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TO: CALIFORNIA CONFERENCE OF LOCAL AIDS DIRECTORS

SUBJECT: PREVENTION GUIDANCE

The purpose of this letter is to provide you with information about some of the changes that have occurred in the California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS (OA) with respect to HIV testing and prevention due to the elimination of State General Funds for prevention and testing activities for the fiscal year (FY) 2009-10 contract period, which began July 1, 2009. We anticipate following up with additional information as new issues arise and/or further direction is needed.

OA's Administration Section recently sent out an e-mail requesting your contact information and budgets. Please select one Program Director for the combined Testing, Prevention, and Partner Services (PS) Program. Additionally, in your detailed budget, please indicate how much funding your local health jurisdiction (LHJ) plans on applying to testing and to prevention services. (Funding allocations for PS previously determined.)

A. Allocations

LHJs must indicate how they will allocate the OA funds; allowable interventions include:

- HIV testing (with/without counseling);
- Prevention with Positives (PwP) in care and non-care settings;
- Centers for Disease Control and Prevention (CDC) Diffuse Effective Behavior-based Interventions (DEBIs) and non-DEBIs; and
- Hepatitis C virus (HCV) testing.

*LHJs receiving a PS allocation must use those funds specifically for PS as administered through CDPH's Sexually Transmitted Diseases (STD) Control Branch as described in Section D.

B. HIV Testing

Agencies shall administer HIV testing by providing anonymous and/or confidential HIV testing services (with or without counseling) to individuals at 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.

At a minimum, 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-medical settings; oral consent is required for Alternative Test Sites (ATS); and oral consent is allowed for testing in medical settings. All individuals tested with OA funds shall be given the results of this test in person. Efforts should be made to refer all clients with positive test results to medical care and to Disease Intervention Specialists (DIS)/PS staff. Risk information obtained during the client assessment and subsequent counseling sessions is used as a basis for data collection and as an indicator of necessary adjustments to the program.

Targeted Testing

As in the past, we encourage LHJs to continue providing testing services to populations at highest risk for HIV infection. LHJs should continue to prioritize testing in clinics/venues where high-risk clients access services. If counseling is provided, high-risk clients should be offered a 20-minute counseling session. High-risk negatives should receive appropriate referrals to other prevention services, STD screening, and social and support services. HIV-positive individuals should be referred to medical care and to DIS/PS staff.

Counseling/No Counseling

As specified in OA's Budget Implementation Plan, LHJs have the option to provide testing with or without counseling. However, if a client has a positive test result, then the client should be given as much time as needed for the results disclosure session; a Counselor Information Form (CIF) must be completed for this encounter type.

Documentation

Client records relating to any program activity or services containing personally identifying information developed or acquired by the agency should be confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian or conservator.

The agency shall maintain signed statements of confidentiality for employees and volunteers who have access to client files of individuals.

The agency must describe a comprehensive, written protocol that provides for: annual review of counselor performance with appropriate standards, client surveys, outreach needs, accessibility of clinic location(s), return rates for disclosure sessions, and the availability of and referral to HIV prevention services for HIV-positive and high-risk HIV-negative clients.

If the agency is providing rapid testing, a written Quality Assurance Plan and site-specific testing protocols must be developed and maintained.

The contractor will be responsible for updating the local HIV-positive referral agency list on an annual basis and providing an updated version to OA.

Information collected during HIV testing, such as Client Assessment Questionnaire (CAQ), CIF, invoices, etc., must be retained by the agency for three years in addition to the current year.

Local Evaluation Online (LEO) Resources Reports

We encourage you to track the number and type of services provided by using the various reports that can be generated in LEO. Please note that records must be marked as complete before they will appear in reports. Generating reports quarterly will assist you in identifying trends and populations served and maintaining quality assurance for your programs.

Data Forms

We recognize that there may be a need to revise LEO and associated reporting forms to accommodate the programmatic changes we have made. This effort will be part of a larger, comprehensive review of testing and prevention activities that we will undertake in the coming months. To expedite provision of this interim guidance, we will maintain current forms at this time.

OA will continue to provide all forms and lab slips needed for testing and prevention services to the 17 funded LHJs. LHJ coordinators will need to submit requests through the LEO Resource Page (www.cdph.ca.gov//programs/AIDS/Pages/OALEO.aspx) by clicking on "Order LEO forms." On the generated e-mail request, coordinators must include: the name of the form(s), the quantity, and contact information including a physical address.

There are a variety of forms used in the testing process; CAQ, CIF, laboratory slips (rapid testing and conventional), Testing Incident Report (TIR), Verified Medical Visit (VMV) Form, and Partner Information Form (PIF).

CAQ: The CAQ is the first step of the test site process; it is not only an initial assessment tool, but allows for the minimum level of data gathering required for federal funding. The CAQ is a self-administered questionnaire that is given to each client upon arrival and completed by every client before services can be delivered. The CAQ collects data about clients to determine risk for HIV and is used to evaluate whether a client meets the criteria for HCV testing.

Data Collection/Data entry: The CAQ is entered into LEO only if the client is assessed as low risk for HIV and is not being tested for HCV.

Counselor Information Form (CIF): The CIF remains the tool for collection of high-risk client demographic, testing history, risk behavior, a risk-reduction plan, referrals, and documentation of test results for both HIV and HCV testing.

Data Collection/Data Entry: The CIF is used to record the outcome of the testing session provided to high-risk individuals. If a counseling session is not provided, the counselors will complete the CIF based on any information voluntarily gathered but must mark "NO" in the data element titled "risk-reduction plan."

Laboratory and Other Associated Forms

Testing sites shall provide laboratory testing services from an OA-approved laboratory or via Clinical Laboratory Improvement Act-waived rapid testing in accordance with all applicable laws, regulations, and guidelines. The testing process shall consist of an U.S. Food and Drug Administration (FDA)-cleared screening procedure (e.g., enzyme-linked immunosorbant assay [ELISA], OraQuick Advance). Initially reactive and indeterminate ELISA results shall be repeated according to established testing protocols. Repeatedly reactive ELISA, preliminary positive OraQuick, or indeterminate results are to be confirmed by FDA-cleared HIV antibody supplemental test (e.g., immunofluorescent assay or Western blot.)

The laboratory forms have not changed and will be completed as in the past. The following is a summary of the two forms and how to use them.

Rapid Testing Laboratory Form: The rapid testing laboratory form is used by anonymous and confidential testing programs. Only qualified personnel who have successfully completed the OA OraQuick test kit training and proficiency testing may

conduct, read, and record the results of the rapid HIV test on this form. The form must be available during counseling sessions when test results are given to clients. Note the area highlighted as Confidential Testing Use Only is reserved for confidential testing use ONLY. This information must NEVER be collected for clients electing to test anonymously.

Data Collection/Data Entry: Proper documentation is critical in order to provide appropriate prevention messages, follow-up services, referrals, and test result interpretation. The form consists of three parts: laboratory copy, test site copy and data entry copy. The data entry copy is stapled to the CIF or CAQ for data entry into LEO. The test site copy is retained by the test clinic/site, and the laboratory copy is only used in the event of a preliminary positive rapid test result. In that case, the laboratory copy must be attached to the conventional laboratory slip which is used to request follow-up testing from a conventional lab.

Conventional Testing Laboratory Form: The form consists of five parts: copy one is the laboratory copy; copies two and three are entitled, "return this copy to test site." (The second "return this copy to test site" is the data entry copy.) Copy four is the test site copy retained by the testing clinic/site, and copy five is the client copy. This copy must be given to the client, who must bring the slip to the test result disclosure session.

The *Confidential Testing Use Only* area of the form is only for clients who elect to test confidentially. The *Tests Requested and Lab Specimen* area is used to specify the type of testing requested for all standard HIV tests and rapid confirmatory and follow-up testing. The **Previous Test Result Identification (ID)** section is used to record the original Unique OA Client Number (OAID) for clients who received a result that requires additional testing. (For example, a preliminary positive rapid test result or an inconclusive standard test result).

Data Collection/Data Entry: The data entry copy is stapled to the CIF or CAQ for data entry into LEO. Please fill in fields needed by the laboratory prior to submission to lab. Upon return from laboratory please enter all data fields required in LEO.

Recording Multiple Tests: Clients who receive preliminary positive rapid test results, invalid rapid test results, or inconclusive standard test results require follow-up testing to determine their HIV status. Additional laboratory request forms are used to request follow-up testing and to record results.

Data Collection/Data Entry: It is critical to accurately document the sequence of tests conducted for each client and ensure that each client receives an

accurate result. Follow the steps listed in our Counseling and Testing Restructure Meeting Manual (2007) which details the procedure to complete and link multiple laboratory request forms for a single client with more than one test.

TIR: TIR is required for any of the HIV testing or disclosure outcomes listed below that occur for an individual client. Multiple sections may be completed for a single client if necessary; however, each TIR should reflect the testing incident(s) associated with a single client. Please mark on the form all sections that apply and complete ONLY the corresponding sections. The form should be completed by the counselor with the assistance of the clinic manager/supervisor as soon as possible after the triggering event. The following lists the triggering events notated on TIR:

Test Results – Discordant Result/Inconclusive Result/Invalid Rapid Test Result.

Rapid Test Disclosure and Confirmatory Sample – Rapid Test Result Not Disclosed/Confirmatory Sample Not Submitted/Confirmatory Test Result Not Disclosed.

Other – any other unusual testing or disclosure outcome.

Data Collection/Data Entry: Data from TIR must be entered into LEO in order to complete any record for which a testing incident occurred. Data entry is accessed through LEO by a tab marked Testing Incident on the client record.

Supplemental Services

VMV: OA places a high value on increasing access to quality medical care and ongoing prevention services for those with a diagnosis of HIV infection. We encourage LHJs to continue the established VMV referral process. The intended outcome is for all clients who test positive to be linked to an HIV care provider and receive medical care. Since the fee-for-service reimbursement structure has been discontinued at the OA level, the special incentive amount is no longer applicable. The programmatic cost associated with providing this service should be accounted for in your prevention budget.

Data Collection/Data Entry: The VMV referral is notated in LEO through a check box on the CIF. However, the actual documentation of the service is recorded on the VMV template provided at the 2007 HIV Counseling, Testing, and Training Coordinator's meeting. Mark the check box on the CIF and enter into LEO that the VMV referral was completed. The timeframe for data entry is dependent upon when follow-up occurs. Complete the VMV template and retain with the CIF at the test site. We are requesting that LHJs continue to provide documentation of this service. *Please notify OA if you do not intend to track this information.*

PS Referral or Offer/Elicitation: OA places a high value on increasing access to PS for individuals diagnosed with HIV infection, and their sexual and needle-sharing partners. Since the OA-associated fee-for-service reimbursement structure has been discontinued, the PS special incentive amounts for PS offer and elicitation is no longer applicable. In general, testing staff should refer clients diagnosed with HIV infection to DIS/PS staff (See Section D.) DIS/PS staff are highly skilled to perform the sensitive activities of client disclosure counseling and elicitation of partner locating information for anonymous notification. Some testing and other prevention services staff may also be cross-trained in PS activities, in which case PS activities may be done on-site by these trained staff members.

Data Collection/Data Entry: A referral to PS is documented on both the CIF and the Health Education/Risk-Reduction (HE/RR) forms and data entered into LEO. In the circumstance where testing staff have training and expertise to provide PS offer and elicitation, then the PS activities, including the type of disclosure (i.e., self-disclosure, dual disclosure, or anonymous third-party disclosure) and number of sex and needle-sharing partners to be notified are documented on the CIF/HE/RR form and should be data entered into LEO. Partner information elicited for dual and third-party notification is documented on a PIF and data entered into LEO. See Section D for details. Due to the necessity for timely partner follow-up, PIFs must be entered within one business day of the original client encounter.

HCV Testing: OA funding may be used to offer HCV testing integrated into the HIV testing session for clients identified at risk through the CAQ assessment process. The costs associated with this service (laboratory tests or home access kits/personnel) should be included your LHJs prevention budget. Therefore, invoicing for HCV testing is accounted for in the consolidated quarterly prevention invoice. There will not be a separate invoice as there was in past years. Please document your HCV activities on the CIF.

Local Variance Allowance (LVA): Due to the discontinuance of our previous fee-for-service reimbursement structure, the LVA process has been discontinued.

Designation of ATS

Historically, there have been 38 LHJs designated as ATS jurisdictions. State statute in 1985 (California Health and Safety Code Sections 120890-120895) created the ATS program. The original intent of the ATS program was to protect the blood supply by having an alternative to blood bank testing where clients could be tested anonymously at no cost. Therefore, any LHJ with a blood bank was included in the ATS program. Since all 17 LHJs that are funded are still designated as ATS LHJs the requirement to

offer ATS testing remains. The number of hours and location(s) dedicated to anonymous testing are not specified and can be determined by assessing local needs. ATS testing must still remain free and anonymous.

Neighborhood Intervention Geared to High-Risk Testing (NIGHT)-Type Activities

For those LHJs that have been approved by OA to continue offering NIGHT-type activities (according to letters mailed to LHJs on October 5, 2009), there will need to be some adjustments to your LEO set up for the new FY before your interventions can be released for data entry. Please contact Kevin Sitter at Kevin.Sitter@cdph.ca.gov or by phone at (916) 449-5814 for technical assistance in identifying appropriate interventions/locations for the continuing NIGHT-type activities. Mr. Sitter will then approve and release your LEO interventions.

As with the other prevention services and activities, the NIGHT-type services are to be included in the overall budget and reflected in the consolidated invoice.

OraQuick Advance HIV Rapid Test Kits

OA will continue to provide Orasure sample collection devices, OraQuick Advance Rapid HIV Test Kits and external controls to the 17 funded LHJs. (Please note that with the recent changes to the phlebotomy laws in California, OA will be exploring potential additional statewide purchase finger-stick-based HIV rapid tests; we will inform LHJs if this occurs.) The process for ordering kits will not change. LHJ coordinators must complete the Rapid Test Kit order form and submit the form electronically to Amy Kile-Puente at Amy.Kile-Puente@cdph.ca.gov.

LHJs receiving Rapid Test Kits from OA are required to complete and submit an inventory form on a monthly basis. The forms should be submitted electronically no later than the seventh of each month. Due to the limited amount of funding available for test kits, OA is committed to maintaining a streamlined inventory system. It is imperative that we receive this data on a monthly basis in order to better account for the statewide rapid testing, as well as form a more accurate estimate of future rapid testing needs. Inventory forms should be submitted to Amy Kile-Puente at Amy.Kile-Puente@cdph.ca.gov.

HIV Counselor Training

Agencies shall ensure that all HIV counseling interventions are provided by staff who have successfully completed the HIV counselor training according to current OA HIV Counselor Training Program Guidelines. California's HIV Prevention Counselor training is designed to provide a high standard of counseling services in all OA-funded HIV

testing programs. Training is required in order to ensure consistent assessment, effective intervention, and appropriate referrals.

With the budget reductions, the Basic I training has been modified from a four-day training to a three-day training entitled, "Basic Test Counselor Skills Training." LHJs are to continue to sign participants up for the pre-training packet. In 2010, there will be a new pre-training online course entitled, "Basic Test Counselor Online Information Course" and a follow-up "Basic Counselor Skills Training Follow-up Online Course." The Basic II and Continuing Education Trainings (CETs) are no longer required for HIV counselors to become and remain certified.

The process for which the LHJ HIV testing coordinator registers an applicant for the Basic Test Counselor Skills Training is the same as for Basic I trainings from previous years. After an applicant is identified for the Basic Test Counselor Skills Training, the LHJ HIV testing coordinator will sign up the applicant for the pre-training online quiz through the University of California, San Francisco's AIDS Health Project (UCSF/AHP) Web site (www.ucsf-ahp.org). The applicant will be sent an e-mail with the link to the pre-Basic I training learning packet (which is in portable document format) and instructions for taking the online pre-training quiz; the questions are based upon the material in the learning packet.

Note: *It is important that participants in Basic Test Counselors Skill Training read the pre-training learning packet thoroughly, as much of the material in the packet will not be covered in the training, and the training relies upon the participant already having read and retained the material contained in the learning packet.* Once the applicant has been signed up to receive the pre-training learning packet and take the online pre-training quiz, the LHJ HIV program coordinator may then begin the rest of the process of registering the applicant for the desired Basic Test Counselor Skills Training. The three-day Basic Test Counselor Skills Training must be completed within 60 days of being employed as, or volunteering as, an HIV Prevention Counselor. Before a HIV counselor can provide single session counseling, they must be trained by OA-approved training.

There are a limited number of trainings and spaces (16) in each Basic Test Counselor Skills Training class and participants will be registered in the order in which *complete* applications (including passing quiz results) are received. Please submit completed applications for the training as early as possible (and at least 30 days in advance of the training). Applications received less than 30 days prior to the training may be too late to be considered for that training. Because of staffing reductions, OA no longer has a dedicated full-time training coordinator; thus, late applications will likely not be accommodated.

OA strongly encourages supervisors to be active participants in their new counselors' orientation process through increasing individual supervision, observing counseling sessions (with client consent), and training by or "shadowing" of experienced HIV counselors. This is particularly important because the Basic Test Counselor Skills Training curriculum includes rapid testing training and all newly trained counselors must be prepared to face the possibility of delivering an HIV-positive test result.

In 2010, UCSF/AHP will create additional modules for the current online Supervisors Course. These modules will outline the new test counseling training approach and help supervisors develop skills to train their staff on information and skills that are no longer covered to the same degree as they were in prior trainings.

Additionally, a one-day follow-up, face-to-face, Advanced Test Counselor Technical Assistance Training will be offered as an option for LHJs that want additional training. Participants must have completed their Basic Counselor Skills Training at least three months prior to this training.

CETs are no longer required.

C. Prevention Activities

We recognize that there may be a need to revise and refine the prevention intervention-related programmatic changes we have made. We may also need to update previous requirements that we have planned to continue this year. Thus, we will undertake a comprehensive review of allowable testing and prevention activities and related requirements in the coming months. This process will include a review of all current CDC guidelines and recommendations and will involve funded LHJ partners. To expedite provision of this interim guidance, we will largely maintain current prevention intervention-related guidance at this time.

LHJs shall fund prevention services provided to clients in accordance with the guidelines in the Education and Prevention 2007-2010 Program Guidance. However, training previously required for implementing certain behavioral interventions is no longer available through OA and, consequently, is no longer mandated. LHJs can elect to provide these interventions as long as other minimum requirements are met.

Prevention activities may include:

- a. Targeted prevention activities ([TPA](#)) for high-risk HIV-negative and HIV-positive persons;
- b. Individual level interventions ([ILI](#));
- c. Group level interventions ([GLI](#));

- d. Comprehensive Risk Counseling and Services (**CRCS**) for individuals with multiple health needs; and
- e. Health Communication/Public Information (**HC/PI**) programs for at-risk Behavioral Risk Groups (**BRG**). (Note that the use of this intervention is discouraged at this time. It was erroneously included in the budget guidance, and thus we are not removing it this year but intend to remove it in the next year, as it is not consistent with OA's budget reduction implementation plan.)

All selected activities will be targeted to LHJ prioritized BRGs most likely to acquire or transmit HIV disease. In selecting BRGs, please utilize recent epidemiological data, needs assessments, gap analyses, community input, and/or other relevant information.

Community Planning

Community input is a significant element in developing a comprehensive HIV prevention plan in the LHJs. Although OA is no longer requiring LHJs to maintain Local Implementation Groups (LIGs), OA remains supportive of this process. If you do not have an LIG in your LHJ, you can obtain community input by other means (i.e., focus groups, surveys).

Allowable Activities

TPAs for high-risk HIV-negative and HIV-positive persons are generally conducted by peer or paraprofessional educators in areas where they typically congregate. A major purpose of TPA is to locate at-risk individuals in high-risk BRGs and assist them into HIV testing services. Additional referrals to prevention interventions and other services that address cofactors and barriers to successful behavioral change can also be made. TPA activities may include distribution of condoms and educational materials.

An **ILI** is provided on an individual basis to assist a client in appraising behavior, planning for behavior change, and monitoring behavior changes. ILIs also facilitate linkages to services in clinic and community settings to support behaviors and practices that prevent HIV acquisition and/or transmission. Risk assessment assists participants in identifying places and influences that put them at risk for acquiring or transmitting HIV, by highlighting specific risk situations and allowing a participant to engage more fully with a trained professional and develop a plan for a specific behavior change. ILIs should include development of a client-centered plan for behavior change.

GLIs use peer and non-peer models involving a range of skills building, information, education, and support to groups of varying sizes. Most effective GLIs have multiple sessions and a written curriculum that help participants with longer-term behavior change. In addition, facilitated support groups that focus on risk reduction and skills

building can also be effective. Educational sessions that primarily provide information on HIV to groups will be reported within the HC/PI category, which is consistent with the CDC categorization. Requirements include: a written curriculum for each group intervention; a group self-administered questionnaire for all one-time groups, and for one session of multi-session groups; and the group short-form for all but one session when the self-administered questionnaire is completed.

Curriculum requirements for standard groups:

- Outline overall goals and objectives for the series; and
- List specific objectives and topics for each session within the series.

For “client-driven” groups:

- Outline a pre-determined set of goals and objectives for the series;
- Log the objectives and topics achieved each session; and
- Steer the group discussion toward any unmet objective or topics before end of series.

CRCS is a client-centered activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. CRCS is a hybrid of HIV risk-reduction counseling and traditional case management, which provides intensive, ongoing, and individualized prevention counseling, support, and links to other vital services.

Screening individuals to determine eligibility for CRCS services is conducted in a single ILI intervention. Only those determined eligible and agreeable to participating in CRCS services should be enrolled in CRCS. (This is the only circumstance where a single ILI is utilized.) CRCS programs will follow the most recent CDC CRCS Implementation Manual (Currently, Spring 2006): www.cdc.gov/hiv/topics/prev_prog/CRCS/index.htm.

Due to budget reductions, the CRCS counselor network, which in the past included a regular newsletter and regular conference calls where CRCS counselors could seek and provide case consultation via the California STD/HIV Prevention Training Center (PTC), is no longer available. Since CRCS involves intensive work with clients who are experiencing multiple barriers to HIV prevention such as substance abuse and mental health, it is recommended that the provider be either a licensed professional or an experienced counselor who has completed CRCS training.

HC/PI is the delivery of planned HIV/AIDS prevention messages to targeted populations and BRGs through one or more channels. HC/PI messages are designed to build general support for safe behavior, support personal risk-reduction efforts, and inform

people at risk for infection about prevention and other services that support the participant's behavior change goals. Typical delivery modes include electronic media, print media, hotlines, clearinghouses, health fairs, and presentation/lectures, including "HIV 101" interventions. (See previous comments regarding future plans for this intervention category.)

Core requirements:

- BRGs must be specified for each HC/PI activity; and
- HC/PI media created locally must be approved by a local materials review committee.

LEO

LHJs will set up a LEO process monitoring system for all selected activities, including entering BRGs, anticipated numbers to be reached, and estimated dollar amounts dedicated to each BRG within each activity. Activities will be documented by:

- a. Completing the appropriate OA LEO data forms;
- b. Entering data into LEO within one week of each client encounter. (Data must be entered into LEO no later than 30 days of each client encounter);
- c. Entering PIFs within one business day of the client encounter to ensure timely partner follow-up; and
- d. Briefly describing the implementation and progress of each activity in the narrative report submitted to OA on a semi-annual basis.

D. PS

Please note that the PS program, including the funding, structure, implementation documentation, and oversight, is an entirely new collaboration between OA and the STD Control Branch. As such, we recognize that there may be many questions about this portion of the guidance document. Please direct your questions to Romni Neiman at Romni.Nieman@cdph.ca.gov and copy Barbara Weiss at Barbara.Weiss@cdph.ca.gov. In collaboration with the STD Control Branch, we will also undertake a review of this program by the end of the FY and consider modifications as needed.

Agencies shall administer HIV PS Programs by offering PS to newly identified HIV-infected individuals and other HIV-positive individuals who have engaged in recent risky behaviors. HIV PS includes: dialogue with an HIV-positive client regarding disclosure to sexual and needle-sharing partners; skill-building with the client on how to inform a partner of their potential exposure; and the anonymous notification of the

partner(s) of an HIV-positive client by a DIS/PS staff. Clients choosing to participate in PS should be referred to local health department (LHD) DIS/PS staff by HIV testing, prevention, and care providers for PS counseling, offer, partner elicitation, and notification activities. If PS expertise exists at the point of access to care, experienced HIV testing, prevention, and care staff can conduct the following activities: PS counseling, offer, elicitation of partner locating information, and dual counseling sessions. All anonymous third-party notifications and field investigations for partner notification are performed by DIS/PS staff. Anonymous notification includes the confidential counseling of partner(s) around their potential exposure to HIV and subsequent offers for HIV testing, prevention services, and referral to medical care.

At a minimum, LHJs should: 1) offer PS to all persons newly identified with HIV and those living with HIV who have participated in recent risky behaviors 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. Risk and other pertinent information collected during the original client PS offer and elicitation and partner notification counseling session and associated outcomes will be used as a basis for data collection and program development. An individualized work plan will be developed by each LHJ based on the level of funding allocated and local needs and resources.

PS Allocation

The funding for PS represents approximately 16.5 percent of the resources allocated for prevention interventions at the local level. Funding and infrastructure for PS varies by LHJ; therefore, allocations will be based upon a PS allocation formula, taking into account local staff resources and PS expertise. The responsibility for PS activities may: 1) fall solely to the local HIV/AIDS program; 2) be provided through interagency agreement/subcontract with the local STD program; or 3) be provided through direct assistance (DA) from CDPH' STD Control Branch Disease Intervention Section Regional Field Office staff. For example, if DIS/PS staff resources are not housed within the local HIV program, PS expertise should be secured through a subcontract/interagency agreement with the local STD Control Program or through DA with the CDPH STD Control Branch regional staff.

PS Delivery

Focus will be on maximizing staff specific expertise, streamlining services, and conducting quality assurance and evaluation of PS activities. Local PS delivery systems may include the provision of PS through: 1) HIV testing, prevention, and/or care staff educating HIV-positive clients about PS and making a referral to DIS/PS staff for comprehensive PS; 2) experienced HIV prevention and care program staff, with

training in PS, can conduct the PS offer, including coaching for self referral, dual notification, and elicitation of identifying and locating information for third-party anonymous notification to be forwarded to DIS/PS staff for field investigation; and 3) some HIV programs have experienced HIV testing, prevention, and care staff that have been trained as DIS/PS staff to conduct comprehensive PS activities. A number of LHJs participated in the California HIV PS Field Investigation Mentoring Program to expand HIV staff ability to facilitate partner notification and conduct field investigation. If a LHJ HIV Program has highly trained DIS/PS staff, the use of these staff to conduct PS activities is permissible, including PS counseling, offer, elicitation, notification, and field investigation. These three options will be monitored to evaluate the number of successful offers, uptake, and outcomes of third-party notification services, and completeness of partner contact information.

PS Expertise/Staff

Funds allocated for PS shall be used to support DIS/PS staff full-time equivalents (FTEs) conducting PS activities and may not be used to pay for HIV testing, counseling, or other HIV prevention interventions or staff. As a gold standard, DIS/PS staff should be utilized to conduct PS activities, as they have proficiency and "certification" in all components of PS, including offer, elicitation, notification, and field investigation. Monitoring of the training and "certification" process and evaluation of staff core competencies will be coordinated by CDPH's STD Control Branch. All LHD DIS/PS staff shall follow CDC's PS guidelines. Additionally, DIS/PS staff should be part of a team of at least two trained DIS/PS individuals to ensure back-up and continuity of service and be supervised by an individual who also has DIS/PS expertise who can provide quality feedback, mentoring, and problem solving on PS performance and challenges. If this expertise is not available within the LHD, CDPH's STD Control Branch Regional DIS/PS staff will provide service back-up and/or supervision.

PS Capacity

LHJs should ensure local delivery systems are available to support comprehensive PS for these individuals by identifying appropriate DIS/PS staff, establishing PS referral systems, and utilizing PS data systems. Key activities include: 1) collaborate with public and private sector HIV testing and care providers to refer clients for PS; special emphasis should be directed toward priority populations, per CDC PS Recommendations, such as persons with a high HIV viral load, persons with evidence of acute infection, or those with recently identified infection if the information is available; 2) identify qualified DIS/PS staff to conduct comprehensive PS activities (offer, elicitation and partner notification, including field investigation); 3) ensure PS staff has appropriate training and supervision, per California recommendations; 4) monitor

HIV PS caseloads of DIS/PS staff to maximize effort and ensure cost-effective PS programs; and 5) complete PS data collection and entry in accordance with PS data management policies and procedures.

HIV PS Program Assessment

LHJs should assess the implementation, process and delivery system of PS using all sources of available information and measure HIV PS offers, acceptance, type of notification (e.g., third-party, dual, self referral) and partner outcomes (e.g., tested, new positive, new negative, previous positive) using the reports in LEO. Key activities include: 1) monitor data from provider, settings, and staff to assess quality and productivity of PS activities, according to established performance measures; 2) measure all PS offers and stratify outcomes by staff, client demographics, and setting (i.e., testing, select HIV testing and care settings and STD co-infection); 3) facilitate ID of best practices and areas for improvement; collaborating with providers, settings and staff to implement systems modification and staff development, as indicated; 4) report PS activities and outcomes to CDPH's STD Control Branch on a quarterly basis; and 5) if performance problems are identified, develop and implement a performance improvement work plan in collaboration with CDPH's STD Control Branch and OA.

Establishing PS Referral Systems

Based on the analysis of provider level data, LHJs should conduct outreach/visitation to key testing and care providers to increase awareness and knowledge of HIV PS and establish PS referral systems. Key activities include: 1) local capacity-building efforts should be directed by the local assessment of needs; 2) work with local and/or state epidemiologists to identify available data sources to facilitate referral for and evaluation of PS activities with high priority providers and priority populations; 3) conduct analyses of provider level data (i.e., HIV testing, HIV surveillance, HIV care, and STD) to identify community providers with high positivity rates or serving priority patient population; 4) conduct site visits to provide information on HIV PS, distribute HIV PS provider/client educational materials, and establish a referral system between testing and care providers and the LHD DIS/PS team to support newly identified HIV-positive clients and other HIV-infected clients interested in PS; 5) implement tailored technical assistance with a few key providers/agencies based on the prioritized needs; and 6) monitor referrals from key providers/agencies and associated PS outcomes.

PS Documentation

Client records relating to any program activity or services containing personally identifying information, which were developed or acquired by the agency, should be confidential and shall not be disclosed, except as otherwise provided by law for public

health purposes or pursuant to a written authorization by the person who is the subject of the record or by his or her guardian conservator.

The agency shall maintain signed statements of confidentiality for staff who have access to client files of individuals.

The agency should develop a comprehensive, written PS program description 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 needed for PS clients and their partners.

If the agency is providing rapid testing, a written Quality Assurance Plan and site-specific testing protocols must be developed and maintained.

The contractor will be responsible for updating the local HIV-positive referral agency list on an annual basis and providing an updated version to OA.

PS forms and information, such as the Original Client (OC) form, the PIF, etc., must be retained by the agency for three years in addition to the current year.

PS LEO Resources Reports

Local programs should track the number, type, and outcome of PS activities provided by using the various reports that can be generated in LEO. Please note that local agency reports can be run to verify open PIFs, and outcomes of client offers and partner notification. Generating reports quarterly will assist you in identifying trends, populations served and maintaining quality assurance for your programs.

PS Data Forms

OA will continue to provide all PIF forms and lab slips needed for PS to the 17 funded LHJs. LHJ coordinators will need to submit requests through the LEO Resource Page (www.cdph.ca.gov/programs/AIDS/Pages/OALEO.aspx) by clicking on "Order LEO forms." On the generated e-mail request, coordinators must include: the name of the form(s), the quantity, and contact information including a physical address.

There are a variety of forms used in the PS process. (*Please see the **PIF Guidance and Protocols** and the **LEO Quick Start Guide** for more detail.*)

For PS activities conducted for HIV-positive individuals identified in HIV testing, prevention, and care venues: Index client information will be documented through:
1) the OC form for a PS referral to a DIS/PS staff; this form along with PIFs will be data

entered into LEO; 2) PS data elements integrated into existing HIV testing, prevention, and care forms (e.g., CIF, HE/RR) used at the point of access; these forms, along with PIFs, will be data entered into LEO.

For PS activities conducted for HIV-positive individuals who are identified with STD co-infection (e.g., reported with infectious syphilis): PS activities will be integrated and documented on appropriate STD OC forms (e.g., syphilis Interview Record [IR]). STD case management forms and field investigation records (FRs) will document PS outcomes and be data entered into the standard STD database.

OC Form: The OC form is a tool for collection of client demographic, testing history, risk behavior, and PS offer and elicitation for HIV-positive clients: 1) identified in private sector HIV testing settings; 2) identified in public and private sector HIV care settings; and 3) referred for PS to DIS/HIV PS staff for comprehensive PS.

Data Collection/Data Entry: The current OC form is under revision. The newly revised OC form will collect data elements to indicate the specific venue/source of PS referral, demographic data on the original HIV client, and data elements to indicate the PS activities and number of partners to be notified. Once the newly revised OC form is completed, LEO will be modified to accommodate OC data entry and generation of associated PIFs through the PS link from the LEO main menu. (*Note:* LEO currently accommodates the OC number only and PIFs will need to be data entered into LEO through the PS link until these modifications are made.)

PIF: The PIF is a user friendly tool to collect identifying, locating and exposure information on sexual and needle-sharing partners elicited for partner notification.

Data Collection/Data Entry: The PIF is used to collect information necessary to conduct dual and anonymous third-party partner notification activities, and to record outcomes of the field investigation (e.g., unable to locate) and partner notification, including testing history, current HIV test results (e.g., previous negative, new HIV positive) and referral to care. PIF comes as a triplicate form: 1) the first page, containing partner identifying and locating information, is routed to DIS/PS staff to conduct follow-up for partner notification; 2) the second page, without identifying and locating information, is routed for data entry; and 3) the third page, without identifying and locating information, is maintained for program management purposes.

PIFs initiated through testing or prevention activities are data-entered in LEO, through the CIF and HE/RR client forms. Stand-alone PIFs can be data entered into LEO from the PS link on the main menu. All PIFs should be entered within

one business day of the OC encounter. Refer to the PIF Guidance for specific instructions on how to handle partner paperwork in the field and partners outside your LHJ.

HIV Testing Forms (i.e., CIF): If the client is HIV positive, CIF and/or the OC form is used to record client PS activities. If PS activities are referred to DIS/PS staff, the PS offer is recorded on CIF. Once the DIS/PS staff initiates the case, the counseling and/or elicitation activities conducted with the HIV-positive client will be recorded on an OC form. If the HIV staff is trained and able to carry out the PS offer, dual or self notification, or elicitation for anonymous third-party notification, then CIF is used to collect the PS activities conducted with the HIV-positive client.

Data Collection/Data Entry: Please see Section B, Testing Data Form for details.

HIV Prevention Forms (i.e., HE/RR client form): If the client is HIV positive, the HE/RR and/or the OC form is used to record client PS activities. If PS activities are referred to DIS/PS staff, the PS offer is recorded on the HE/RR form. Once the DIS/PS staff initiates the case, the counseling and/or elicitation activities conducted with the HIV-positive client will be recorded on an OC form. If the HIV staff is trained and able to carry out the PS offer, dual or self notification, or elicitation for anonymous third-party notification, then the HE/RR is used to collect the PS activities conducted with the HIV-positive client.

Data Collection/Data Entry: Please see Section C, HIV HE/RR Data Form for details.

Syphilis IR: The IR remains the tool for STD case management and the collection of client demographic, risk behavior, and documentation of STD clinical (i.e., signs and symptoms, treatment) and laboratory (STD testing) information and client referrals. If the STD client is HIV positive, the IR is used to record the outcome of the integrated (syphilis/HIV) PS offer.

Data Collection/Data Entry: The newly revised IR contains data elements to better delineate the outcomes of integrated PS. It includes the number of partners to be notified via anonymous third-party, and/or dual notification and/or self referral. The IR is data entered into the LHJs or CDPH's STD Control Branch Regional Office's STD Database.

FR: The FR remains the tool used in the field for collection of identifying, locating and exposure information, and documentation of LHD field investigation and partner notification outcomes.

Data Collection/Data Entry: The FR is the form used in the field to record outcomes of LHD field investigation (e.g., unable to locate) and partner notification, including testing history, current HIV/STD test results and referral to care. Codes are used to record disease information and outcomes are recorded as “disposition codes.” The FR number is recorded on the PIF and the Syphilis IR record and entered into LEO or STD database, respectively.

Partner Referrals

OA places a high value on increasing access to quality medical care, treatment, and/or ongoing prevention services for all high-risk individuals. All referrals made for high-risk partners located and counseled through dual or third-party notification are recorded on PIF. This includes any referrals to HCV/STD testing, additional CRCS counseling, drug/alcohol treatment, PS, and/or care/treatment (including verified referrals with a known AIDS Regional Information and Evaluation System [ARIES] number).

VMV Form: We also encourage LHJs to continue the VMV referral process and implement use of this form during PS activities, specifically when notified partners receive testing and a subsequent new HIV-positive diagnosis.

Laboratory and Other Associated Forms

Laboratory Testing: LHJs shall provide laboratory testing services for sexual and needle-sharing partners initiated for dual and third-party anonymous partner notification. The testing process and forms should be consistent with that described above, including the use of rapid testing, conventional testing, and OraQuick advance HIV rapid test kits. Partners should receive confidential HIV testing in accordance with all laws, regulations, and guidelines, when OA funds are used to pay for the test.

Fee-for-Service Reimbursement: Due to the discontinuance of our previous fee-for-service reimbursement structure the HIV prevention PS financial incentive process has been discontinued in terms of increased reimbursement for clients who are offered PS, and a higher payment for those with partners elicited or initiated in testing and HIV prevention programs.

HIV DIS/PS Training

Agencies shall ensure that all PS activities are provided by staff who have successfully completed the CDC or California's HIV PS Training(s), and in accordance with current CDC PS Recommendations. CDC and California's HIV PS training is designed to provide a high standard for PS.

CDC's Introduction to STD Intervention (ISTDI), HIV PS, and Top Safe (Field Safety) courses are currently available through the California STD/HIV PTC. All DIS/PS staff should complete the CDC's ISTDI to promote competency in comprehensive PS (i.e., client-centered counseling, motivational interviewing, risk assessment, PS offer, partner elicitation, partner notification, and field investigation). Experienced HIV testing, prevention, and care staff should complete CDC's HIV PS Training which provides an overview of comprehensive PS activities, skill building in PS offer and elicitation, and an understanding of the anonymous third-party notification process. Contact STD Control Branch for more information on this training, as there are a limited number of trainings and spaces in each.

OA strongly encourages supervisors to be active participants in new HIV DIS/PS staffs' orientation process through increased individual supervision and observed PS counseling sessions (with client consent), notification sessions and field visits until PS skills are proficient. Existing staff should be observed when counseling, notifying and in the field at least semi-annually. HIV testing and prevention staff should also be observed when providing PS offers and elicitations and should periodically "shadow" experienced DIS/HIV PS staff in the field to gain a better understanding of the anonymous third-party notification process.

E. Technical Assistance and Capacity Building for Testing, PS and Other Prevention Services

Staff in OA's Prevention Program Section are available to provide consultation and technical assistance services to funded LHJs and subcontracted community-based organizations (CBOs).

Intervention Specialists can assist with the development, implementation, and evaluation of behavioral interventions; provide training on LEO; and assist in identifying additional funding opportunities and training resources. OA will now be maintaining the ChoiceHIV Web site in-house, and it will be updated on a regular basis. The ChoiceHIV Web site offers information and resources in developing, implementing, and evaluating HIV prevention programs. An Intervention Selection tool assists with selecting interventions that are scientifically-based and targeted to specific BRGs, and includes links to obtain additional information or the actual intervention curriculum. Within the Local Profile page, information about each LHJ throughout California is provided, including descriptions of services provided and contacts within each LHJ.

If you have questions for the Intervention Specialists, please contact Kevin Sitter at Kevin.Sitter@cdph.ca.gov or Dennis Fleming at Dennis.Fleming@cdph.ca.gov.

Other technical assistance is available as follows:

Testing in medical settings: Kama Brockman, Social Work Consultant, at Kama.Brockman@cdph.ca.gov.

Testing in non-medical settings: Dennese Neal, Non-Medical Testing Specialist, at Dennese.Neal@cdph.ca.gov.

PwP: Carol Crump, Behavioral Health Specialist, at Carol.Crump@cdph.ca.gov.

PS: Romni Neiman, Chief, Disease Intervention Section, STD Control Branch, CDPH, at Romni.neiman@cdph.ca.gov.

F. Materials and Condoms

Due to the State budget reduction, OA has eliminated funding for activities through the California AIDS Clearinghouse (CAC) contract with the Los Angeles Gay and Lesbian Center. OA staff are currently working on administering materials distribution activities in-house. We plan to have educational materials and condoms available for distribution soon.

In the meantime, to request materials, including condoms, please send an e-mail with the name of the organization, complete contact information, and a specific description of materials and/or services requested to: CACTransitionInfo@cdph.ca.gov. We will fulfill the order as soon as possible.

G. Training and Technical Assistance Resources

Funding for training and technical assistance through many CDPH partners and contractors has been reduced or eliminated; however, there are a variety of training resources still available either through the following partners or other resources. These include:

California STD/HIV PTC
www.stdhivtraining.org/

The California STD/HIV PTC continues to offer CDC PS courses and many DEBI and other behavioral and biomedical intervention-related classes to CDC-funded and subcontracted agencies. Planning courses such as *Bridging Theory to Practice* and *Selecting Effective Behavioral Interventions* may be periodically open for registration, if funding is available. Agencies not directly funded by CDC, may take courses if space is available. Registration fees may be required.

PTC has made podcasts available at www.stdhivtraining.org/Podcasts.html for many current and former training classes. Reference materials may also be available depending on the topic. New podcasts are added to the existing library, as resources permit. For updates on new podcasts or other online learning opportunities, you can join the California PTC's Distance Learning Updates e-mail list by sending an e-mail to Cindy.Levin@cdph.ca.gov. Simply write the word "Subscribe" in the subject line.

CDC

www.effectiveinterventions.org

CDC's DEBI Web site offers a plethora of information on behavioral interventions that have been shown to be effective in preventing the acquisition or transmission of HIV, including: fact sheets, resource guides, training programs, and technical assistance/capacity building opportunities.

www.cdc.gov/hiv/topics/cba/index.htm

CDC's Capacity Building Branch provides and coordinates capacity building assistance and related resources. The Capacity Building Assistance (CBA) Request Information System (CRIS) is used to submit CBA requests, as well as monitor, track, and follow-up on CBA requests. For more information, please contact Cheryl Austin at Cheryl.Austin@cdph.ca.gov.

Center for HIV Identification, Prevention and Treatment Services (CHIPTS)

<http://.chipts.ucla.edu>

CHIPTS offers consultation on the development of new research projects and assistance with obtaining funds for these initiatives. Their Web site provides training resources and informational materials including sample surveys/scales, slides and videos of past presentations, materials for DEBIs and other effective interventions, as well as summaries of CHIPTS sponsored colloquia.

Accion Mutua (Shared Action)

AIDS Project Los Angeles' Capacity Building Assistance Program provides trainings and one-on-one technical assistance for CBOs on Organizational Infrastructure and Program Sustainability, Evidence-Based Interventions (EBIs), and Public Health Strategies and Monitoring and Evaluation. APLA also provides trainings and one-on-one technical assistance for LHDs on EBIs and Public Health Strategies and Monitoring and Evaluation. All services are free and can be delivered in English or in Spanish. Information can be accessed through at www.accionmutua.org or by calling (213) 201-1408.

UCSF

Center for AIDS Prevention Studies (CAPS)

www./caps.ucsf.edu

CAPS provides technical assistance, capacity building, and educational materials to LHDs, researchers, and prevention providers. The downloadable *Research Portfolio* lists and explains all current research projects and training programs offered through CAPS.

Center of Excellence for Transgender HIV Prevention

<http://transhealth.ucsf.edu>

The Center of Excellence offers interactive, tailored training programs focused on HIV prevention for transgender populations. Please e-mail Jo Anne Keatley JoAnne.Keatley@ucsf.edu to request assistance.

Pacific AIDS Education and Training Center (PAETC)

<http://aetcnec.ucsf.edu>

PAETC provides AIDS-related training, education, and information services to health care providers. Presentations on current issues in testing and other biomedical interventions are available.

National Association of State and Territorial AIDS Directors (NASTAD)

www.nastad.org

The focus of NASTAD is to build the capacity of LHDs to implement and manage HIV/AIDS prevention programs. They provide a wealth of resources including Power Point presentations, lectures, publications, and fact sheets on a wide range of prevention issues. They also sponsor a number of Web seminars on current HIV issues.

Academy for Educational Development (AED)

www.aed.org

AED, a nonprofit organization working globally to improve education, health, social and economic development, presents a number of resources for HIV prevention issues including stigma/discrimination, community mobilization, and behavioral interventions.

National Minority AIDS Council (NMAC)

<http://www.nmac.org/>

NMAC develops leadership in communities of color to address the challenges of HIV/AIDS. Specialty training programs in issues relating to health disparities in people of color are offered as need and funding permit. NMAC sponsors both the HIV Prevention Leadership Summit and U.S. Conference on AIDS conferences and provides scholarships to those who otherwise could not afford to attend.

The Institute at Harm Reduction Coalition (HRC)

www.harmreduction.org

HRC is a capacity building and advocacy organization that promotes the health and dignity of individuals and communities impacted by drug use. They offer an array of low-cost, technical assistance, and capacity building training classes at their Oakland office. Most classes are \$70, and Continuing Education Units are offered. Please check the Web site for the class calendar.

H. Allocation of Funds for Services to African Americans

LHJs receiving OA prevention funding will be required to certify in the first progress report (without providing documentation) that they spend prevention allocation dollars on prevention interventions focused on African Americans in proportion greater or equal to two times the proportion of living African American male HIV/AIDS cases in their LHJ. LHJs may request a waiver from OA. The waiver request should be no more than two pages and must include a narrative that addresses the means by which the LHJ plans to programmatically fulfill the intent of this requirement, including the data used to support this funding decision. Waiver requests must be submitted to Sandy Simms, Chief, Program Operations Section, at Sandy.Simms@cdph.ca.gov.

I. Progress Reports

Progress reports will be required on a semi-annual basis. The first progress report will cover the first six months of the contract year from July 1, 2009 to December 31, 2009. This report will be due on February 15, 2010. The second and the comprehensive year-end report will cover the period of January 1, 2010 through June 30, 2010. The second and comprehensive year-end report will be due August 16, 2010.

The second and comprehensive year-end report should address items in the second six months of the contract year as well as a comprehensive year-end report. The comprehensive year-end report should include activities for the project year covering July 1, 2009 through June 30, 2010.

The new progress report format is currently being developed but will not differ significantly from past reports. It will address, but is not limited to the following categories:

- Administrative Issues.
 - Challenges and Barriers.
 - Strategies to Overcome Challenges and Barriers.
 - Successes.

- Programmatic Issues.
 - Challenges and Barriers.
 - Strategies to Overcome Challenges and Barriers.
 - Successes.
- Major Programmatic Changes and Developments.
- Technical Assistance Needs/Capacity Building Needs.
- Evaluation Efforts.

J. Budgets/Invoice Changes

With the consolidation of prevention services program funds the testing program fee-for-service reimbursement/invoicing process has been discontinued. You are not required to set up the internal budget/invoicing system in LEO. Since the invoice functionality remains in LEO you may choose to use the invoice capability for your own tracking needs; however, this is optional. Should you choose to use LEO for this purpose, please note that any invoices generated by LEO should NOT be submitted for payment, they are solely for back-up documentation and internal tracking purposes.

There will now be one scope of work/budget per LHJ for all prevention and testing services. The five-line item budget/invoice reflects the scope of work and includes the following services; allowable prevention interventions, HIV testing, NIGHT-type activities (if your LHJ was approved by OA to continue this activity), and HCV testing. PS allocations must be used to fund these DIS/PS staff FTEs to conduct comprehensive PS; PS-funded FTEs are required to be itemized in this budget.

The budget consists of the following line items; Personnel, Operating Expenses, Capital Expenditures, Other Costs, and Indirect Costs. To streamline the invoicing process you will need to submit only one prevention invoice per quarter that covers all the services listed in your scope of work.

K. Operations Advisors

Below is the list of Operations Advisors, who are available to answer your questions about budgets, scope of work, and LEO.

Mary Geary (916) 449-5804 Mary.Geary@cdph.ca.gov	Clar Rohde (916) 445-4346 Clar.Rohde@cdph.ca.gov	Cheryl Austin (916) 449-5810 Cheryl.Austin@cdph.ca.gov
Alameda	Contra Costa	Kern
Long Beach	Fresno	Sacramento
Los Angeles	Riverside	San Joaquin
Orange	San Bernardino	San Mateo
San Diego	Santa Clara	Solano
San Francisco	Sonoma	

Conclusion

If you have any questions regarding this letter, please contact Barbara Weiss, Chief, Prevention Program Section, OA, for programmatic questions at (916) 449-5790 or by e-mail at Barbara.Weiss@cdph.ca.gov, or Sandy Simms, Chief, Prevention Program Operations Section, OA, for administrative questions at (916) 449-5538, or by e-mail at Sandy.Simms@cdph.ca.gov.

Sincerely,



Brian Lew, M.A., Chief
HIV Prevention Services Branch
Office of AIDS

cc: Gail Bolan, M.D., Chief
STD Control Branch
Division of Communicable Disease Control
Center for Infectious Diseases
California Department of Public Health
850 Marina Bay Parkway, Building P, Second Floor
Richmond, CA 94804

Ms. Romni Nieman, Chief
Disease Intervention Section
STD Control Branch
Division of Communicable Disease Control
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850 Marina Bay Parkway, Building P, Second Floor
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HIV Counseling and Testing Coordinators

HIV Education and Prevention Coordinators

California Conference of Local AIDS Directors
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bcc: Sandy Simms
Barbara Weiss
Dennese Neal
Kevin Sitter
Dennis Fleming
Carol Crump
Kama Brockman
Mary Geary
Clar Rohde
Cheryl Austin
Mark Neff