <ul style="list-style-type: none"> • Regularly screen HIV-infected individuals to determine whether they are on ARV therapy; • Routinely assess treatment adherence and monitor viral suppression of those on ARV therapy to identify individuals who would benefit from treatment adherence interventions; and • Develop appropriate referrals for those not on ARV therapies and for those identified as having challenges in maintaining adherence to their HIV medication requirements. This may include delivering treatment adherence interventions. <p>3) OA prevention funds cannot be used to pay for medications or medical services. Purchasing supplies to assist with medication adherence is an acceptable expense when used within treatment adherence intervention programs.</p> <p>4) OA requires LHJs to use ARIES or LEO to track service utilization by clients referred to treatment adherence interventions.</p>
<p>Syringe Services Programs</p> <p>Tier I</p>	<p>LHJs may use their OA HIV prevention funds to:</p> <ol style="list-style-type: none"> 1) Support local non-prescription syringe sales in pharmacies: This may take the form of working to increase the number of pharmacies providing non-prescription syringe sales and/or encouraging IDUs to purchase sterile equipment in pharmacies which provide non-prescription syringe sales. Alternately or additionally, LHJs may provide educational literature or training about recent changes in pharmacy practice to law enforcement, pharmacy staff, IDUs and health and social service professionals who work with IDUs. 2) Support efforts to increase proper syringe disposal among IDUs. 3) Support policy work necessary to facilitate structural change to expand access to sterile syringes and/or improve sharps disposal among IDUs, as long as the work does not include efforts to influence ordinances. <p>LHJs may not use their OA HIV prevention funds to:</p> <ol style="list-style-type: none"> 1) purchase needles and syringes; 2) fund staff time used

	<p>specifically to distribute needles or syringes; and/or 3) pay for delivery modes such vehicles or rent for fixed sites used specifically for distributing needles and syringes. Additionally, these funds may not be used for any activity designed to influence legislative change at the local, state, or federal level.</p>
<p>Integrated HIV, Hepatitis, TB, and STD Screening for HIV-Positive Persons</p> <p>Tier I</p>	<ol style="list-style-type: none"> 1) Activities for integration of screening for and monitoring of Hepatitis, TB, and STDs for HIV-positive individuals will be determined by each LHJ and will vary depending on the needs and opportunities within each LHJ. Activities may include, but are not limited to: <ul style="list-style-type: none"> • Providing continuing medical education highlighting the benefits of compliance with recommended clinical monitoring can be offered to increase staff integration of screening; • Using ARIES or electronic health records to document clinical testing of medical case management clients and Ryan White clinic patients as appropriate; and • Supporting client education that increases awareness of clinical laboratory monitoring standards and encouraging clients to talk with their health care providers about exposure or transmission risks of Hepatitis, TB, and STDs. 3) OA funding cannot be used to pay for clinical laboratory tests, except as noted for HIV testing and hepatitis screening. 4) LHJ will be required to report on their activities supporting the integration of this screening and monitoring in their bi-annual and annual progress reports.
<p>Condom Distribution</p> <p>Tier I</p>	<ol style="list-style-type: none"> 1) Using OA epidemiologic data in collaboration with a LHJs local knowledge and resources, the LHJ will identify venues in their LHJ that serve the targeted population in communities where HIV/AIDS is most prevalent. 2) LHJs will be required to contact and recruit at least ten eligible venues into the condom distribution program for FY 2012-13. 3) In order for a venue to be eligible for participation in the condom distribution program, they must: 1) provide their services in a zip code that has identified HIV/AIDS cases; and 2) have a clientele (whole or partial) that is made up of the targeted population. 4) Once the LHJ has identified a venue, the LHJ must fill out the <i>Participating Venue Information (PVI)</i> form for each participating venue. There is no limit to how many eligible venues each LHJ can have participating in the program. Should an LHJ recruit more venues throughout the year, a PVI form for each new venue will need to be received by OA before the venue is allowed to order condoms. 5) Condom orders cannot be placed by an LHJ or another entity on behalf of the participating venue. Condom orders cannot be placed by an LHJ for distribution at a one-time event such as

	<p>festivals, health fairs, concerts, etc., unless the events themselves specifically target OA's priority populations.</p> <p>6) LHJs should include information about their condom distribution plans in their bi-annual and annual progress reports.</p>
<p>HCR</p> <p>Tier I</p>	<p>1) Each funded LHJ is required to dedicate a proportion of a specific FTE position to HCR planning activities. Duties for each local HCR staff person and the percentage of time spent will be determined by each LHJ and will vary depending on local policies and resources.</p> <p>2) The HCR staff position may or may not be from within the LHJ's HIV/AIDS program; however, if it is not, a strong partnership should be maintained between the HCR staff and the local HIV/AIDS program.</p> <p>3) LHJs should include information about their HCR-related activities in their bi-annual and annual progress reports to OA.</p>
<p>HCV Testing</p> <p>Tier II</p>	<p>1) OA funding may be used to offer HCV testing to clients identified by the assessment process to be at risk for HCV. Although HCV testing is a Tier II activity, LHJs may choose this activity prior to completion of all Tier I activities.</p> <p>2) OA funds may be used for HCV laboratory tests, HCV rapid tests, and Home Access kits.</p> <p>3) HIV counselors must be certified prior to administering the new HCV rapid test.</p> <p>4) As of January 1, 2012, trained HIV test counselors who are authorized in California to perform rapid CLIA-waived HIV tests may also perform rapid CLIA-waived HCV and combination rapid HIV/HCV tests. HIV test counselors performing rapid CLIA-waived HCV tests or rapid combination HIV/HCV tests, including those tests administered by finger stick, will need to meet the same performance and training requirements as that for rapid CLIA-waived HIV testing. Training for the rapid CLIA-waived HCV and combination rapid HIV/HCV tests will be available in the beginning of FY 2012-13.</p> <p>5) HCV test information should be collected on CIF and entered into LEO.</p>
<p>Behavioral Interventions for High-Risk Negative People</p> <p>Tier II</p>	<p>1) LHJs may provide high-risk HIV-negative populations with evidence-based HIV behavioral interventions to reduce the rate of new HIV infection within identified high-risk target populations. Behavioral interventions may include:</p> <ul style="list-style-type: none"> • Targeted prevention activities for high-risk HIV-negative persons; • Individual level interventions (ILI); • Group level interventions (GLI); and • Comprehensive Risk Counseling and Services for individuals

	<p>with multiple health needs.</p> <ol style="list-style-type: none"> 2) Intervention providers must screen potential participants prior to starting the intervention to ensure participants are part of intended target population, and divert lower risk and non-target population individuals to alternative resources. OA funds should not be used to support interventions for low-risk negatives. 3) All OA-funded behavioral interventions should be recorded in LEO.
<p><u>Social Marketing, Media and Mobilization</u> <u>Tier II</u></p>	<ol style="list-style-type: none"> 1) According to CDC, social marketing is the application of commercial technologies to the planning and implementation of prevention programs. Social marketing for HIV prevention aims to bring about behavior change that improves health by promoting specific HIV prevention messages. 2) OA has chosen health messages for social marketing activities, media, and mobilization activities which include the following: <ul style="list-style-type: none"> • Benefits of early detection of HIV infection; • Need for routine and regular HIV health care; • Benefits of ARV therapy for health of people living with HIV; • Role of suppressed viral load in reducing HIV transmission; • Benefits of integrated screening for HIV, TB, STDs, and hepatitis; • Value of initial and ongoing PS; • Information about Community Viral Load; and • Emerging messages from CDC or OA. 3) Messaging should address one or more of the health messages above and be targeted to HIV-positive people, or priority populations as defined by OA. 4) LHJs choosing to conduct social marketing, media, or mobilization activities must submit a plan to OA prior to starting a campaign. The plan should include a definition of the health issue being addressed and the rationale for its selection. The plan should also describe both the health messages to promote ARV therapy, PS, integration of STD, hepatitis, TB screening, and PS into HIV services, as well as the formative work planned to ensure community participation in the campaign development. Monitoring and evaluation activities must also be included in the plan. A summary of the LHJ's search for pre-existing material and justification for creating any new material must be submitted prior to commencing any social marketing, media or mobilization activities. Due to limited resources, campaigns should already be developed and demonstrated effective. 5) Progress on activities will be clearly documented in bi-annual and annual progress reports submitted to OA, as well as entered into LEO.

<p><u>PrEP Planning and/or Delivery</u></p> <p><u>Tier II</u></p>	<ol style="list-style-type: none"> 1) PrEP is a bio-medical prevention strategy which involves the administration of HIV ARV medications to HIV-negative people before exposure to HIV in order to reduce their chances of becoming infected. Since results from recent trials have demonstrated the efficacy of PrEP in men who have sex with men (MSM), CDC has identified PrEP as a recommended HIV prevention intervention for MSM at high risk for HIV acquisition. OA has included PrEP planning as an approved Tier II activity. 2) OA funds may be used for the following PrEP activities: <ul style="list-style-type: none"> • Assessing LHJ capacity; • Planning, educational, and promotional materials; • Personnel; and • Required client activities. Appropriate client activities include: assessing for high risk, assessing for adherence, risk reduction, and medication adherence counseling and referrals to relevant services. 3) OA funds may not be used for medical care, STD testing, hepatitis B testing and vaccination, blood work, or for the purchase of ARV medications. 4) LHJs should develop protocols for monitoring the HIV status, STD incidence, medication adherence, and risk behaviors of each PrEP client every two to three months. Clients who report multiple risk behaviors and/or inconsistent medication adherence should be monitored and supported more closely. Guidelines should also be established to address serious adherence issues or high rates of seroconversion among participants. LHJs should include information about formative work in the bi-annual and annual progress reports to OA.
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V. LEO CONTRACT/FUNDING SET UP

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

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

- **Targeted testing interventions require specific target populations to be entered.** Population definitions include the number intended to be reached and the funding amounts planned to be spent testing each target population.
- **Include direct, indirect, and other expenses in intervention allocations so the sum of all intervention allocations within a funding stream equals the amount listed on your HIV Prevention Program Service Category Summary tables.** When setting up interventions, each target population requires the estimated number of clients you intend to serve and the amount allocated to this target population. The totals for both of these values should match the information on the Program Service Category Summary in the budget documents for all OA-funded interventions. The amount allocated to each population within the intervention should include all expenses, including administrative costs and program costs so that the total of all intervention costs equals the totals for the respective service categories in Section 3 of the Service Category Summary.
- **Non-client services are not tracked in LEO** including HCR or service activity integration activities. PS are typically integrated within other interventions, such as within counseling and testing, in HE/RR ILI sessions or as part of a care visit. Therefore, your LEO Contract Annual Review Page will not reflect your PS or Non-Client Services activities amounts listed on your HIV Prevention Program Service Category tables.
- **Activities funded by multiple sources must be set up as distinct interventions, one for each funding source.** For example, if you are funding HIV testing for MSM for \$1,000, using 75 percent OA funds and 25 percent from another grant, enter two interventions:
 - MSM testing (OA funding), n = 75 MSM, \$750
 - MSM testing (funding from another grant), n = 25 MSM, \$250

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

- **Budgeted amounts in LEO should be consistent and reasonable estimates for actual costs.** For example, do not enter a budget amount of \$3,000 for the first target population and \$1 for each additional target population. While it may cost more to provide the same service to some target populations compared with others, make sure the cost per encounter does not vary extremely between target populations or interventions of the same type. To assist you, the intervention set-up page in LEO shows the total number of people expected to be served, the total budgeted amount for the intervention and the anticipated cost per encounter for each target population and the overall intervention.
- **LEO set-up for FY 2012-13 C&T and HE/RR interventions must be completed by August 24, 2012.** This is necessary for OA to submit required reports to the CDC.

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

entry, the less likely errors or omissions can be accurately corrected.

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

VI. REPORTING REQUIREMENTS

Progress Reports

Progress Reports will be required on a semi-annual basis to be submitted to LHJ's assigned HIV Operations Advisor via e-mail. The first progress report will cover the first six months of the contract from July 1, 2012 to December 31, 2012. This report will be due on February 15, 2013. The second semi-annual report will cover the second six months of the contract from January 1, 2013 to June 30, 2013 and also a comprehensive account of FY 2012-13 activities. The final and comprehensive year-end report will be due August 15, 2013.

The progress reports should address, 1) all applicable services performed in Tier I and/or Tier II, 2) required information as outlined in the Information for Program Planning (IPP) guidance for Fiscal Year 2012-2013 (click here for [IPP](#)), and 3) relevant follow-up items from the Activity Review of the Workbook that you submitted.

Please report on activities that both the LHJ and subcontracted agencies have implemented. Tier I and Tier II activities include: HIV testing in non-health care settings (with/without counseling); HIV testing in health care settings; LTC; PS; retention and re-engagement in care; risk assessment, linkage to services, and behavioral interventions for PLWH/A; HIV treatment adherence; integrated HIV, Hepatitis, TB, and STD screening; allowable syringe services activities; condom distribution; HCR; HCV testing; behavioral interventions for high-risk negative people; social marketing, media and mobilization; and PrEP planning and/or delivery.

Please limit your reports to 5 to 15 pages, including attachments.

The progress report should address, but is not limited to the following categories:

1. Administrative Issues

Successes – Examples include, but are not limited to the following:

- a. Staffing (e.g., vacancies and/or staff accomplishments);
- b. Training/Capacity Building (e.g., attended and/or provided); and/or
- c. Collaborative Activities (e.g., with subcontracted agencies and/or other service providers, and collaborative work between prevention and care providers).

Challenges and Barriers – Examples include, but are not limited to the following:

- a. Staffing (e.g., gaps and/or turnover);
- b. Training/Capacity Building (e.g., capacity limited, training unavailable, and/or training needs unfulfilled); and/or
- c. Collaborative Efforts (e.g., unsuccessful efforts with subcontracted agencies and/or other service providers).

Strategies to Overcome Challenges and Barriers – Example include, but are not limited to the following:

- a. Describe the LHJs plan to resolve administrative challenges and/or barriers;
- b. Identify alternatives that the LHJ developed to address administrative challenges and/or barriers; and/or
- c. Identify resources that the LHJ used to address administrative challenges and/or barriers.

2. Programmatic Issues:

Successes – Examples include, but are not limited to the following:

- a. Describe progress your LHJ is making toward providing services to your proposed target populations (e.g., analysis of specific locations and selection of locations that reach the target population(s) most effectively);
- b. Describe progress your LHJ is making toward reaching the number of clients that you proposed to reach;
- c. Describe progress your LHJ is making toward providing services to high-risk populations; and/or
- d. Describe the interplay and benefits of comprehensive prevention programming (e.g., how retention and re-engagement activities, treatment adherence activities and assessment and prevention with positive services contribute to successes).

Challenges and Barriers – Examples include, but are not limited to the following:

- a. Describe any issues that are preventing your LHJ from providing services to your proposed target populations (e.g., unable to enroll a sufficient number of individuals to provide a GII or attrition for ILI interventions);
- b. Describe any issues that are preventing your LHJ from providing services to the number of clients that you proposed to reach; and/or
- c. Describe any issues that are preventing your LHJ from reaching high-risk populations (e.g., unable to promote activities within specific venues such as gay bars, HIV clinics or other venues utilized by the high-risk population(s)).

Strategies to Overcome Challenges and Barriers – Examples include, but are not limited to:

- a. Describe the LHJs plan to resolve programmatic challenges and/or barriers (e.g., staff meeting with providers to describe services available or consumer focus groups to learn about population(s) needs and suggestions for service delivery);
- b. Identify alternatives that the LHJ developed to meet program goals (e.g., move venue where service will be provided or selecting a different time or day to provide services); and/or
- c. Identify resources that the LHJ used to address programmatic challenges and/or barriers.

3. Administrative and Programmatic Changes – Examples include, but are not limited to the following:

- a. Reorganization;
- b. New or discontinued subcontracted agencies; and/or
- c. New or discontinued program activities.

4. Technical Assistance Needs/Capacity Building Needs – Examples include, but are not limited to the following:

- a. LEO;
- b. Administrative;
- c. Programmatic; and/or
- d. Training, technical assistance, and continuing education.

5. Evaluation Efforts – Examples include, but are not limited to the following:

- a. From the routine reports available in LEO, please provide a summary of your progress for ensuring that those that test HIV positive receive their test results and are referred to PS and medical care, for targeting high-risk individuals and completing interventions; and/or
- b. Based on these reports and other evaluation measures, please describe any alterations you are implementing in to your prevention program.

VII. HIV PREVENTION PROGRAM CONTACTS

HIV Prevention Program		
HIV Prevention Branch Chief	Brian.Lew@cdph.ca.gov	(916) 449-5812
HIV Prevention Operations Section Chief	Sandy.Simms@cdph.ca.gov	(916) 449-5538
HIV Prevention Program Section Chief	Amy.Kile-Puente@cdph.ca.gov	(916) 449-5805

Prevention Operations Advisors	Assigned Contracts
<p>Cheryl Austin (916) 449-5810 Cheryl.Austin@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Monterey • Santa Barbara • Santa Cruz • Stanislaus • Ventura
<p>Clar Rohde (916) 445-4346 Clar.Rohde@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Contra Costa • Fresno • Kern • Santa Clara • Sonoma
<p>Jill Harden (916) 445-2561 Jill.Harden@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Long Beach • Riverside • San Bernardino • San Joaquin • Solano
<p>Matthew Willis (916) 449-5797 Matthew.Willis@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Alameda • Orange • San Diego
<p>Yvonne Gaide (916) 650-0573 Yvonne.Gaide@cdph.ca.gov</p>	<ul style="list-style-type: none"> • Sacramento

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

Please e-mail the completed budget documents (*Excel file*) to: MAMOUdocs@cdph.ca.gov by **August 31, 2012**.