

Strengthening Our Foundation Through Integration:

2019 Guide to HIV Prevention and Surveillance

April 2018



HIV
PREVENTION
BRANCH

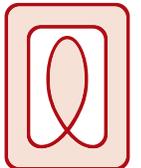
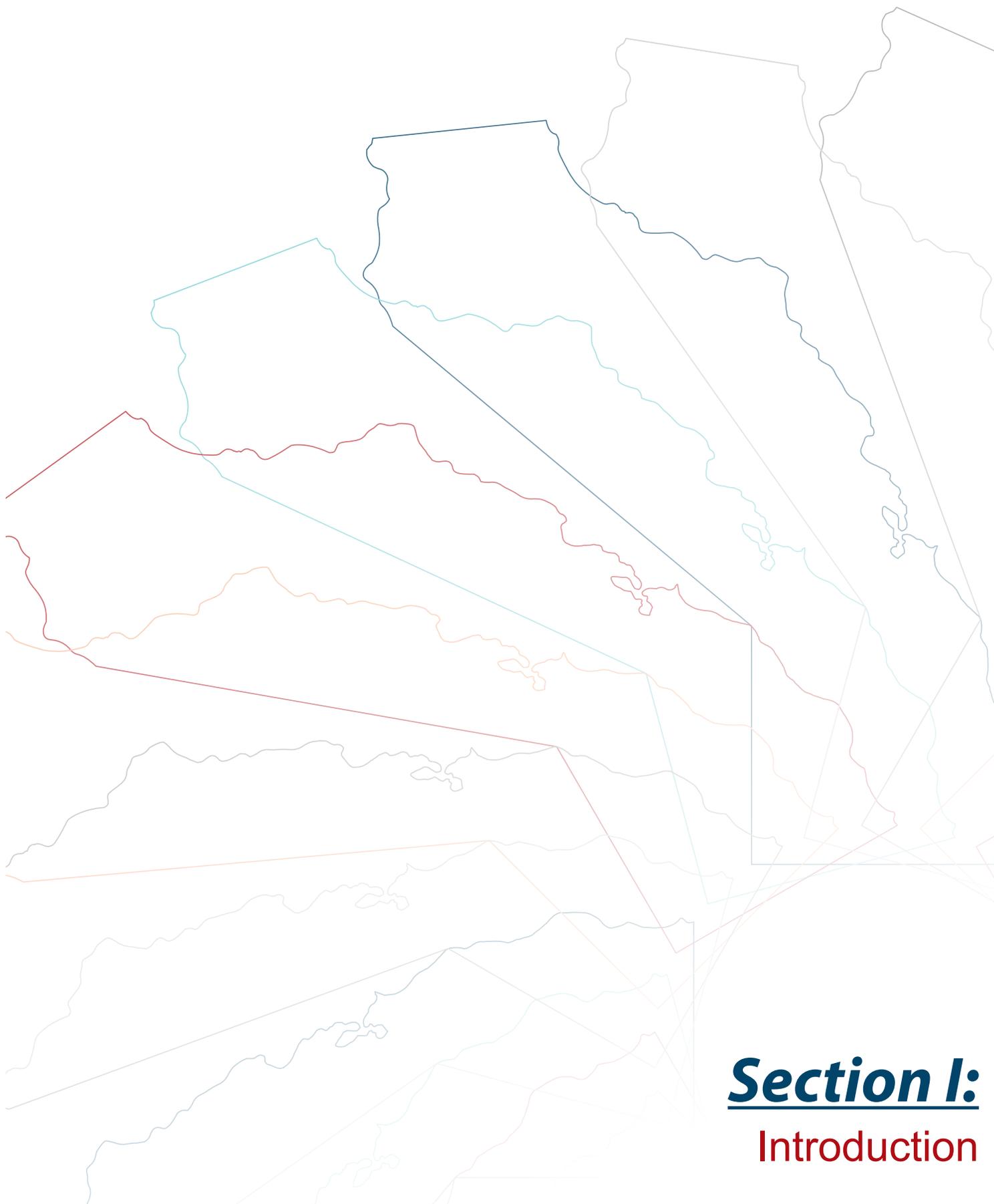


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Section I: **Introduction**

Background

California continues to be among the nation’s leaders in pioneering innovative strategies and interventions to reduce new HIV infections. However, sobering disparities in the rates of new infections among black or African American (hereafter referred to as African American) and Hispanic/Latino gay, bisexual, and other men who have sex with men (collectively referred to as MSM), transgender women (TGW), and young MSM ages 13-24 years, demand increased rigor and coordination across the state. While new infections among people who inject drugs (PWID), heterosexuals, and perinatal transmission remain relatively low, recent increases in rates of chronic hepatitis C virus (HCV) among young adults, as well as increases in congenital syphilis, indicate that these populations require attention in order to avoid resurgence in HIV infections and emphasizes the importance of routine opt-out HIV testing in medical settings.

This document, *Strengthening Our Foundation through Integration: 2019 Guide to HIV Prevention and Surveillance*, provides the California Department of Public Health (CDPH), Center for Infectious Diseases Office of AIDS (OA) guidance to local health jurisdictions (LHJs) implementing HIV prevention and surveillance efforts. The PS18-1802 funding opportunity from the US Centers for Disease Control and Prevention (CDC), titled *Integrated HIV Surveillance and Prevention Funding for Health Departments*, integrates HIV prevention and surveillance funding for the first time.

With the OA funding provided through PS18-1802, LHJs will continue to focus on reducing new HIV infections, with an enhanced emphasis on achieving viral suppression for people living with HIV (PLWH) by using surveillance-based strategies¹. These strategies will help California achieve the statewide goals of *Laying a Foundation for Getting to Zero: California’s Integrated HIV Surveillance, Prevention,*

and Care Plan (GTZ plan), the 2016 plan that established the blueprint for achieving HIV prevention, care, and treatment goals in California, and which serves as the foundation for this guidance.

Purpose of This Document

PS18-1802 is the five-year federal HIV prevention and surveillance grant that began January 1, 2018, and ends December 31, 2022. OA has designated the first year of the grant, January – December 2018, as a transition year for prevention activities dedicated to planning and preparing for the changes required by both PS18-1802 and OA’s GTZ plan. The *2019 Guide to HIV Prevention and Surveillance* outlines OA’s recommended approach to HIV prevention program planning during the 2018 transition year and provides an overview of activities fundable under PS18-1802.

A summary sheet of all required approaches, required activities, and non-fundable activities can be found in [Appendix 12](#).

Specifically, this document guides each HIV Prevention Branch-funded LHJ to:

1. Use surveillance data to examine current progress towards achieving GTZ objectives;
2. Select HIV prevention activities using the GTZ Strategies and guided by analysis of local data; and
3. Develop and submit to OA a work plan and logic model that describe intended HIV Prevention activities for 2019.

¹ In California, PS18-1802 funds HIV prevention efforts in the California Project Area (CPA), which includes all California counties except San Francisco and Los Angeles Counties, which are directly funded by CDC. The 20 LHJs receiving PS18-1802 funding through OA represent 93 percent of living HIV/AIDS cases within the CPA. OA’s Surveillance Section uses California state general funds to support surveillance activities in all LHJs in California except Alpine County, which has no reported HIV cases.

See [Appendix 1](#) for a list of OA Prevention-funded LHJs in the California Project Area (CPA).

OA's HIV Prevention Framework

The **2019 Guide to HIV Prevention and Surveillance** is aligned with California's GTZ plan. The GTZ plan uses the National HIV/AIDS Strategy (NHAS) as its organizing framework, and outlines objectives, strategies, activities, and resources to reach NHAS goals.

California's GTZ goals are to:

1. Reduce new HIV infections in California;
2. Increase access to care and improve health outcomes for PLWH in California;
3. Reduce HIV-related disparities and health inequities in California; and
4. Achieve a more coordinated statewide response to the HIV epidemic.

The GTZ plan outlines [twelve objectives for achieving the statewide goals, and 15 strategies](#) for carrying out the objectives. This **2019 Guide to HIV Prevention and Surveillance** focuses on the five core HIV prevention strategies:

[GTZ Plan Strategy A: Improve PrEP Utilization](#)

[GTZ Plan Strategy B: Increase and Improve HIV Testing](#)

[GTZ Plan Strategy C: Expand Partner Services](#)

[GTZ Plan Strategy D: Improve Linkage to Care](#)

[GTZ Plan Strategy K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs](#)

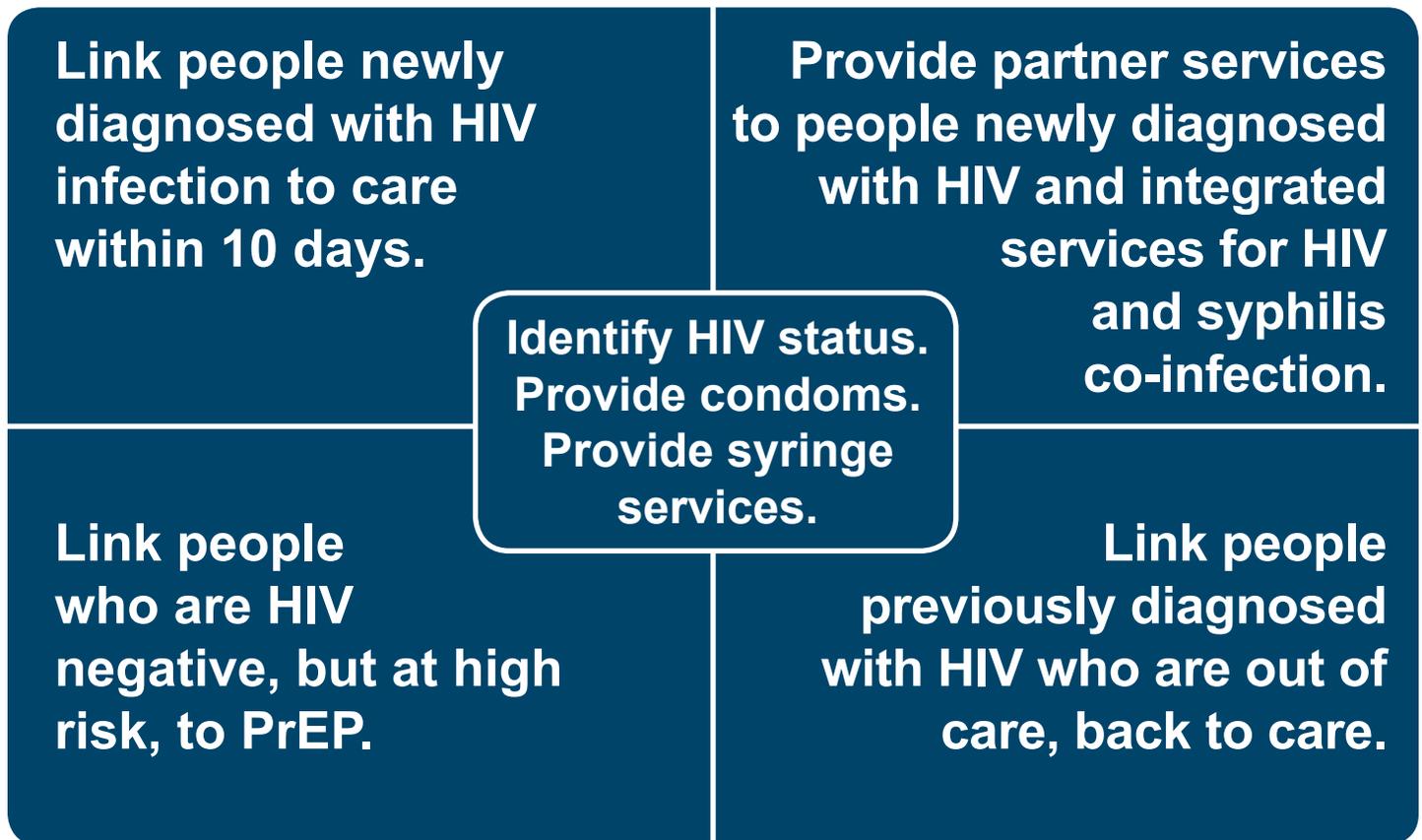
To improve these core services, LHJs must use **interventional surveillance**, defined as the process of using local HIV and sexually transmitted disease (STD) surveillance data to facilitate, monitor, and evaluate progress for individuals, agencies or jurisdictions. Examples of how surveillance and other data could inform decision-making are provided on [page 15](#).

OA's approach to HIV prevention is also centered on the integration of prevention and treatment efforts, with the understanding that **people living with HIV on effective treatment who are virally suppressed do not sexually transmit HIV, commonly referred to as Undetectable = Untransmittable, or U=U.**

Aligning the guidance document with the GTZ strategies and the U=U approach is a departure from previous guidance documents, which used a two-tier system to designate high priority and low priority activities. Under PS18-1802, OA's orientation is towards improving HIV prevention and treatment outcomes. The role of HIV and STD surveillance data is crucial in this effort, and OA emphasizes the use of surveillance data for program planning, decision-making, and performance evaluation.

Requirements New to PS18-1802

During the PS18-1802 funding cycle, all OA Prevention-funded LHJs must:

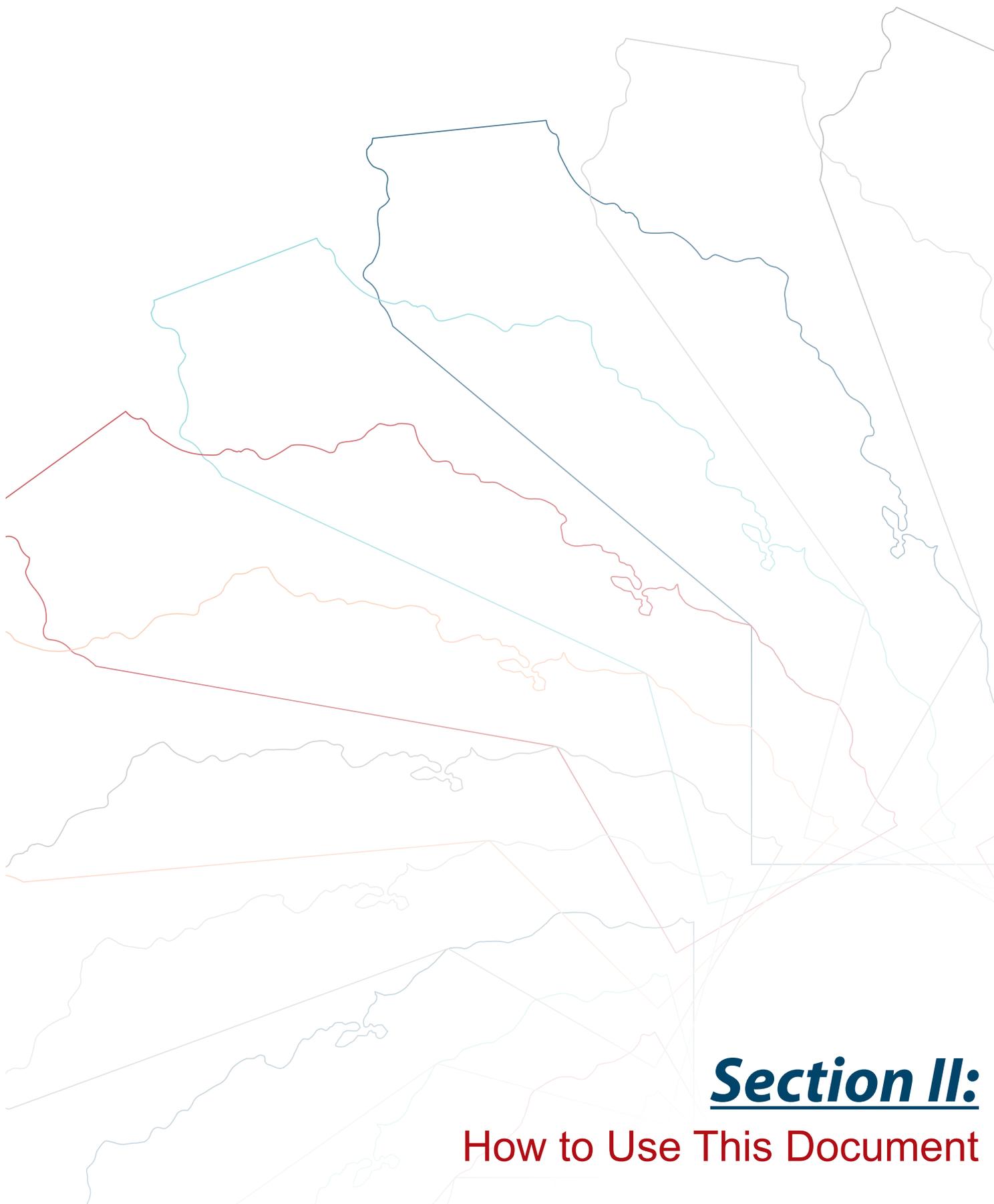


LHJs **may not use** PS18-1802 funds to:

- Continue funding focused test sites that have not identified new cases of HIV between January 1, 2016, and December 31, 2017.
- Introduce or continue to support Risk Reduction Evidence-Based Behavioral Interventions (RR EBIs) or locally-developed interventions. The CDC is no longer supporting data collection for RR EBIs or other risk reduction activities (RRAs) and OA

Prevention will no longer support activities for which data are not collected or evaluated. PS18-1802 funds will no longer be used to support RR EBIs or locally-developed interventions after July 1, 2018, and OA Prevention will no longer support data collection in Local Online Evaluation (LEO) for these activities.

A summary sheet of all required approaches, required activities, and non-fundable activities can be found in [Appendix 12](#).



Section II: **How to Use This Document**

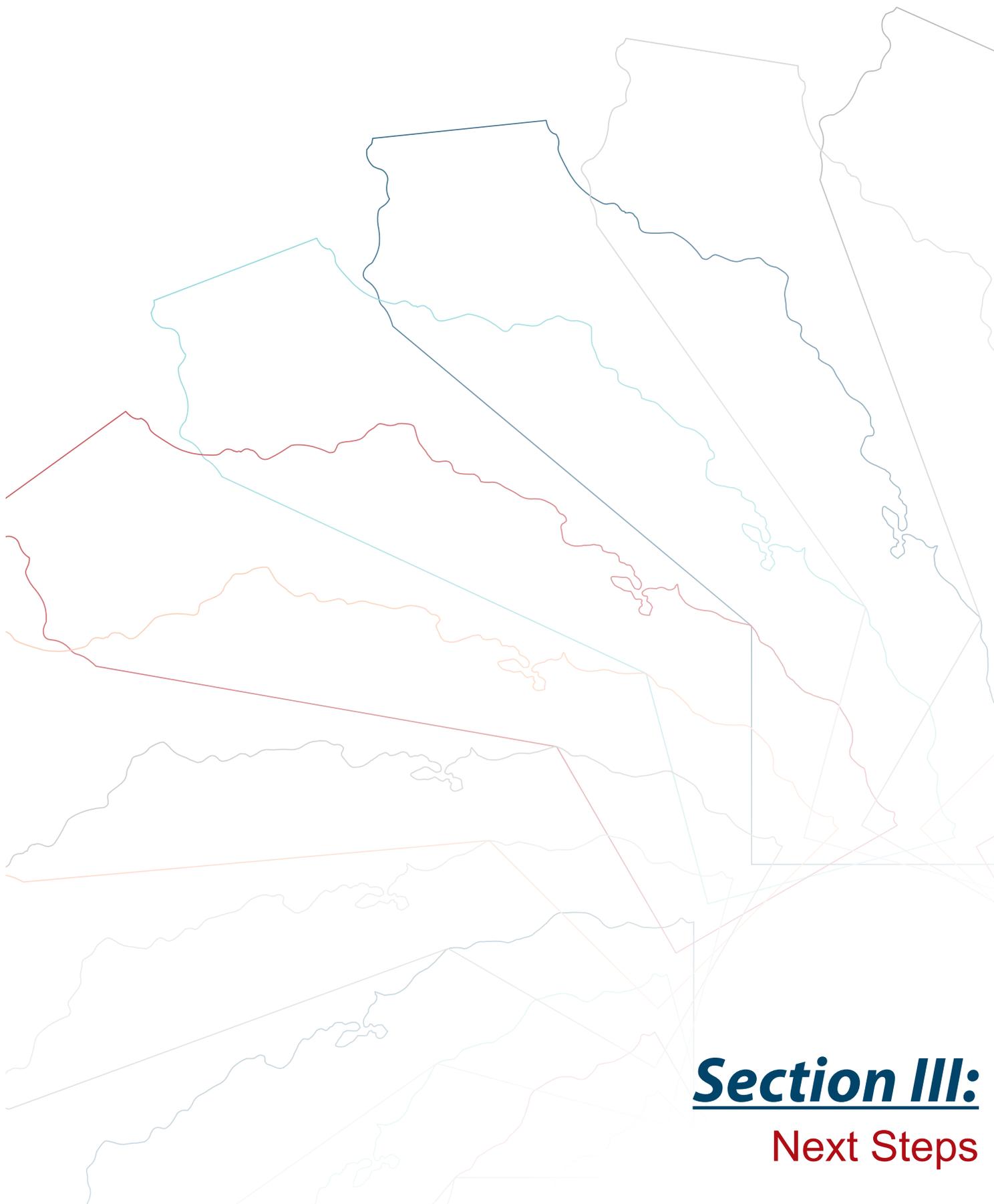
The **2019 Guide to HIV Prevention and Surveillance** is organized around the five required strategies outlined above: improving PrEP utilization, increasing and improving HIV testing, expanding partner services, improving linkage to care, and increasing and improving HIV prevention and support services for people who use drugs. LHJs are required to have at least one activity associated with or related to each strategy in their work plan. Activities associated with each strategy may be supported through other funding sources or through the use of combining funding from other sources, e.g., utilizing Ryan White funding, or state general fund or local funds. For example, a LHJ may have PrEP activities funded in their jurisdiction through the state funded PrEP Navigator Project and may build in activities in their plan funded under the PrEP Navigator Project to meet the requirement of the work plan to address PrEP.

Each Strategy section includes:

- Background;
- Guidance;
- Example fundable activities;
- Resources provided by OA; and
- Metrics that will be used to report activity level and measure GTZ Strategy effectiveness.

The example fundable activities described in this guidance document are intended to orient LHJs. However, they do not represent an exhaustive list of activities that can be funded by the PS18-1802. OA supports and encourages LHJs to propose other activities not listed, provided those activities are evidence-based, and logically contribute to achievement of GTZ strategies and objectives.

Additional resources and further information will also be provided in the Appendices.



Section III: **Next Steps**

Development of 2019 Work Plans and Logic Models

All OA prevention-funded LHJs will develop and submit summary work plans and logic models for planned 2019 activities to OA by **June 29, 2018**. LHJs will determine which activities under each required strategy to prioritize for greatest impact and value for cost after compiling and reviewing the data outlined below. Once key activities

have been chosen, LHJs will develop final work plans and logic models, using the 2019 work plan and logic model template provided with this guidance document as an excel file. LHJs should reference the global prevention logic model, provided in [Appendix 7](#), to develop their own logic models.

LHJs will begin their 2019 planning process by reviewing HIV epidemiology for their jurisdiction:

	INDICATOR	DATA SOURCE (*available through LHJ Surveillance Coordinators)
Where are people newly diagnosed with HIV being tested?	Facilities and/or providers that are identifying new HIV diagnoses	*Quarterly Data to Care list –HIV diagnosis facility column
What are the characteristics of your newly diagnosed PLWH?	Demographic and risk characteristics for new diagnoses	*Most recent LHJ detailed continuums
	STD prevalence, especially syphilis in MSM and TGW populations	STD Summaries
	Demographic and risk characteristics of special populations (PWID, previously incarcerated, homeless, etc.)	CA Opioid Overdose Surveillance Dashboard CA Viral Hepatitis Surveillance Data Other data sources as available
Are your newly diagnosed PLWH accessing care?	New Diagnoses: Linkage to care in 30 days – outcomes overall and by demographic/risk groups	*Most recent LHJ detailed continuums, tab 1
	New Diagnoses: Viral suppression in six months – outcomes overall and by demographic/risk groups	*Most recent LHJ detailed continuums, tab 2
Are your previously diagnosed PLWH accessing care?	Living Cases: Engagement in care overall and by demographic/risk groups	*Most recent LHJ detailed continuums, tab 6
	Living Cases: Viral suppression overall and by demographic/risk groups	*Most recent LHJ detailed continuums, tab 5
Where can you identify appropriate candidates for PrEP?	MSM and TGW with a recent syphilis or gonorrhea diagnosis	STD surveillance data by diagnosis facility
	Facilities and/or providers that are identifying new HIV diagnoses	*Quarterly Data to Care list -diagnosis column
	Focused (targeted) testing sites that are identifying new HIV diagnoses	LEO

These data should be compared to California statewide HIV epidemiology, described in detail in [Section IV](#).

To identify disparities in linkage to care, retention in care, and viral suppression locally, LHJs should review detailed care continuums available through local surveillance coordinators. Additional data resources may be provided as they become available to assist LHJs in program planning. Specific requests for HIV surveillance information not available from local surveillance coordinators may be sent using the [data request form](#) available online.

Submission Dates

LHJ 2019 work plans and logic models must be submitted to OA on or before noon on **June 29, 2018**. OA will review LHJ 2019 work plans and will contact LHJs during the review period for questions and clarifications in order to finalize and approve work plans by August 1, 2018. OA will review work plans and logic models, and if needed, require modifications, to ensure that activities in the work plan meet needs as demonstrated by data. Once LHJ 2019 work plans have been reviewed and finalized, OA will initiate the contracting process with LHJs to develop and finalize new Cooperative Agreements. OA will release PS18-1802 budget

guidance in spring 2018 to LHJs to assist in preparing budgets.

Reporting Requirements (Progress Reports)

OA requires LHJs to submit semi-annual progress reports. The progress report template will be derived from each LHJ’s work plan and logic model, as well as from the required data elements and metrics identified by the CDC and by OA. OA data systems will be updated to include revisions to the required data elements as they are finalized by the CDC. **The list of metrics represent both GTZ Plan metrics and preliminary PS18-1802 indicators that CDC has released to grantees.** These metrics lists, along with the global logic model in [Appendix 7](#), should be used as a planning tool when developing LHJ logic models and data collection strategies.

In the metrics tables provided in this guidance, the last column indicates whether the LHJ will be responsible for collecting and reporting the data related to this metric. A “Yes” indicates that the data point is either reported by the LHJ through an OA database or that reporting will be done by the LHJ through inclusion of an aggregate table in a progress report. Additional detail on reporting these metrics will be forthcoming. CDC

SUBMISSION DATES AND DEADLINES

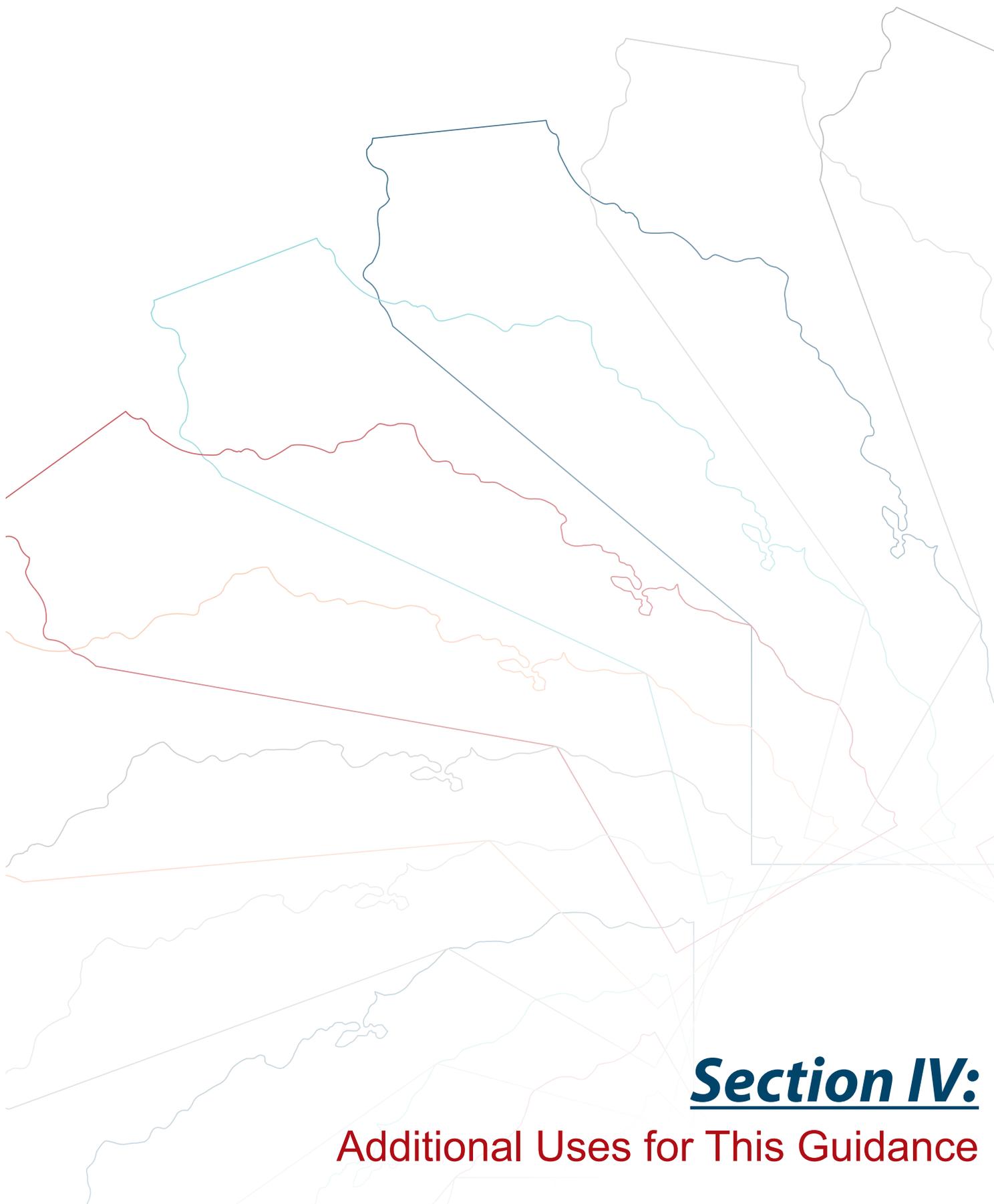
Deliverable/Activity	Submission Date/Deadline
2019 work plan and logic model submitted to OA	June 29, 2018
Syringe services program (SSP) opt-out justification submitted to OA (<i>only for LHJs requesting to opt out of SSP activities</i>)	June 29, 2018
End support for EBIs and/or locally developed prevention activities	July 1, 2018
2019 work plan and logic model finalized with OA	August 1, 2018

will release the Data Variable Set, data collection guidance and tools within the next few months. Mandatory data submission dates will coincide with deadlines provided to OA from the CDC.

OA Technical Assistance for Development of 2019 Work Plans and Logic Models

OA provides OA Prevention Specialist and Surveillance technical assistance (TA) contacts

for each Strategy. LHJs are strongly encouraged to work with these contacts as they review local data and draft 2019 work plans and logic models. OA will also hold a series of webinars open to all LHJs to discuss use of data for planning, required data reporting requirements as they become available, and developing work plans and logic models.



Section IV: **Additional Uses for This Guidance**

Although this guidance is focused mainly on HIV prevention activities and aimed primarily at LHJs that will receive HIV prevention funding via PS18-1802, it is also relevant for:

- **Local surveillance staff** – to better understand the emerging role of surveillance data in HIV prevention interventions, such as for Data-to-Care activities and cluster investigations. Surveillance data also play a new role as an overarching source of information about progress towards GTZ goals, and is the cornerstone of collaborations between prevention and surveillance staff at the local level;
- **LHJs who do NOT receive funding for HIV prevention via PS18-1802** – to understand how the goals and priorities of the GTZ plan have been translated into recommended activities and to inform the use of other funding sources, such Ryan White, HOPWA, Surveillance, or local HIV and/or STD-related funding;

- **Other public health program staff, such as STD, TB, and HCV staff** – to understand how programmatic goals in those areas may overlap and be coordinated with HIV prevention activities; and
- **LHJs who receive 18-1802 funding directly from the CDC** – to provide a broad understanding of the goals, priorities, and activities being undertaken in the California Project Area, in order to facilitate a synergistic and cooperative approach across the state.

In short, this guidance is intended to serve as a practical resource for the entire state of California for selecting effective HIV prevention activities, and describes requirements for LHJs receiving PS18-1802 HIV prevention funding. LHJ HIV staff, including HIV Prevention Coordinators and HIV Surveillance Coordinators, should read this guidance document in its entirety and refer to it throughout their planning processes. OA will update and disseminate the **2019 Guide to HIV Prevention and Surveillance** as needed.

How Six Different LHJs Might Use Surveillance Data to Create Their HIV Prevention Work Plan

LHJ 1: After completing a review of their data, LHJ 1 knows that of the 95 new HIV diagnoses during 2014-2017, 60% were Latino MSM. Of these, only 40% are engaged in care compared to 56% of other risk/demographic groups. LHJ 1 therefore has prioritized activities targeting linkage to care and navigation services for Latino MSM. In 2019, LHJ 1 plans to use 18-1802 funding to hire three Spanish-speaking linkage to care (LTC) Navigators and collaborate with testing settings where the majority of these clients are identified.

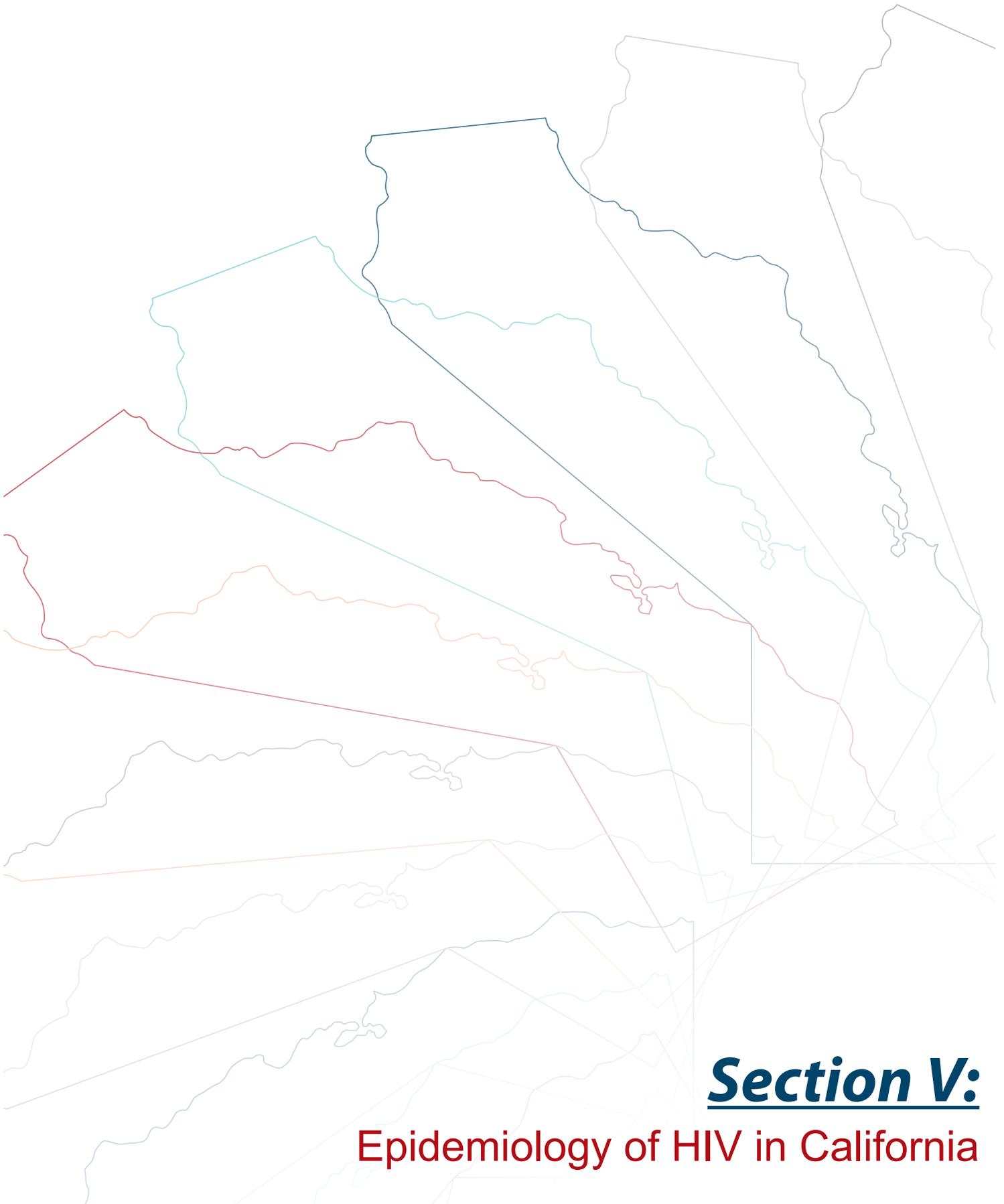
LHJ 2: LHJ2 has seen a significant increase in syphilis over the last 5 years. The increase has been among MSM and women of childbearing age. According to STD and HIV surveillance data, about half of the MSM with syphilis also have HIV. Very few of the women have HIV, but 14% report injecting methamphetamine, and due to a rise in congenital syphilis, there may be a significant risk that some babies will become infected with HIV as well. LHJ 2 has integrated STD and HIV activities and receives funding from both state-level programs. LHJ 2 plans to have STD-funded Disease Investigators focus on determining whether women with syphilis are pregnant, and to have HIV-funded Disease Investigators focus on MSM.

LHJ 3: After analyzing the last two years of HIV surveillance data of people newly infected with HIV, LHJ 3 understands that the majority of those people are diagnosed at three local health care settings: a hospital, a federally qualified health center (FQHC), and a private primary care clinic. At the FQHC, almost 80% of people diagnosed are linked to care within 45 days and 65% achieve viral suppression within 6 months. At the hospital, 45% of the people diagnosed are linked to care and 40% of those people achieve viral suppression. At the private primary care clinic, 50% of people diagnosed are linked to care, and only 25% show viral suppression within 6 months. LHJ 3 plans to hire a LTC Navigator to work with hospital and private primary care personnel to determine what is blocking their clients from linking to care. This LTC Navigator will work with the OA LTC Specialist to identify resources for private providers, and will also work with data-to-care staff to identify specific individuals in need of intensive navigation and LTC services.

LHJ 4: LHJ 4's HIV continuum data reveal that high percentages of PLWH in the LHJ are linking to care and achieving viral suppression. After looking at PleasePrEPMe.com, LHJ4 determined that only three of their primary care providers were listed as screening for and prescribing PrEP. LHJ 4 plans use 18-1802 funding to informally survey which other local primary care providers are screening for and prescribing PrEP, and ensure that their contact is listed on PleasePrEPMe.org. Once LHJ 4 has determined which providers are not providing PrEP services, they plan to offer PrEP training to these providers.

LHJ 5: LHJ 5 saw a sharp increase in the rate of newly reported chronic hepatitis C infections from 2011-2015, with the greatest increases among males age 12-19 years, males age 20-29 years, and females age 20-29 years. CDC estimates suggest that approximately two-thirds of new HCV infections are injection drug use-related. Two local clinics reported increases in new HCV cases among HIV-positive MSM-PWID and HIV-positive non-injecting MSM methamphetamine users. In addition, the California Opioid Overdose Dashboard showed increases in heroin-related overdose deaths from 2012-2015 as well as a sharper increase in overdose deaths associated with synthetic opioids (fentanyl). LHJ 5 plans to fund increased staffing for its local syringe services program, allowing them to expand hours of operation and develop outreach activities targeting people under 30 who inject drugs. Integrated HIV/HCV screening and referrals will be increased, as will overdose prevention education and distribution of naloxone.

LHJ 6: Working with STD surveillance, LHJ 6 determined which health care providers were diagnosing the highest number of people with syphilis. LHJ 6 knows that two of these providers are successful PrEP providers, and three are not. In 2019, LHJ 6 plans to retrain the RRA coordinator to be a Sexual Health Navigator who will work with these health care providers to make sure they offer PrEP to all of their eligible clients. The Sexual Health Navigator will then work with other health care providers to incorporate PrEP services into their practice.



Section V: **Epidemiology of HIV in California**

HIV surveillance data is foundational to understanding the scope and specifics of HIV infection in California, and for measuring progress towards reducing new HIV infections and HIV-related disparities. The following section presents the most recent HIV epidemiology in the state, and should be used by LHJs to understand the statewide breakdown of HIV infection by demographic, and to compare local statistics with statewide numbers and averages.

California at a Glance

Since the beginning of the HIV epidemic over 30 years ago, thousands of people throughout California have been infected with HIV. Since the introduction of highly active antiretroviral therapy (HAART) in 1995, deaths among PLWH have declined while the number of PLWH has continued to increase. According to the most recent CDC estimation method, there were approximately 145,600 people living with HIV in California in 2015, of whom 88 percent had been diagnosed². Both living and newly diagnosed PLWH remain concentrated in MSM communities, and account for the majority of the epidemic in California.

In 2015, 72 percent of Californians diagnosed PLWH were in HIV care and 61 percent were virally suppressed. Seventy-four percent of infections were among MSM, including 7.1 percent MSM who inject drugs (MSMWID). An additional 6.3 percent were among non-MSMWID. More Whites (41.1 percent) were living with diagnosed HIV infection than any other racial/ethnic group, followed by Hispanics/Latinos (34.6 percent) and African Americans (17.6 percent). However, African Americans are the most disproportionately impacted, with a prevalence rate of 1,010 per 100,000 population for African Americans, compared to 353 per 100,000 for Whites and 293 per 100,000 for Hispanics/Latinos.

Disparities among new HIV diagnoses persist as well: among the 4,948 people newly diagnosed

with HIV in California in 2015, African Americans had the highest rate of infection (39.5 per 100,000), followed by Hispanics/ Latinos (14.3 per 100,000), and multi-racial persons (11.0 per 100,000). Sixty-nine percent of people newly diagnosed were MSM, including 3.2 percent MSMWID. Seventy-two percent of newly diagnosed were linked to care within one month of diagnosis; 53 percent were virally suppressed within 6 months.

California's GTZ goals for 2021 include increasing the percentage of Californians newly diagnosed with HIV who are linked to care within one month of their HIV diagnoses to at least 85 percent, and increasing the percentage who are virally suppressed within six months to 75 percent.

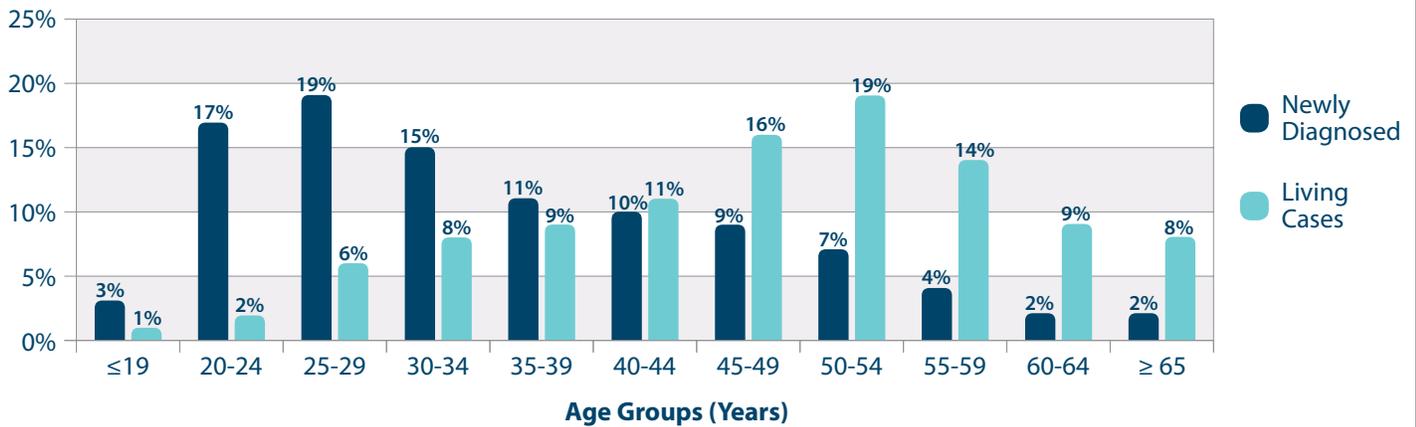
At the state level, notable disparities in viral suppression in PLWH were found in the following groups: African Americans, American Indians/ Alaska Natives, Hispanics/ Latinos, transgender women, 13-24 year olds, and PWID. Disparities in linkage to care within 30 days for individuals newly diagnosed with HIV were particularly notable in women, African Americans, Hispanics/ Latinos, PWID, and non-high-risk heterosexuals.

Age

Among people living with diagnosed HIV (PLWDH) in California in 2015, the 50-54 age group was the largest (18.6 percent) followed by the 45-49 age group (15.5 percent). Of significance for directing services and activities under PS18-1802, over 51 percent of people newly diagnosed with HIV were individuals between 20-34 years old. The 25-29 age group was the largest (19.3 percent) followed by the 20-24 age group (17.2 percent).

² This estimate is based on the current CD4 count based estimation model, which will be used by OA going forward. Hall HI, Song R, Tang T, An Q, Prejean J, Dietz P, Hernandez AL, Green T, Harris N, McCray E, Mermin J. HIV Trends in the United States: Diagnoses and Estimated Incidence. *JMIR Public Health Surveillance* 2017;3(1):e8

Newly Diagnosed and Living HIV Cases by Age Group - California, 2015

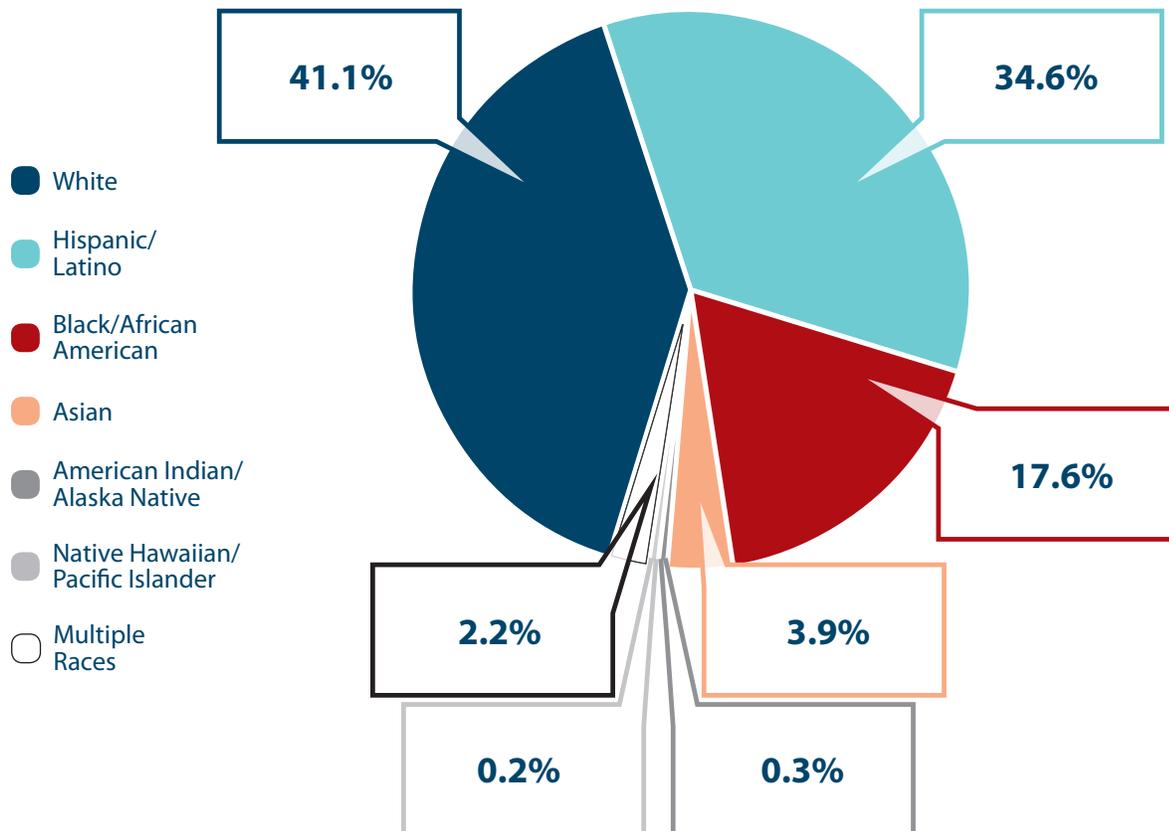


Ethnicity

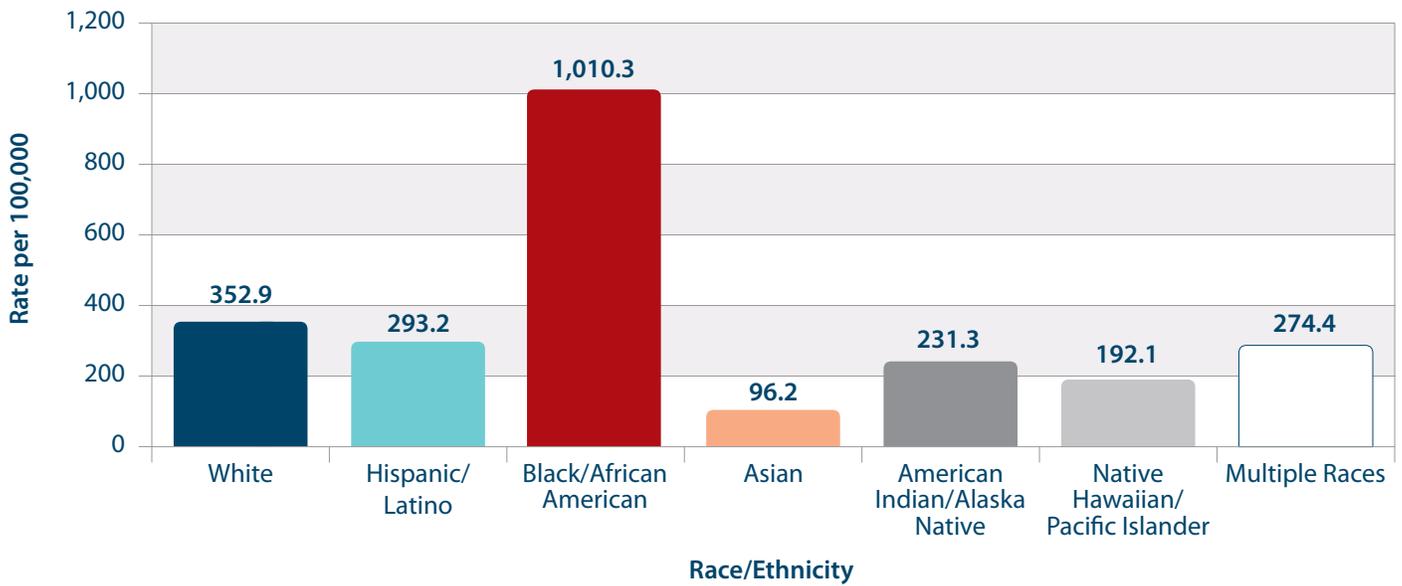
More Whites (41.1 percent) were living with diagnosed HIV infection than any other racial/ethnic group, followed by Hispanics/Latinos (34.6

percent) and African Americans (17.6 percent). However, African Americans had the highest prevalence rate (1,010 per 100,000 population), followed by Whites (353 per 100,000) and Hispanics/Latinos (293 per 100,000).

People Living with Diagnosed HIV by Race/Ethnicity - California, 2015



Rate of HIV Infection for PLWDH by Race/Ethnicity - California, 2015

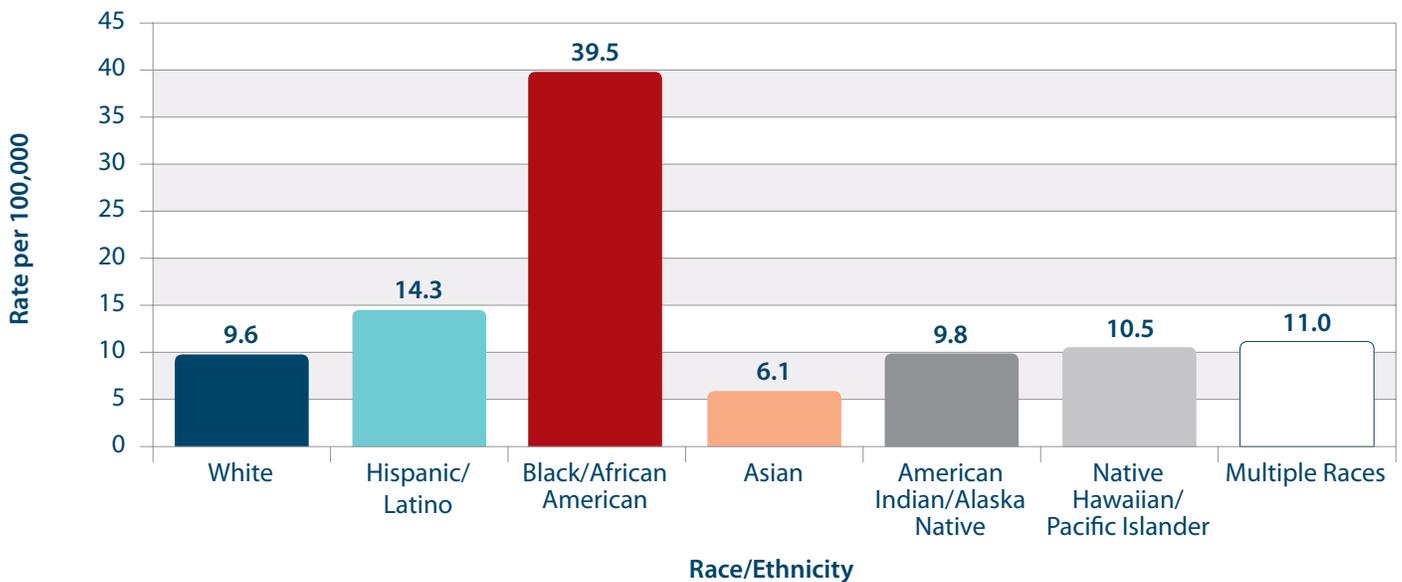


Among the 4,948 people newly diagnosed with HIV in California in 2015, African Americans had the highest rate of infection (39.5 per 100,000), followed by Hispanics/ Latinos (14.3 per 100,000), and Whites (9.6 per 100,000).

Gender

Men made up 88.1 percent of newly diagnosed HIV infections and 87.0 percent of PLWDH in California in 2015 while women made up 10.5

Rate of HIV Infection by Race/Ethnicity for Newly Diagnosed PLWDH - California, 2015



percent of newly diagnosed HIV infections and 11.7 percent of PLWDH. Transgender people made up 1.3 percent of newly diagnosed HIV infections in 2015 and 1.2 percent of PLWDH.

Transmission Category

Transmission category is defined by the CDC for classifying cases based on a person’s reported HIV risk factors. The classification results from selecting the single risk factor most likely to have been responsible for transmission, even if multiple risk factors were reported. The CDC hierarchy of risk factors, from most likely to lead to HIV transmission, to least likely, is as follows:

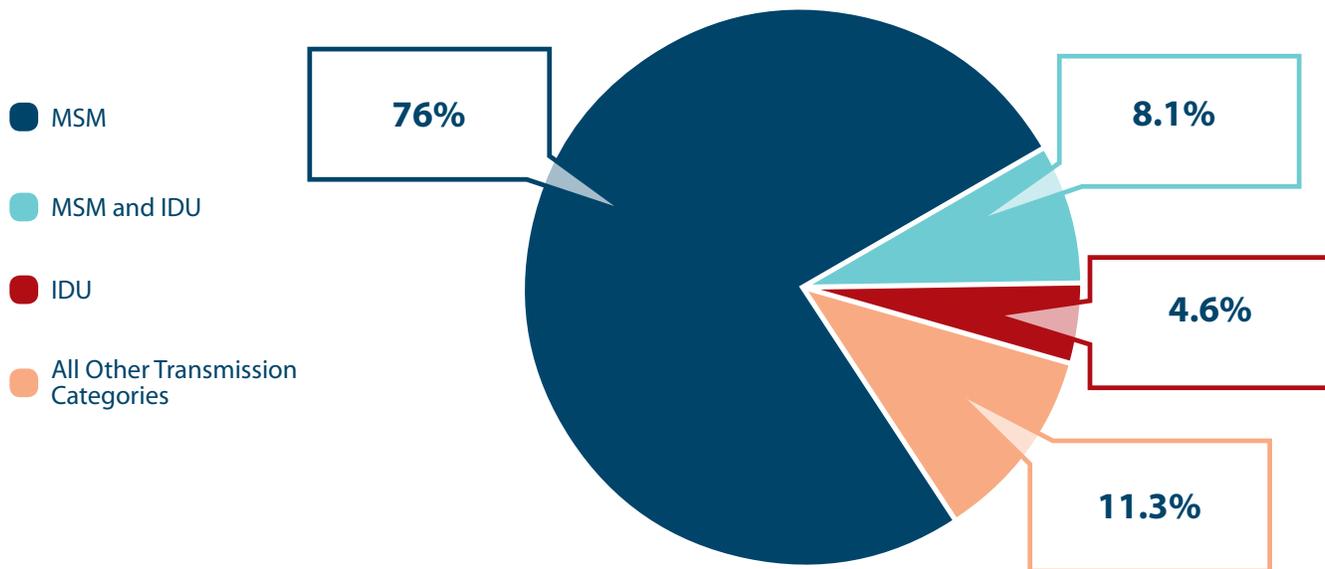
- MSM and IDU (referred to in this document as MSMWID);
- MSM alone;
- IDU (referred to in this document as PWID) alone;
- Receipt of clotting factor blood product for treatment of hemophilia or other chronic coagulation disorder; and

- High-risk-heterosexual (HRH) contact (e.g., having a partner who is MSM, PWID, or HIV-positive).

Non-high-risk heterosexual (non-HRH) contact was added by OA to capture individuals who report sexual activity with a member of the opposite sex but the individual is not aware of their partner’s risk behaviors. It is last in the hierarchy. As required by the CDC, classifications are based on sex-at-birth and reported behaviors, rather than sexual orientation (gay, bisexual, heterosexual) or current gender identity. The CDC and OA are aware that this classification does not appropriately account for people who are transgender due to the use of the sex-at-birth variable instead of the current gender identity variable. The CDC has committed to exploring better ways to account for the unique transmissions risks of people who are transgender. OA remains committed to fully implementing the current gender identity variable and using it to more fully express the how people who are transgender are represented in California’s HIV epidemic.

Among male PLWDH in 2015, 75.5 percent were reported as having MSM as their primary risk

HIV Transmission Category Among Male PLWDH - California, 2015



factor. An additional 8.1 percent of males had a reported risk factor as MSMWID, followed by PWID at 4.6 percent. Among female PLWDH, the largest risk factor categories were high-risk heterosexual contact (52.3 percent), non-high-risk heterosexual contact (20.1 percent), and injection drug use (18.5 percent).

Among males newly diagnosed with HIV in California in 2015, 74.1 percent were reported with MSM as their primary risk factor, and an additional 3.5 percent were reported as MSMWID. An additional 3.0 percent of newly diagnosed males were PWID. For newly diagnosed females, 41.2 percent were reported as non-high-risk heterosexual contact, 37.2 percent as high-risk heterosexual contact, and 11.3 percent as PWID.

Scope of Epidemic

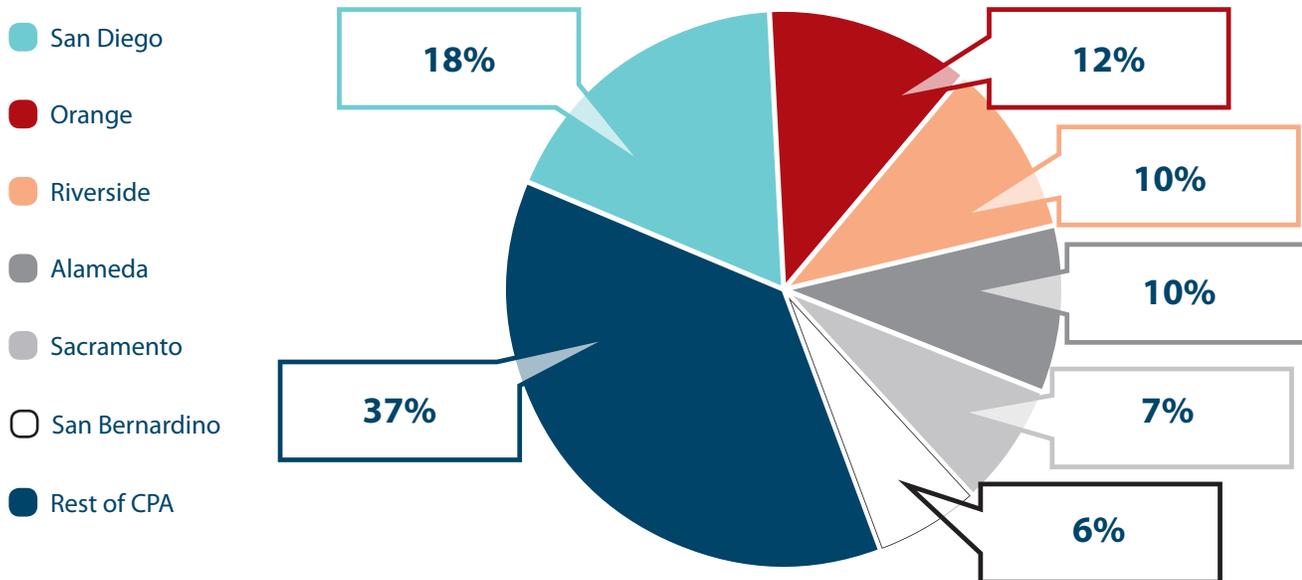
In 2015, Los Angeles County had the most people with newly diagnosed HIV infections (40 percent) as well as the most PLWDH (40

percent). San Francisco County accounted for 6 percent of people with newly diagnosed infections and 11 percent of PLWDH. The CPA accounted for the remaining 54 percent of people with newly diagnosed HIV infections in California and 49 percent of all PLWDH.

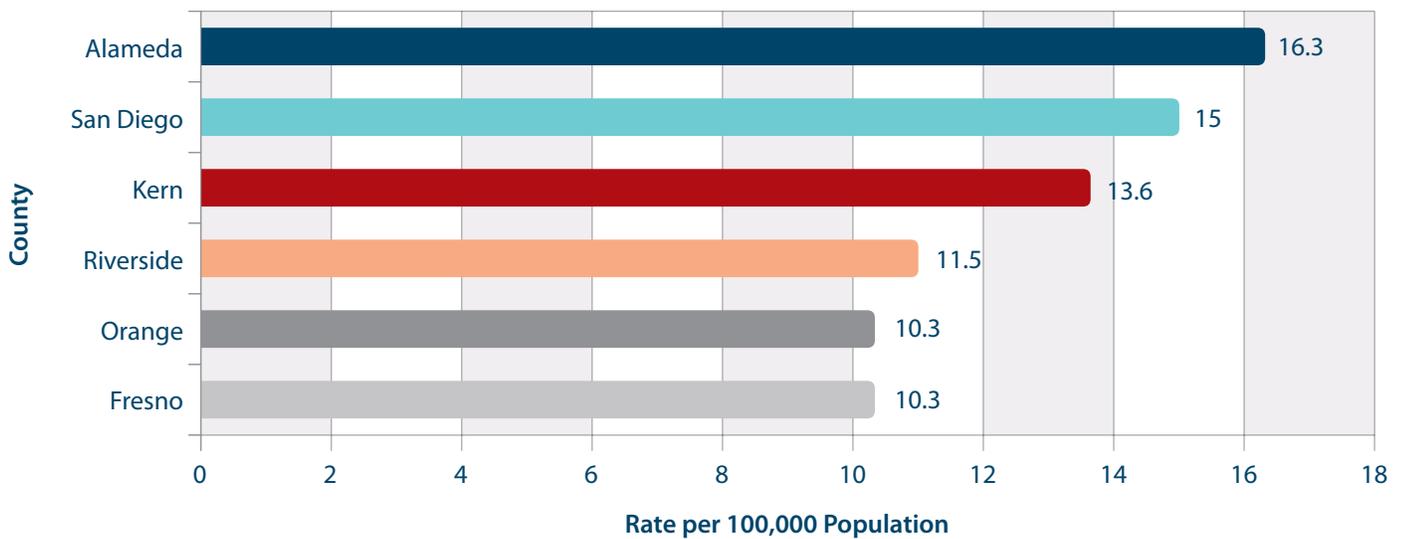
Six local health jurisdictions made up over 63 percent of people with newly diagnosed HIV infections within the CPA (San Diego – 18 percent, Orange – 12 percent, Riverside – 10 percent, Alameda – 10 percent, Sacramento – 7 percent, and San Bernardino – 6 percent).

Los Angeles and San Francisco counties also had the highest rate of newly diagnosed infections in 2015 with 19.4 and 34.6 respectively per 100,000 population. Within the CPA, Alameda had the highest rate (16.3 per 100,000), followed by San Diego County (15.0 per 100,000), Kern (13.6 per 100,000), Riverside (11.5 per 100,000), and Orange and Fresno counties (10.3 per 100,000).

New HIV Diagnoses by County - CPA, 2015



Rate of HIV Infection for Newly Diagnosed - CPA, 2015



STD Prevalence

In 2016, bacterial STDs in California significantly increased; according to the CDC data from 2016 for all states, California had the highest number of cases of chlamydia, gonorrhea, and syphilis nationwide, including the highest number of congenital syphilis cases. Important disparities persisted, with the highest rates found among young people, African Americans, and MSM. These vulnerable populations are at higher risk for related serious health outcomes including HIV infection.

Early syphilis (ES) which includes primary, secondary, and early latent stages, continued to increase in 2016 in all regions of the state. MSM accounted for 85 percent of early syphilis cases in males (with known gender of sex partners). Among MSM ES cases with known HIV status, 56 percent were HIV-positive. Early syphilis rates among HIV-positive MSM was more than ten-fold higher (2507.3 per 100,000) than HIV-negative MSM (232.1), and higher than heterosexual males (10.9) and females (3.2). The proportion of HIV-negative MSM ES cases reporting HIV PrEP use increased from 17 percent in 2015 to 26 percent in 2016 in the CPA.

MSM accounted for 63 percent of the state’s 2016 male gonorrhea cases (with known gender of sex partner). Among MSM gonorrhea cases whose HIV status was known, 34 percent were HIV-positive. Among interviewed MSM gonorrhea cases who were HIV-negative, 36 percent reported receiving HIV PrEP. Ongoing assurance of HIV testing for gonorrhea cases can facilitate opportunities for PrEP and ultimately reduce HIV transmission in the community.

Health Disparities

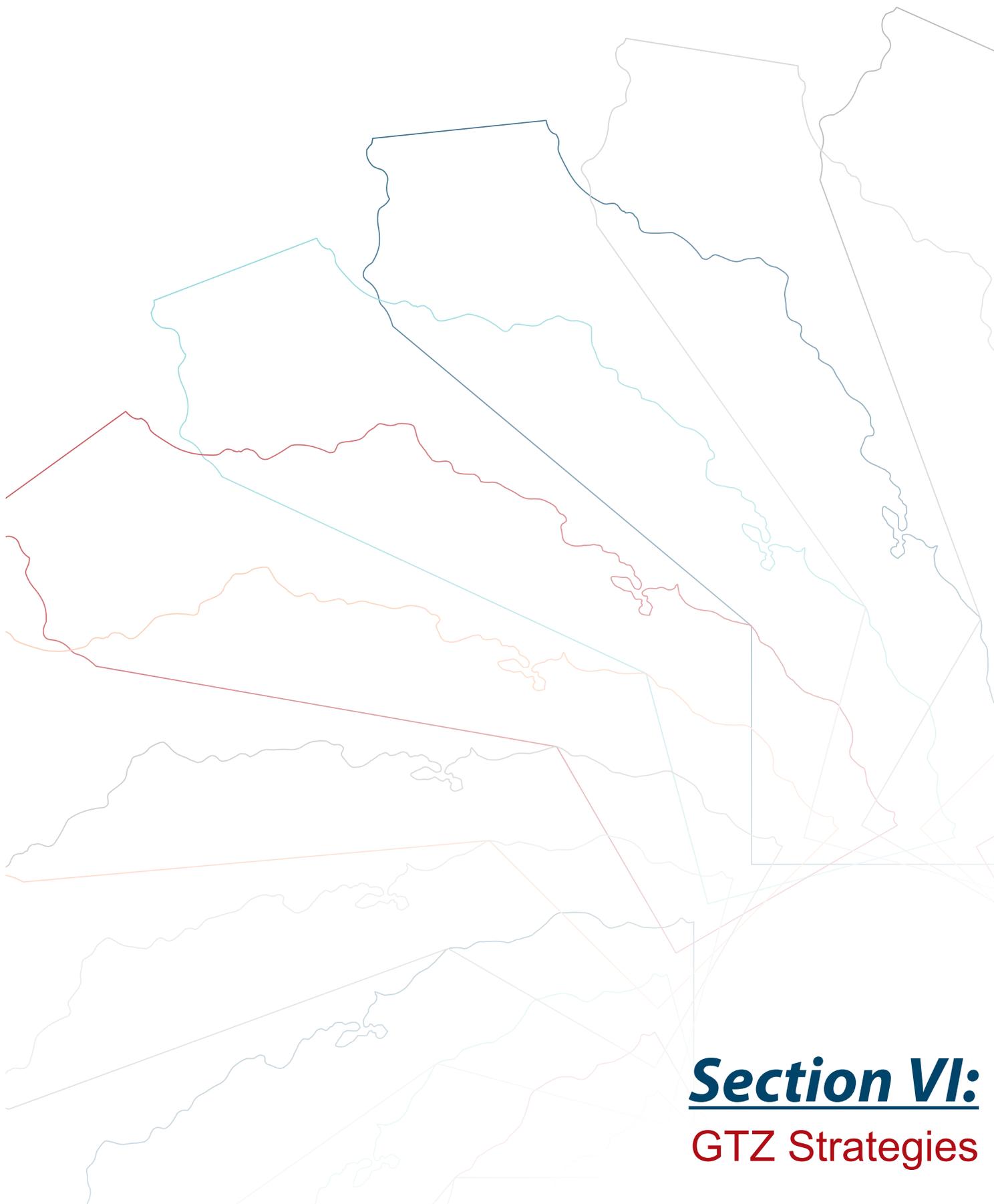
Nationally, populations disproportionately impacted by HIV include MSM of color, specifically Hispanics/Latinos and African Americans; MSM of all race/ethnicities aged 13-24 years; transgender women; and PWIDs. People who fall into these demographic categories are less likely to use PrEP, be linked to care, be retained in care, or be virally suppressed.

In California, notable disparities in viral suppression were found in the following groups: African Americans, American Indians/Alaska Natives, Hispanics/ Latinos, transgender individuals, 13-24 year olds, and PWID.

Disparities in linkage to care for people newly diagnosed with HIV were particularly high in women, African Americans, Hispanics/Latinos, and PWID and non-HRH transmission category. One study found that similar health disparities are found with STD and can be compounded with a dual diagnosis; Black MSM had a 2.3 times the odds (adjusted for SES factors and behavior) of new HIV diagnosis with any STD diagnosis, compared to those without an STD diagnosis³.

California's 2015 data indicate that, like all STDs, new HIV diagnoses are highest among young people: 29.3 per 100,000 among people aged 20-24, and 34.7 per 100,000 among people aged 25-29.

³ (6 cities) Mayer K. et al. PLoS ONE January 2014; 9(1):e87298



Section VI: **GTZ Strategies**

STRATEGY A: Improve PrEP Utilization

Background

Post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) are biomedical interventions that present significant opportunities to protect individuals who may be at risk for HIV. PrEP and PEP’s effectiveness in protecting individuals from HIV acquisition signifies a shift in HIV prevention programming from testing/counseling and behavior change, to client-centered sexual health empowerment. Additionally, PrEP and PEP may serve as pathways to more comprehensive healthcare services.

African American and Hispanic/Latino MSM, all young MSM, and transgender women are at the highest risk of acquiring HIV in California. Building and enhancing provider capacity, patient navigation to PrEP and PEP, and health insurance navigation for these groups is a vital part of reducing new HIV acquisitions and improving health equity in California.

Building LHH capacity to raise awareness of, and increase access to PrEP and PEP includes developing or enhancing systems to navigate individuals to PEP and PrEP. A successful PEP and PrEP navigation system will reliably grant all clients access to PEP and PrEP, with the goal of same-day access to PEP and access to PrEP in seven days or less with same-day PrEP initiation offered whenever possible. For more information on navigation, please refer to [Strategy D: Improve Linkage to Care](#).

Guidance

LHJs will collaborate with STD colleagues and use local STD and HIV surveillance data to expand the availability of both PrEP and PEP in their jurisdictions through:

- **Provider engagement and education; and/or**

- **Client navigation to PrEP/PEP.**

LHJs **may not** use PS18-1802 funds to purchase or supplement the costs of medications. LHJs may not use PS18-1802 funds to develop new public education or media campaigns.

In developing the work plan and logic model, LHJs will use STD and HIV surveillance data to inform the distribution of resources for expanding PEP and PrEP uptake within their LHH. This data analysis will assist in choosing between and among activities (see “Example Fundable Activities” section below).

Example Fundable Activities

Approaches to Strategy A include, but are not limited to the following GTZ activities:

GTZ Activity A1: Expand PrEP and PEP Access

- **Increase PrEP uptake through expanding partner services and supporting Disease Intervention Specialists (DIS)**
LHJs may use PS18-1802 funds to support HIV and STD partner services, including strengthening data systems and expanding partner services/DIS staffing. Funds may also be used to enhance local partner services ability to navigate HIV negative individuals exposed to STDs and/or HIV to PrEP.
- **PrEP/PEP collaborative meetings**
LHJs may use PS18-1802 funding to support the organization and facilitation of regularly scheduled local PrEP/PEP Navigator and Service Provider collaborative meetings.
- **Data to Care for PrEP**
Funded Data-to-Care activities can include, but are not limited to, funding staff to identify

individuals at high risk for HIV acquisition using available STD case data from the California Reportable Disease Information Exchange (CalREDIE) and/or STD clinics. In particular, individuals with cases of rectal gonorrhea, rectal chlamydia, and syphilis have a higher than average risk for HIV infection. LHJs may use PS18-1802 funds to identify individuals with known HIV-positive partners by using surveillance-based partner services.

GTZ Activity A2: Educate Medical Providers About PrEP and PEP

- **Provider Education & Collaboration with CBA providers**

LHJs may use PS18-1802 funding to support the education of medical providers about PrEP, PEP, and STDs. LHJs may collaborate with CBA providers who provide education to medical providers, and who offer TA to enhance LHJs' ability to educate medical providers. PS18-1802 and CBA provider resources may be combined, for example, to receive CBA training to develop a LHJ-based medical provider detailing program, or a CBA provider may be engaged to directly educate providers. Additionally, LHJs should educate PrEP and PEP providers regarding the [CDC recommendations for routine STD screening](#). For more information on CBA providers, refer to [Appendix 3](#).

- **Identify target audience through data analysis**

LHJs may use PS18-1802 funding to support the use of CalREDIE and STD surveillance data to identify the providers reporting high volumes of STDs in the local health jurisdiction; these providers can be targeted for PrEP provider trainings and education.

- **Increase staffing**

LHJs may use PS18-1802 funding to support

PrEP-AP

OA's [AIDS Drug Assistance Program \(ADAP\) Branch](#) will implement a Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) for uninsured and insured individuals for prevention of HIV in spring 2018. OA received statutory and budgetary authority from the 2016 Budget Act to implement a PrEP-AP for individuals at risk for HIV. Statutory authority is codified in Health and Safety Code 120972. OA is using existing ADAP Enrollment Site infrastructure to enroll clients into the PrEP-AP. The program will provide assistance with PrEP-related clinical services and access to medications for the prevention of HIV and treatment of STDs to individuals who meet the following eligibility criteria:

- ✓ Are residents of California;
- ✓ Have a negative HIV test result (dated within 6 months of the PrEP-AP application);
- ✓ Are at least 18 years of age;
- ✓ Have an annual Modified Adjusted Gross Income (MAGI) that does not exceed 500 percent of the Federal Poverty Level (FPL), based on family size and household income;
- ✓ Are not fully covered by Medi-Cal or other third party payers; and
- ✓ Are enrolled in Gilead's manufacturer's assistance program for Truvada for PrEP.

Both insured and uninsured individuals will receive assistance with PrEP-related medical costs and medication on the PrEP-AP formulary for the treatment of STDs and the prevention of HIV; however the PrEP-AP will not pay for Truvada for PrEP for uninsured clients as PrEP medication is provided to uninsured clients at no cost by [Gilead's Patient Assistance Program](#). For insured clients, the PrEP-AP will pay medication copays for PrEP after the manufacturer's co-payment assistance annual threshold is reached. Information on the co-payment assistance program can be found at [Gilead's Co-Pay Assistance Program](#) page.

OA is establishing a PrEP-AP Provider Network to ensure uninsured clients have access to PrEP-related clinical services and labs, as recommended by the CDC. Uninsured clients will be referred to clinics in the PrEP-AP Provider Network via a referral form to be provided by an enrollment worker during initial enrollment into the program.

staffing for provider education (e.g. nurse practitioner to carry out education, LHJ staff to coordinate outreach and trainings, surveillance staff to identify geographic areas and providers). LHJs may develop PrEP, PEP, STD, and sexual health toolkits and materials for patients and providers that meet the needs of the populations/providers within their LHJ. PleasePrEPMe.org, the CDC, ICAP and many others have toolkits already developed or have resources for building patient and provider toolkits.

Ryan White HIV/AIDS Program Early Intervention Services funds for this purpose (see below).

- **Leverage Ryan White Early Intervention Services (EIS) funds**

The Ryan White HIV/AIDS Program (RWHAP) is for low-income, HIV positive individuals; one component of the program is Early Intervention Services (EIS). The goal of EIS is to increase an individual's awareness of their HIV status and, if needed, facilitate access to the HIV care system through four coordinated components: (1) HIV testing, (2) referral to services, (3) linkage to care, and (4) outreach/health education. All four components must be present in the service area though not necessarily paid for by RWHAP. EIS is allowable under RWHAP Part A and Part B. While RWHAP funds cannot be used to pay for PrEP medications and the related medical services, such as physician visits and laboratory costs, [the RWHAP legislation permits RWHAP providers and recipients to provide other specified prevention services](#). HIV prevention providers should discuss with their RWHAP counterparts ways to use EIS to navigate clients to PrEP.

GTZ Activity A3: Increase availability of PrEP for key populations at no cost or low cost

- **PrEP – AP enrollment and clinical sites**

LHJs may use PS18-1802 funds to support staff to use surveillance data to identify focused testing sites, community-based organizations (CBO), or FQHCs that yield the highest HIV positivity rates and that are most frequented by populations with low PrEP uptake, to become PrEP-AP enrollment sites (if they are currently ADAP sites, see text box). Funded staff may also be used to assist with providing “warm hand-offs” between identified agencies and PrEP-AP enrollment sites. This will allow optimal access for uninsured and underinsured people, people who are HIV negative, but at high risk for HIV, and PLWH to seek enrollment in regular ADAP for coverage for HIV treatment.

Additionally, LHJs are encouraged to become ADAP Enrollment Sites in order to increase access to and use of the PrEP-AP, if eligible.

- **PrEP – AP Navigation**

LHJs may use PS18-1802 funds to ensure that all PrEP Navigators are trained and supported to carry out PrEP navigation services and to understand PrEP-AP, in order to successfully navigate clients to PrEP support services. LHJs may also leverage

GTZ Activity A4: Promote and educate about PrEP in key populations with low uptake

- While OA does not permit the use of PS18-1802 funds to develop large scale social marketing or social media campaigns, LHJs are encouraged to use materials developed and tested by the CDC to reach key populations with information around PrEP. PS18-1802 funds may also be used to share information about PrEP on social media platforms (e.g. Facebook, Instagram, Grindr, etc.).

GTZ Activity A5: Improve services that support linkage and retention in PrEP

- **Using data to identify and re-engage persons on PrEP in care or case management**

LHJs may use PS18-1802 funding to support staff to use STD surveillance data to identify and re-engage individuals who have fallen out of PrEP care and/or case management, via Navigators, partner services, or DIS for PrEP.

- **PrEP Navigation**

LHJs may use PS18-1802 funds to support the training, and if necessary hiring, of PrEP Navigators to reach the populations most vulnerable in their LHJ for acquiring HIV. PrEP Navigators may also be trained as PrEP-AP enrollment workers (if they work in an ADAP – PrEP AP site) and/or as Covered California enrollment workers. They may also be trained or have experience with substance use and mental health assessments. Suggested PS18-1802 fundable topic areas for PrEP Navigator training include, but are not limited to:

- Orientation to the local healthcare system;
- Effective strategies for reaching/ navigating young African American and Latino MSM and transgender people to PrEP;
- Orientation to Covered California and Medi-Cal and PrEP-AP;
- Cultural competency and humility;
- Client-centered healthcare;
- Adherence counseling; and
- Harm Reduction strategies.

Resources Provided by Office of AIDS

Technical Assistance Contact:

Program and Policy: Clark Marshall, PrEP Specialist, clark.marshall@cdph.ca.gov, or (916) 650-6752

Data Tracking/Evaluation: Kolbi Parrish, Research Scientist II, kolbi.parrish@cdph.ca.gov, or (916) 445- 8491

Additional Resources:

[PrEP for women: HIVE](#)

[San Francisco CBA PrEP Resources](#)

[UCSF Center of Excellence for Transgender Health](#)

[NaRCAD](#) Provider Education

[PrEP Guide for Providers](#)

[Project Inform PrEP navigation manual](#)

[Project Inform Getting PrEPped flowchart](#)

[PleasePrEPMe.org CA resources](#)

[Truvada for PrEP Medication Access Guide](#)

[CA PrEP Navigators Google Group](#)

California HIV/AIDS Research Program (CHRP) Policy Brief [Addressing PrEP Disparities Among Young Gay and Bisexual Men in California](#)

[CHRP transgender PrEP demonstration project](#) provides free Truvada and other medications for those who choose to participate in the research (LA, SD, Alameda, Sacramento, SF).

[CHRP Linkage to Care Research Projects](#)

Metrics

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Number of trainings conducted	GTZ PLAN	Grantee Semi-Annual Progress Report	Yes
Number of providers participating in PrEP/PEP trainings	GTZ PLAN	Grantee Semi-Annual Progress Report	Yes
Number of educational materials distributed	GTZ PLAN	Grantee Semi-Annual Progress Report	Yes
Number of clients served by PrEP navigation programs	GTZ PLAN	LEO	Yes
Percentage of HIV-negative persons not already on PrEP at time of HIV testing who are screened for PrEP eligibility	PS18-1802 (CDC)	LEO	Yes
Percentage of HIV-negative persons not already on PrEP at time of HIV testing and screened for PrEP who are identified as eligible for PrEP	PS18-1802 (CDC)	LEO	Yes
Percentage of persons eligible for PrEP who are linked to PrEP providers	PS18-1802 (CDC)	LEO	Yes
Number of referrals of HIV-negative persons at risk for HIV infection to other essential support services (e.g. healthcare benefits, behavioral health, and other medical and social services)	PS18-1802 (CDC)	LEO	Yes
Number of PrEP referrals among persons eligible for PrEP	PS18-1802 (CDC)	LEO	Yes
Percentage of persons eligible for PrEP who are linked to PrEP providers	PS18-1802 (CDC)	LEO	Yes
Number of prescriptions for PrEP given to persons for whom PrEP is indicated	PS18-1802 (CDC)	LEO	Yes
Percentage of HIV negative early syphilis cases who are referred to PrEP	STDCB SOW	CaIREDIE	Yes
Percentage of HIV negative partners of early syphilis cases who are referred to PrEP	STDCB SOW	CaIREDIE	Yes
Number of clients receiving support through ADAP for PrEP medication assistance	GTZ PLAN	ADAP	No
Percentage of MSM, PWID, and high-risk heterosexuals on PrEP	GTZ PLAN	National HIV Behavioral Surveillance (NHBS) AIDSvu Gilead data	No
Percentage of MSM and transgender persons reporting PrEP use	GTZ PLAN	California Health Interview Survey (CHIS)	No
Number of providers prescribing PrEP/PEP	GTZ PLAN	PleasePrEPMe.org	No
Number of PrEP prescriptions filled by Medi-Cal clients	GTZ PLAN	Medi-Cal	No

* The metrics list included in this guidance document is preliminary and subject to change

STRATEGY B: Increase and Improve HIV Testing

Background

Routine, opt-out HIV testing of all patients in health care settings regardless of age, gender identity, race, ethnicity, risk profile, and presence/absence of symptoms is recommended by the CDC, the [United States Preventive Services Task Force](#), and OA as the best strategy for making people aware of their HIV status. Routine, opt-out HIV testing in health care settings has been successful in accessing populations who are unaware of their HIV status as well as destigmatizing HIV testing.

Providing HIV testing services to individuals who are at the highest risk for HIV acquisition, often referred to as **targeted HIV testing**, facilitates access to HIV testing for individuals who may not access HIV testing services through health care providers. The CDC is now referring to this type of HIV testing as **focused HIV testing**. The focused HIV testing programs of LHJs must only provide HIV testing services in locations where individuals with high risk of acquiring HIV will be identified. These programs must ensure that people who are newly-diagnosed with HIV are linked to HIV care and offered partner services, and that people who test negative for HIV are provided navigation to PrEP services.

Guidance

LHJs will collaborate with STD Treatment HIV care colleagues, primary care providers, and emergency room providers, and use local STD and HIV surveillance data to increase and improve HIV testing in their jurisdiction through:

- **Routine, opt-out testing (at least one new site in 2019);**
- **Use of laboratory-based Fourth Generation HIV Testing Algorithms; and**
- **Focused testing of priority populations.**

OA has determined that the following populations in California may be at the highest risk for HIV acquisition:

- **MSM;**
- **PWID;**
- **Transgender women;**
- **African Americans;**
- **Hispanics/Latinos;**
- **People in low-income communities; and**
- **People diagnosed with an STD, particularly syphilis or gonorrhea.**

LHJs **may not** use PS18-1802 funds to support:

- Focused HIV testing locations that have not found any newly-identified confirmed positive results since January 1, 2016.
- Medical care provider staff time related to routine opt-out testing.
- Costs associated with HIV testing in routine opt-out testing, including specimen collection or laboratory test processing, without prior discussion with OA.
- Purchase or upgrade electronic medical record systems.
- Prescription or over-the-counter medications.
- Orders for condoms intended for distribution at a one-time event unless the event specifically involves one or more of the priority populations (e.g. Gay Pride Festival, etc.).
- Purchase additional types of condoms or lubrication for distribution.

In developing the work plan and logic model, LHJs will use STD and HIV surveillance data to inform the distribution of resources for increasing and improving HIV testing within the LHJ. This data analysis will assist in choosing between and among fundable activities (see “Example Fundable Activities” section below).

Data submitted to the Office of AIDS from CY 2014 – CY 2017 show that nearly 70% of focused HIV testing locations that conducted HIV tests found no newly-identified confirmed positive (NICP) or preliminary positive people. Therefore, testing locations that have not identified new cases of HIV after January 1, 2016, should be discontinued and testing efforts and/or funding should be redirected to efforts that support working with local health care providers to increase routine opt-out testing, LTC, partner services, navigation to PrEP or to locations that are successful in reaching NICPs. In addition, LHJs should reach a one percent HIV positivity yield in accordance with CDC goals in order to continue support to focused testing locations.

Example Fundable Activities

Approaches to Strategy B include, but are not limited to the following GTZ activities:

GTZ Activity B1: Expand routine, opt-out testing

- **REQUIRED: Establish new routine opt-out HIV testing programs**

All OA prevention-funded LHJs will use PS18-1802 funds to establish at least one new routine, opt-out HIV testing program within their jurisdiction in 2019. Health care settings such as hospital EDs, community health clinics located in areas with high HIV/STD prevalence, STD clinics, and local jails are excellent sites for expanding routine opt-out HIV testing⁴.

- **Use surveillance data to expand routine opt-out testing**

LHJs may use PS18-1802 funds for local surveillance staff time to identify communities, locations, and providers that would most benefit from expanded access to routine opt-out testing (high HIV/STD prevalence, populations at high-risk for HIV acquisition, high community viral load). For example, LHJs can use surveillance data to identify providers with high levels of HIV/STD diagnoses and initiate outreach efforts for expanding routine, opt-out HIV testing.

- **Educate and support health care staff to implement routine opt-out testing**

LHJs may use PS18-1802 funds to cover staff time, materials, and other resources needed to encourage and educate health care providers and other staff in hospital emergency departments, urgent-care clinics, community clinics, STD clinics, tuberculosis (TB) clinics, substance abuse treatment clinics, correctional health care facilities, and other primary care settings. This may include conducting needs assessments of health care settings, and providing/coordinating training and TA for health care facility staff. OA can work with LHJs to evaluate whether using HIV prevention funds to pay for a limited percentage of lab-based testing would encourage more routine HIV testing at a minimal cost.

- **Ensure HIV testing for people with STD diagnosis**

LHJs may use PS18-1802 funding to support activities that enhance HIV testing and navigation to PrEP with STD diagnosis and public health follow-up. Potential strategies include collaboration with categorical STD clinics and high volume STD care providers to implement routine, opt-out HIV testing.

⁴ The California Department of Corrections and Rehabilitation (CDCR) screens all people incarcerated in state prisons for a full panel of STDs including HIV. OA funds should be focused on routine, opt-out HIV testing within the health care systems of county jails and youth detention facilities, rather than within CDCR-run state prisons.

Additionally, HIV testing and navigation to PrEP should be integrated as an essential element in the public health follow-up of people diagnosed with STDs, if it has not already been conducted as a component of STD clinical care. Funds may support HIV and STD surveillance and partner services/ DIS staff in verification of HIV status, and facilitation of HIV testing and navigation to PrEP for individuals diagnosed with syphilis and/or gonorrhea and their sexual and needle-sharing partners. Data informed (with knowledge of HIV status) public health follow-up for syphilis cases and their partners can better inform individual risk assessment, counseling, navigation to PrEP and enhance HIV testing and linkage to care outcomes. For more information regarding partner services refer to [Strategy C](#).

GTZ Activity B2: Increase use of laboratory-based Fourth Generation algorithms for HIV testing to identify acute infections

- **Use laboratory-based fourth generation HIV testing algorithm**

In order to encourage lab-based fourth generation HIV testing LHJs may use some of their PS18-1802 funding to offset lab-based HIV testing fees, especially in local public health labs. LHJs that plan to use funding for this purpose must consult with OA during the planning process.

GTZ Activity B3: Focus HIV testing programs in non-clinical settings to key populations

- **Use surveillance and LEO data to focus testing efforts**

LHJs must focus HIV testing toward priority populations and at locations where people have been newly identified with HIV. PS18-

1802 funds may be used to support staff time and processes for reviewing HIV surveillance data towards this end. Use the OA LEO data system to generate testing reports. LEO data can be reviewed for specific sites, allowing monitoring and prioritizing high-positivity test sites over lower-positivity test sites. HIV Testing Coordinators should use these indicator reports and other data reports to assist in identifying those areas in their LHJs that maximize use of their resources (staffing, time, and materials) to identify newly diagnosed HIV-positive individuals.

- **Support focused HIV testing locations**

LHJs that choose to continue to support focused testing sites are required to:

- Assess their ability to identify new positives through focused HIV testing, and examine their testing locations and funded HIV testing providers that either

- **(a)** do not target the majority of testing efforts to individuals at high risk for acquiring HIV as listed in the above key populations, or

- **(b)** did not identify any new cases of HIV, including confirmed or preliminary positive cases, between January 1, 2016, and December 31, 2017. LHJs should discontinue focused testing at these locations and redirect testing efforts and/or funding to locations that are successful in identifying NICPs, or to efforts that support working with local health care providers to increase routine, opt-out HIV testing, LTC, and partner services;

- Collaborate with EIS and/or Ryan White Part B programs to establish systems such as policies, protocols, tracking systems, support networks, and/or partnerships for linking newly diagnosed

HIV-positive or preliminarily positive clients into HIV care and treatment with a verified health care visit within 30 days of diagnosis;

- Ensure that clients are offered partner services; and
- Establish a plan for referring clients to other prevention services. These services may include but not be limited to STD testing and treatment, syringe services programs, and/or PEP or PrEP.

Further requirements for focused HIV testing sites can be found in [Appendix 10](#).

• **Order HIV test kits**

OraQuick: OA will continue to provide OraQuick Advance Rapid HIV Test kits and external controls to funded LHJs. The number of HIV test kits provided will be on an as needed basis. The LHJ may also use their own funding to purchase OraQuick rapid HCV test kits directly from OraSure Technologies, Inc. and are eligible to receive the California public health pricing rate when purchasing kits and control devices. HCV testing should be recorded in the LEO system.

OraQuick HIV test kits may be ordered by the LHJ coordinators using the HIV test kit order form (available from OA Operations Advisors). The form should be submitted electronically to OAtestkits@cdph.ca.gov. Allow 15 business days to process an order. While only the LHJ staff can place an order, test kits can be shipped directly to an LHJ's subcontractor.

Alere Determine HIV – 1/2 Ab/Ag Combo: OA will provide Alere Determine rapid test kits and external controls to funded LHJs. LHJs must have certified test counselors receive training from OA on the Alere Determine rapid test. An order form is available from each LHJ's OA Operations advisor. The form should be submitted electronically to

OAtestkits@cdph.ca.gov. Allow 15 business days to process an order. While only the LHJ staff can place an order, test kits can be shipped directly to an LHJ's subcontractor. LHJs interested in receiving training to use the Determine test kit, please contact Karin Hill at Karin.Hill@cdph.ca.gov or at 916-319-9641 for more information. More information can be found in [Appendix 2](#).

HIV Lab Slips: Lab slips may be ordered by sending a request to LEOSreq@cdph.ca.gov. Include the quantity for each specific lab slips and/or form(s) needed, the contact person, a street address (not a P.O. Box) and a telephone number. The order will be processed by OA within 15 business days. In order to decrease the need to request and process orders on an ongoing basis, OA will contact each LHJ prior to the beginning of the next contract year to determine how many rapid HIV lab slips will be needed during the first six months of the contract period.

GTZ Activity L3: Continue widespread condom promotion and distribution

• **Distribute free condoms**

LHJs and funded agencies may partner with venues (e.g., community-based organizations, community health centers/clinics, LGBT centers, bars, dance clubs, sex clubs, bathhouses, barber shops/hair salons, etc.) to distribute free condoms to their respective clients/patrons. Each OA-funded LHJ should use local knowledge and resources to identify and recruit venues in their jurisdiction that specifically serve one or more of OA's priority populations⁵ (which

⁵ Please note that youth are not considered at high-risk for HIV infection unless they specifically fall into one or more of OA's priority populations. If a venue's clientele is primarily youth who are outside of the priority populations, the venue should not be eligible for participation in the condom distribution program. Those venues can find free condoms for their clients at Teensource.org (www.teensource.org/ts/condoms/free) or at Condomfinder.org (www.condomfinder.org).

is the eligibility pre-requisite for the program) in communities where data show HIV is most prevalent. Specific attention should be placed on finding those venues who serve the populations disproportionately affected by HIV. Instructions for ordering and maintaining eligibility can be found in [Appendix 11](#).

Resources Provided by Office of AIDS

Technical Assistance Contact:

Routine opt-out testing: Dennis Fleming, HIV Prevention Specialist/Routine Testing in Medical Care Settings: dennis.fleming@cdph.ca.gov, or 916-440-7744

Focused testing: Matthew Willis, Targeted Testing Specialist: matthew.willis@cdph.ca.gov, or 916-449-5797

Testing training: Karin Hill, HIV Prevention Training Coordinator: karin.hill@cdph.ca.gov or at 916-319-9641

Fourth generation testing: Kama Brockmann, Specialist for HIV Prevention and Surveillance Integration: kama.brockmann@cdph.ca.gov, or 916-449-5964

Condom orders: CACorders@cdph.ca.gov

Data collection: Kolbi Parrish, Research Scientist II: kolbi.parrish@cdph.ca.gov, or (916) 445- 8491

Additional Resources:

[CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings](#)

[U.S. Preventative Services Task Force: Final Recommendation Statement for Human Immunodeficiency Virus \(HIV\) Screening](#)

OA has contracted with Cardea Services to provide training, organizational development and TA on a variety of issues and topics related to the implementation and evaluation of routine opt-out testing. Examples include billing/reimbursement, development of policies and procedures, disclosure of HIV positive results, clinic workflow, data management and evaluation.

Capacity building assistance (CBA) is also available through the CDC free of charge. For more information CBA, please contact Matthew Willis at matthew.willis@cdph.ca.gov and refer to [Appendix 3](#).

Metrics

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Number of HIV tests conducted in each of the targeted populations	GTZ PLAN	LEO	Yes
Number of persons tested for HIV who were at risk for HIV and in communities with high HIV prevalence tested for HIV	PS18-1802 (CDC)	LEO	Yes
Percentage of local agencies conducting routine opt-out testing that have protocols in place to help facilitate implementation of routine opt-out testing	PS18-1802 (CDC)	Grantee Semi-Annual Progress Report	Yes

Metrics (continued from previous page)

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Percentage of local agencies conducting routine opt-out testing that have processes in place to help facilitate implementation of routine opt-out testing	PS18-1802 (CDC)	Grantee Semi-Annual Progress Report	Yes
Percentage of early syphilis cases who have a documented HIV test within 30 days of diagnosis	STDCB SOW	CaREDIE	Yes
Percentage of LHJ Prevention-funded HIV tests that are positive	GTZ PLAN	LEO	Yes
Number of persons newly diagnosed with HIV who are diagnosed with acute HIV infection	GTZ PLAN	HIV Surveillance Data – through electronic lab reports (ELR)	Yes
Percentage of early syphilis cases with HIV negative or unknown status who are tested for HIV within 14 days of interview	STDCB SOW	CaREDIE	Yes
Percentage of persons newly diagnosed with HIV (through LHJ Prevention-funded testing) who are provided an HIV test result	PS18-1802 (CDC)	LEO	Yes
Number of condoms distributed to persons living with or at risk for HIV infection	PS18-1802 (CDC)	Grantee Semi-Annual Progress Report	Yes
Percentage of residents reporting having had an HIV test	GTZ PLAN	California Health Interview Survey (CHIS)	No

* The metrics list included in this guidance document is preliminary and subject to change

STRATEGY C: Expand Partner Services

Background

Partner Services is a highly effective intervention to identify people who are unaware of their HIV status. It provides a vital opportunity to test people at risk for HIV acquisition, and link them to care (if they test HIV positive), or to prevention interventions such as PrEP (if they test HIV negative). The partner services process includes disclosure assistance counseling for PLWH to identify their sexual and needle-sharing partners, and supports notification of sexual and needle-sharing partners regarding possible HIV exposure. Partner services is always voluntary, client-centered, and confidential for both the PLWH and their partner(s). HIV partner services

are prioritized for the following populations:

- People newly diagnosed with HIV;
- People with acute HIV infection;
- PLWH who are not virally suppressed; and
- PLWH with a concurrent STD diagnosis (syphilis, gonorrhea, chlamydia).

California statute and regulation permits data sharing that supports surveillance-based partner services activities. Building LHJ capacity to expand partner services requires integration of partner services activities between HIV and STD

programs. HIV and STD program collaboration is also important for activities such as cluster investigation⁶. This integration, regardless of how a health department is organized, should ensure that:

- All individuals in the jurisdiction who receive a diagnosis of HIV or syphilis understand counseling options available for disclosure and partner services;
- Co-infected index clients are not interviewed separately (i.e. by different DISs) for HIV and other STDs;
- Partners of co-infected patients are not notified of exposure to HIV and other STDs separately (i.e. by different DISs); and
- Partners receive appropriate and comprehensive clinical services, including HIV and STD testing, and LTC (linkage to HIV care for partners testing HIV positive, and linkage to PrEP for partners who test HIV negative).

Guidance

LHJs will collaborate with STD colleagues and use local STD and HIV surveillance data to expand Partner Services in their jurisdiction through:

- **A Surveillance-based Partner Services Program plan;**
- **Systems, procedures and protocols to routinely share personally identifying information about individuals reported to**

be HIV positive with LHJ staff responsible for partner services activities; and

- **Linkage of partners to care (if HIV positive) or PrEP (if HIV negative).**

In developing the work plan and logic model, LHJs will use STD and HIV surveillance data to inform the distribution of resources for expanding Partner Services within the LHJ. This data analysis will assist in choosing between and among activities (see “Example Fundable Activities” section below).

Example Fundable Activities

Approaches to Strategy C include, but are not limited to the following GTZ activities:

GTZ Activity C1: Increase utilization of surveillance-based Partner Services activities

- **REQUIRED: Develop a surveillance-based Partner Services Program Plan**
All funded LHJs must develop a strategic, surveillance-based Partner Services Program plan to be implemented in 2019. The plan should outline how your LHJ will use locally-acquired surveillance data to identify all newly diagnosed PLWH and initiate partner services with them within 10 days of diagnosis, and will outline activities to increase the number of HIV care providers who routinely offer partner services, in order for 85% of all newly diagnosed PLWH in the LHJ to be interviewed for partner services by the end of the PS18-1802 funding period. The 2019 plans should assess the current HIV partner services program activities, plans for implementation of surveillance-based HIV partner services activities focusing on persons newly diagnosed with HIV, and identify outcome and process measures. It should include an assessment of data sharing practices,

⁶ Cluster investigation is a special circumstance for the delivery of partner services in which an active transmission cluster is identified using either molecular HIV surveillance data or time/space analysis to identify a group of related new diagnoses that may be indicative of recent and ongoing transmission within a population. Effective investigation of clusters requires rapid collaboration across many groups, including HIV surveillance and program staff and STD surveillance and program staff at both the state and local level.

staff capacity to conduct partner services activities (elicitation and partner notification/field investigation), and staff training needs and professional development plans. The plan should also discuss integration of STD/HIV partner services activities, with an emphasis on syphilis and HIV co-infection. Finally, the plan should describe barriers to implementation of these program enhancements.

- **Use HIV and STD surveillance data to initiate client contact**

LHJs may use PS18-1802 funds to conduct record searches to assess a client's HIV test and care status or determine a client's whereabouts using people search software such as Accurant. For clients who are reported to the local health department with an early syphilis diagnosis, LHJs are encouraged to conduct a record search to determine a client's HIV test and care status. If the client is co-infected with syphilis and HIV this information should be available to those providing partner services and LTC so that the client receives these activities for both infections at the same encounter. LHJs are encouraged to use their HIV prevention funds to develop local Accurant capacity for HIV and STD searches. All locator searches for people with HIV must be done at the local level, even if the person has an STD co-infection. State-level STD locator resources should not be used for any patient who also has an HIV diagnosis.

GTZ Activity C2: Enhance field-based programs for partner notification and testing

- **Increase staffing**

LHJs may use PS18-1802 funds to train, hire, and or increase staff time for HIV and STD partner services staff, including DIS, and/or surveillance or data management staff.

DIS staff should be trained and supported to conduct integrated HIV and STD partner services activities. Surveillance or data management staff may support HIV and STD case report matching for the purpose of identifying those who need HIV testing, LTC, or linkage to PrEP.

GTZ Activity C3: Improve linkage of partners to care (if HIV positive), or PrEP (if negative)

- **Build HIV testing and care provider capacity**

LHJs may use PS18-1802 funds to build the capacity of focused testing sites and/or HIV and STD care providers to establish in-house partner services. LHJs should first assess surveillance data to identify high volume focused HIV testing sites or HIV care sites. LHJs may allocate PS18-1802 resources towards supporting surveillance or data management staff time for generating these provider-specific data. Once high volume providers are identified, staff training through OA technical assistance is available to support integration of partner services and elicitation of partner information into client disclosure and case management encounters. Collaborative agreements between local health departments and key providers are encouraged and should outline collaboration and referral processes of sexual or needle-sharing partner names and locating information to the local health department for third party/anonymous notification by local health department DIS.

- **Develop protocols for LTC and linkage to PrEP**

LHJs may use PS18-1802 funds to develop protocols for linking partners of index clients to care (if HIV positive) or PrEP (if HIV negative) once partners have been identified and contacted. This may involve local planning processes, CBA, and/or OA

technical assistance to develop protocols, as well as guidance and CBA to DIS staff to improve linkage to care and linkage to PrEP (for partners diagnosed with early syphilis who are HIV negative or test status unknown) processes.

Resources Provided by Office of AIDS and STD Control Branch

All DIS/communicable disease investigators and other program staff conducting disease intervention activities should cross train in both HIV and STD partner services. OA recommends that local program staff conducting client interviews, partner elicitation, and field-based partner notification, attend the CDC Passport to Partner Services Course relevant to their main area of focus HIV or STD. Additionally, any staff who talk to clients about disclosure and HIV partner services activities with NICPs or PLWH, should attend the *Introduction to HIV Partner Services in California* training offered by OA/STDCB. This course offers tools to discuss partner services as a key support within the full context of the life of PLWH, and addresses the nuances of practicing partner services in California.

STD Control Branch offers a disease intervention mentorship program to build local capacity in client interview, field investigation and partner notification. OA also maintains a list of local coordinators for HIV Partner Services programs to facilitate exchange of information and expertise on the local level.

Technical Assistance Contact:

Office of AIDS Partner Services Specialist: Manny Rios, manny.rios@cdph.ca.gov or 916-449-5824

STD and HIV partner services integration: Brett AugsJoost, Program Advisor: brett.augsjoost@cdph.ca.gov or 510-620-3189

Disease Intervention Mentorship: Anna Branzuela, anna.branzuela@cdph.ca.gov or

510-620-3195

Partner services data analysis: Ryan Murphy, ryan.murphy@cdph.ca.gov or 510-620-8811

Data sharing: Emily Phillips, Chief, HIV Quality Management Unit, Office of AIDS/CDPH, (916) 322-6804 or emily.phillips@cdph.ca.gov

HIV Cluster investigation: Diem Tran, Epidemiologist, HIV Surveillance Section, Office of AIDS/CDPH, (916) 449-5837 or diem.tran@cdph.ca.gov

Accurint: Kama Brockmann, Prevention Surveillance Integration Specialist, kama.brockmann@cdph.ca.gov or 916-449-5964

Metrics

Surveillance and program evaluation data should be used to evaluate partner services outcomes (new HIV positives identified among partners tested, partners linked to care, partners linked to PrEP). This is valuable data for assessing the HIV partner services process (e.g. number of new HIV positive clients offered and accepted partner services, number of partners elicited, number of syphilis cases co-infected with HIV with HIV partners elicited, number of partners notified, number of partners tested for HIV, partner HIV test results). Partner services outcome and process measures can be analyzed to gauge implementation progress, identify models of success in various program types (HIV Data to Care, STD/HIV partner services integration, focused testing sites, HIV care sites, etc.), and identify areas for quality improvement or potential training need. HIV partner services data (on index clients and partners) should be analyzed at least quarterly, to identify potential sexual, needle-sharing, and social network connections that can be early indicators of clusters and outbreaks. Suspicious events and potential clusters should be brought to the attention of OA as soon as possible to receive technical assistance in data analysis and cluster/outbreak response.

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Percentage of persons newly diagnosed with HIV who understand the partner services available to them	GTZ PLAN	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of persons newly diagnosed with HIV who accept partner services	GTZ PLAN PS18-1802 (CDC)	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Number of partners identified through partner services	GTZ PLAN	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Number of partners contacted through partner services	GTZ PLAN	CalREDIE	Yes
Number of partners receiving an HIV test	GTZ PLAN	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of persons previously diagnosed with HIV who are interviewed for partner services	PS18-1802 (CDC)	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of persons newly diagnosed with HIV who provide contact information for one or more partners	GTZ PLAN	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of named, notifiable partners identified through HIV partner services who are notified for HIV partner services	PS18-1802 (CDC)	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of named, notifiable partners identified through HIV partner services who are tested for HIV infection	PS18-1802 (CDC)	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of notified partners identified through HIV partner services who tested positive for HIV infection	GTZ PLAN PS18-1802 (CDC)	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of partners who test negative for HIV who are linked to PrEP navigation services	GTZ PLAN PS18-1802 (CDC)	To be added to CalREDIE partner services following migration	Yes

Metrics (continued from previous page)

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Percentage of partners who test positive for HIV who are linked to care	GTZ PLAN PS18-1802 (CDC)	Currently LEO/ARIES/ CalREDIE; After partner services migration, CalREDIE	Yes
Percentage of persons diagnosed with early syphilis and newly diagnosed HIV infection who are interviewed for partner services	PS18-1802 (CDC)	CalREDIE	Yes
Percentage of persons diagnosed with early syphilis with previously diagnosed HIV infection who are interviewed for partner services	PS18-1802 (CDC)	CalREDIE	Yes
Percentage of named, notifiable partners, identified through HIV partner services of HIV/syphilis co-infected clients who are notified through HIV partner services activities	PS18-1802 (CDC)	CalREDIE	Yes
Percentage of named, notifiable partners identified through Partner Services of HIV/syphilis co-infected clients, who are tested for HIV infection within 14 days of index case interview	PS18-1802 (CDC) STDCB SOW	CalREDIE	Yes
Percentage of partners of early syphilis cases who are evaluated for exposure to syphilis/HIV and tested within 14 days of index case (syphilis/HIV co-infection) interview.	STDCB SOW	CalREDIE	Yes
Percentage of notified partners identified through HIV partner services of HIV/syphilis co-infected clients who test positive for HIV infection	PS18-1802 (CDC)	CalREDIE	Yes

* The metrics list included in this guidance document is preliminary and subject to change

STRATEGY D: Improve Linkage to Care

Background

Linkage to care (LTC) assists individuals who are diagnosed with HIV to enter into HIV medical care and treatment. LTC is accomplished when a person with a new HIV diagnosis, or when a person with a known HIV infection but not engaged in care, attends an appointment with a health care provider with prescribing privileges (e.g., physician, physician assistant, nurse practitioner) to receive medical care and antiretroviral treatment for their HIV infection.

The goal of LTC is for a patient with HIV to receive care from an HIV specialist **within 10 days of their diagnosis** and begin antiretroviral therapy (ART) immediately in order to achieve viral suppression as quickly as possible. Statewide, California aims to increase the percentage of newly diagnosed persons linked to medical within one month of their HIV diagnosis to 85 percent, and the percentage of newly diagnosed persons who are virally suppressed within six months of diagnosis to at least 75 percent.

Effective LTC is foundational to reducing new HIV infections in California, since **people living with HIV on effective treatment who are virally suppressed do not sexually transmit HIV (U=U)**. Early initiation of HIV treatment and long-term adherence reduces transmission, and individuals on treatment experience better health outcomes. Conversely, PLWH who have not been diagnosed or retained in care account for 61 percent of HIV transmissions in the US⁷.

Strategies to link clients into care can involve a variety of different approaches. OA will not prescribe approaches for LTC because LHJs are more familiar with local resources and barriers, and are therefore best suited to design their LTC approach. Most health departments' LTC programs fall into one of three overarching models:

- **Health Department Model** - Health department-initiated linkage outreach – using surveillance data, health department staff can identify newly-diagnosed PLWH and attempt to contact the client by telephone, email, or home visit and assist the individual in linking to care;
- **Healthcare Provider Model** - Healthcare provider-initiated linkage outreach – using surveillance data, health department staff can identify newly-diagnosed to inform and assist healthcare providers in contacting clients to facilitate linkage to care rather than contacting the individuals directly. These collaborations tend to be limited to certain providers or facilities, rather than jurisdiction-wide; and
- **Combination Health Department/Healthcare Provider Model** - a combination of both approaches.

Guidance

LHJs will collaborate with HIV care and STD colleagues and use local STD and HIV surveillance data to improve linkage to care in their jurisdiction through:

- **Systems and protocols for rapid linkage to care; and**
- **Patient/client navigation programs.**

In developing the work plan and logic model, LHJs will use STD and HIV surveillance data to inform the distribution of resources for improving linkage to care within the LHJ. This data analysis will assist in choosing between and among activities (see “Example Fundable Activities” section below).

Example Fundable Activities

Approaches to Strategy D include, but are not limited to the following GTZ activities:

GTZ Activity D1: Implement systems for rapid linkage to care

- **REQUIRED: Develop LTC protocols**
All funded LHJs must use PS18-1802 funds to support LHJ (or contract CBO) staff to establish and implement written protocols for a LTC system that:
 - Identifies all newly-diagnosed PLWH within the LHJ;
 - Refers individuals with preliminary and confirmed HIV-positive test results to a HIV care provider for follow-up within 30 days, and ideally within 10 days; and

⁷ Skarbinski J. Human immunodeficiency virus transmission at each step of the care continuum in the United States. *JAMA Intern Med* 2015; 175:588–596.

- Confirms that the person attended their first appointment or follows up with additional efforts to refer the person to a provider.

Protocols should be written and established to provide the fewest handoffs possible, and to ensure that “all handoffs are warm handoffs”, with staff actively involved in moving a patient from one point of care to the next during the LTC process. Jurisdictions that have successfully implemented rapid LTC protocols typically ensure that uninsured clients are initially seen by a Ryan White provider, and are later linked to Medi-Cal or other insurance based on eligibility. Protocols should address potential barriers to successful LTC (medical insurance including drug benefits, mental health, substance use, unstable housing, immigration status, legal challenges, etc). Plans should also identify HIV care providers to which clients will be referred, develop systems to verify that the client attended the medical appointment, and work with HIV care providers to implement clinic/facility policies to allow newly-diagnosed PLWH to be seen more quickly.

- **Develop partnerships with other public health programs**

LHJs may use PS18-1802 funds to cover staff time needed to develop partnerships with other public health programs who have access to PLWH through public health follow-up of communicable disease reports (e.g. syphilis, gonorrhea, tuberculosis). LHJs may use funds to establish agreements with STD programs and service providers to integrate HIV screening with current services, and create an effective system for referrals between agencies in order to coordinate HIV screening and linkage or re-engagement in care. Additionally, LHJs may hold regular meetings with neighboring LHJs to develop partnerships to coordinate services and data sharing protocols, and establish agreements to allow LHJs or contracted staff to assist

non-Ryan White primary healthcare providers with LTC, partner services, and/or re-engagement in care.

GTZ Activity D2: Enhance data to care activities to more rapidly identify people who have fallen out of care and actively re-engage them in care

- **Increase staffing and/or build staff capacity**

PS18-1802 funds may be used to train, hire, and or increase staff time to support staff (LHJ or contracted CBO staff) to implement Data-to-Care activities, which includes:

- a) Rapidly determining whether a person testing positive for HIV is new or known to HIV surveillance in order to allow for appropriate prioritization of LTC and partner services;
- b) Rapidly determining whether sex or needle-sharing partners named by a newly-diagnosed client through Partner Services are already known to be living with HIV allowing for prioritization of Partner Services outreach for other partners;
- c) Determining whether clinic clients who are “not-in-care” are receiving care elsewhere, or should be prioritized for outreach and re-engagement into care; and
- d) Conducting fieldwork to find and re-engage PLWH who have fallen out of care.

GTZ Activity D3: Expand use of patient/client navigation programs

- **Build navigation programs**

To support a robust Navigation system, LHJs may use PS18-1802 funds to hire and/or train PrEP/LTC Navigators and/or other support staff to assist with navigation to care, insurance enrollment and supportive benefits. LHJs may also consider developing a protocol for identifying clients' insurance status, and referring uninsured individuals to an insurance navigator or other resource for insurance enrollment.

Although there are some limitations and eligibility requirements, there are resources available for the under or uninsured individuals needing financial assistance for medical and supportive services. The table in [Appendix 6](#) identifies several sources of funding for medical insurance, HIV care, STD treatment, and medical copays for medications, including PrEP.

GTZ Activity D4: Identify barriers to linkage to care and develop strategies to address them

- **Identify barriers**

PS18-1802 funding may be used to support LHJ staff (or contract CBO staff) to identify barriers to LTC, identify and/or engage with a provider for referral for care, and provide and/or identify resources for referrals for healthcare benefits, behavioral health, and other medical and social services.

- **Involve stakeholders**

LHJs may use PS18-1802 funds to involve those most impacted by HIV in program planning and implementation, as well as build effective collaborations with other key public health stakeholders. These include

Navigation

Navigation is a process of service delivery to help a person obtain timely, essential, and appropriate HIV-related medical care and social support services that will optimize their health and prevent HIV transmission. Not only does navigation include linking a person to the HIV care system, but it also includes linkage and assistance with insurance enrollment, transportation, and other supportive services that would create a barrier to care and treatment. Some navigators specialize in assisting individuals with obtaining benefits or other medical or supportive services (e.g. behavior health, housing, and other social services).

There are several benefits to navigating PLWH and people at risk for acquiring HIV to insurance/benefits:

- Eliminating the burden of medication and treatment costs;
- Provides access to enrollment for uninsured individuals comprehensive medical care;
- Minimizes the risk of HIV and STD transmission; and
- Allows PLWH and high-risk individuals a link to limited specialty care providers and primary care providers.

health care providers, CBOs, substance use disorder treatment counselors, mental health providers, and other LHJ health and human service agencies. Possible activities for engaging local stakeholders include:

- Reviewing representation of PLWH and people vulnerable to HIV on community planning councils and other advisory groups;
- Creating a Consumer Advisory Committee to review and provide input on prevention program planning, or integrate prevention program planning into the Ryan White community planning group process; and
- Holding focus groups with community members during program planning

and to receive feedback during implementation.

Resources Provided by Office of AIDS

OA has a number of resources and sources of assistance for LHJs coordinators with their LTC programs. There are examples of verification forms, work flow charts, and LTC protocols that you can request from the OA TA contacts listed below. The [CDC provides strategies](#) to assist linking HIV positive individuals into care. CBA support for rapid linkage to care is also available.

Technical Assistance Contact:

HIV Linkage to Care & PrEP Navigation

Specialist: Abel Martinez MPH, (916) 322-6812 or abel.martinez@cdph.ca.gov

Prevention Surveillance Integration Specialist:

Kama Brockmann, (916) 449-5964 or kama.brockmann@cdph.ca.gov

Chief, HIV Surveillance, Office of AIDS/CDPH:

Deanna Sykes, (916) 449-5835 or deanna.sykes@cdph.ca.gov

Linkage to Services

LHJs should use local resources that are within their community to link people at risk of acquiring HIV or newly diagnosed PLWH to services. Examples of resources available include:

- RWHAP part B- Early Intervention Services (EIS);
- Minority AIDS Initiative;
- ADAP drug assistance;
- ADAP OA-HIPP;
- Medicare;
- Medi-Cal;
- Planned Parenthood;
- Syringe Exchange Supply Clearinghouse;
- Family PACT;
- Division of Adolescent and School Health (DASH);
- Pacific AIDS Education Training Center (PAETC);
- California Prevention Training Center (PTC);
- Behavioral Health Providers;
- FQHCs;
- CBOs; and
- Substance Use Disorder Treatment Providers.

Metrics

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Number of Ryan White clinics with at least one peer navigator on staff	GTZ PLAN	Semi-Annual Grantee Progress Report	Yes
Number of HIV care provider locations trained on peer/client navigation	GTZ PLAN	Semi-Annual Grantee Progress Report	Yes
Written policy and barriers analysis on linkage to care established locally	GTZ PLAN	Semi-Annual Grantee Progress Report	Yes
Number of PLWH provided with ART medication adherence support	PS18-1802 (CDC)	LEO	Yes
Number of PLWH screened and referred to other essential support services (e.g. healthcare benefits, behavioral health, and other medical and social services)	PS18-1802 (CDC)	LEO	Yes
Percentage of persons newly diagnosed with HIV who are linked to care within 30 days of diagnosis	GTZ PLAN	eHARS/CalREDIE/LEO	Yes
Median time to viral suppression for persons newly diagnosed with HIV	GTZ PLAN PS18-1802 (CDC)	eHARS/CalREDIE	Yes
Percentage of PLWH who are classified as out of HIV care	GTZ PLAN PS18-1802 (CDC)	eHARS (eventually CalREDIE)	Yes
Percentage of PLWH who are in care	GTZ PLAN PS18-1802 (CDC)	eHARS/CalREDIE	Yes
Percentage of persons with newly diagnosed HIV infection identified through 18-1802 testing activities linked to HIV medical care in ≤ 30 days after HIV diagnosis	PS18-1802 (CDC)	LEO	Yes
Percentage of persons with newly diagnosed HIV infection identified through 18-1802 testing activities linked to HIV medical care in ≤ 14 days after HIV diagnosis	PS18-1802 (CDC)	LEO	Yes
Median number of days from initial HIV diagnosis to date of first viral load test of all PLWDH	PS18-1802 (CDC)	eHARS/CalREDIE	Yes
Percentage of PLWDH retained in medical care	PS18-1802 (CDC)	eHARS/CalREDIE	Yes
Percentage of PLWDH virally suppressed	PS18-1802 (CDC)	eHARS/CalREDIE	Yes
Percentage of early syphilis cases with new HIV diagnosis linked to care within 30 days of specimen collection	STDCB SOW	CalREDIE	Yes
Percentage of early syphilis cases previous HIV positive/out of care, linked to care within 30 days of interview	STDCB SOW	CalREDIE	Yes
Percentage of PLWDH identified through HIV surveillance data as being in care and having an elevated viral load who are confirmed to be in care and have an elevated viral load	PS18-1802 (CDC)	eHARS/CalREDIE	Yes
Percentage of PLWDH confirmed to be in care and have an elevated viral load using HIV surveillance data, who achieved viral suppression ≤6 months after an intervention was initiated	PS18-1802 (CDC)	eHARS/CalREDIE	Yes

* The metrics list included in this guidance document is preliminary and subject to change

STRATEGY K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs

Background

Access to sterile syringes is essential for preventing the transmission of HIV, hepatitis, and other blood-borne diseases. California provides syringe access through non-prescription syringe sales in pharmacies (NPSS) and syringe services programs (SSPs).

7.5 percent of new HIV infections in California in 2015 were among people who report injection drug use as a risk factor. Underscoring the importance of access to prevention services for people who inject drugs (PWID) is the national epidemic of viral hepatitis as well as HIV outbreaks fueled by the opioid crisis. The importance of access is highlighted further in the CDC's determination that California is at risk for an increase in viral hepatitis or HIV infections due to injection drug use.

Definition of SSPs

As defined by the CDC, SSPs provide sterile needles, syringes, other drug preparation equipment, and disposal services as part of a comprehensive, harm reduction approach to working with PWID. Comprehensive SSPs may include additional services such as HIV and hepatitis testing and linkage to treatment, education about overdose prevention and safer injection practices, provision of naloxone, and tools to prevent HIV, STDs and viral hepatitis, including condoms, counseling and vaccinations.

CDC Requirements

Under PS18-1802, the CDC categorizes syringe services programs as a community-level HIV prevention activity that must be implemented in order to meet funding requirements. CDC specifies increased access to syringe services programs as an intended implementation outcome of PS18-1802 funding.

Harm reduction is a set of practical strategies aimed at reducing negative consequences associated with drug use. Harm reduction works with people “where they’re at,” never denies people services based on their drug use, and takes a whole-person approach to HIV prevention and care.

Guidance

LHJs will collaborate with HIV care and STD colleagues and use local STD and HIV surveillance data to increase and improve prevention and support services for PWID in their jurisdiction through:

- **A community capacity assessment (LHJs with no authorized SSP);**
- **Building capacity of SSPs to deliver comprehensive HIV prevention services for PWID; and**
- **Establishing SSPs and/or expanding non-prescription syringe sales in pharmacies.**

LHJs with authorized SSPs will strengthen the capacity of those SSPs to deliver comprehensive HIV prevention and other necessary services for PWID. *Capacity building* is not a one-time effort to improve short-term effectiveness, but a continuous improvement strategy toward creating a sustainable organization. Effectively strengthening capacity will help bring an SSP to the next level of operational, programmatic, and organizational maturity. See examples below.

Jurisdictions with No Authorized SSP will conduct a community assessment to determine

local capacity for expansion of syringe access through either through establishing SSP and/ or establishing or expanding non-prescription syringe sale (NPSS) in pharmacies. The due date for the community assessment will vary by LHJ and will be established in the work plan. OA will provide a template to assist in conducting the community assessment as well as technical assistance for conducting the assessment. Upon completion, OA will offer technical assistance and support to determine and implement next steps that align with GTZ goals.

Jurisdictions Allocated \$170,000 or less

may opt to meet the requirement by developing or enhancing collaboration with local SSPs to enable effective linkage and referrals for PWID, or by working to increase the number of pharmacies that sell syringes without a prescription. See examples below.

Opting out of Requirement to Increase SSP Capacity

If an authorized SSP is operating in an LHJ but the LHJ wishes to opt out of the requirement to increase SSP capacity to deliver comprehensive prevention services, a strong justification must be submitted to OA explaining why the activity cannot be conducted, based on need, resources, and/or policy restrictions. Data must be provided to support the justification. This justification will be due by June 29, 2018. Upon review of the justification, OA will work with the LHJ to determine next steps.

LHJs **may not** use PS18-1802 funds to support:

- Purchase of needles or syringes (authorized California SSPs can obtain needles, syringes and other supplies from the California Syringe Exchange Supply Clearinghouse).
- Any activities designed to influence legislative change at the local, state, and federal level.

Example Fundable Activities

GTZ Activity K2: Fund syringe exchange programs

- **Increase staffing and/or build staff capacity**
PS18-1802 funds may be used to train, hire, and or increase staff time (LHJ or contracted CBO staff) to implement SSP services.
- **Provide support**
(materials, staff, access to facilities or mobile units) allowing the SSP to expand hours of operation or add additional sites.
- **Build Navigation programs**
LHJs may use PS18-1802 funds to hire and/ or train Navigators and/or other support staff to assist with navigation to care, insurance, substance use disorder treatment and supportive benefits.

GTZ Activity K3: Implement harm reduction-based models of HIV prevention and care services that integrate other health services critical to people who inject drugs

- **Increase SSP ability to offer comprehensive services**
PS18-1802 maybe be used to provide integrated HIV/HCV testing, as well as STD testing and navigation to care, treatment, PrEP, housing services and other needed health and social services.
- **Enhance collaboration with local SSPs**
For LHJs allocated \$170,000 or less level, LHJs may work to integrate harm reduction approaches and agencies in existing collaborations. Examples of activities to enhance collaboration with local SSPs include:

- Including SSPs as active partners in linkage and referral networks for HIV prevention, care, and PrEP;
- Providing HIV testing and HCV screening and linkage at SSP locations;
- Including SSP staff and participants in stakeholder meetings and discussions; and
- Providing information about SSP services on the health department website and other public or printed materials.
- Reach out to local law enforcement with information about syringe possession laws, which have changed in recent years to allow individuals 18 and older to possess an unlimited number of syringes for personal use.

Resources Provided by Office of AIDS

OA's [Needle Exchange & Syringe Access](#) web page includes a directory of California SEPs, fact sheets on legal and other issues, information about CDPH certification of SEPs, CDPH guidance for syringe exchange programs, and links to other tools and resources. It also includes a [toolkit for health departments](#) interested in expanding pharmacy participation in non-prescription syringe sale.

The California Syringe Exchange Supply Clearinghouse provides a baseline level of supplies to all authorized California SSPs. Supplies, provided free of charge, include syringes, needles, other harm reduction materials, and naloxone. Assistance with sharps disposal is also available to community-based organizations. For further information, contact Leslie Knight at leslie.knight@cdph.ca.gov. All SSPs that receive supplies must follow the [Guidelines for Syringe Exchange Programs Funded by the California Department of Public Health, Office of AIDS](#) and meet data reporting requirements.

Technical Assistance Contact:

Conducting community assessments for establishing SSPs and/or nonprescription syringe sales: Matt Curtis, Harm Reduction Specialist at matt.curtis@cdph.ca.gov or 510-545-9033; or Carol Crump, Behavioral Health Specialist at carol.crump@cdph.ca.gov or 916-449-5965.

State Certification of an SSP: Carol Crump, Behavioral Health Specialist at carol.crump@cdph.ca.gov or 916-449-5965.

GTZ Activity K5: Encourage access to syringes through nonprescription sale of syringes in pharmacies

- **For LHJs with no SSPs, LHJs may support nonprescription syringe sales in pharmacies (NPSS):**
 - Reach out to local pharmacies with information about NPSS.
 - Pharmacies selling syringes without a prescription are required to give customers information about how to access HIV and HCV testing and treatment and substance use disorder treatment. OA provides *Patient Information Sheets in English and Spanish* that meet this requirement, but many customers prefer local referrals.
 - Provide education to local pharmacy associations and schools of pharmacy.
 - Update the health department website to include information about NPSS and a list of local pharmacies that participate in nonprescription syringe sales.

Questions related to policy and law governing syringe exchange and nonprescription syringe sale: Alessandra Ross, Injection Drug Use Specialist at alessandra.ross@cdph.ca.gov or 916-449-5796
syringes for personal use.

Additional Resources

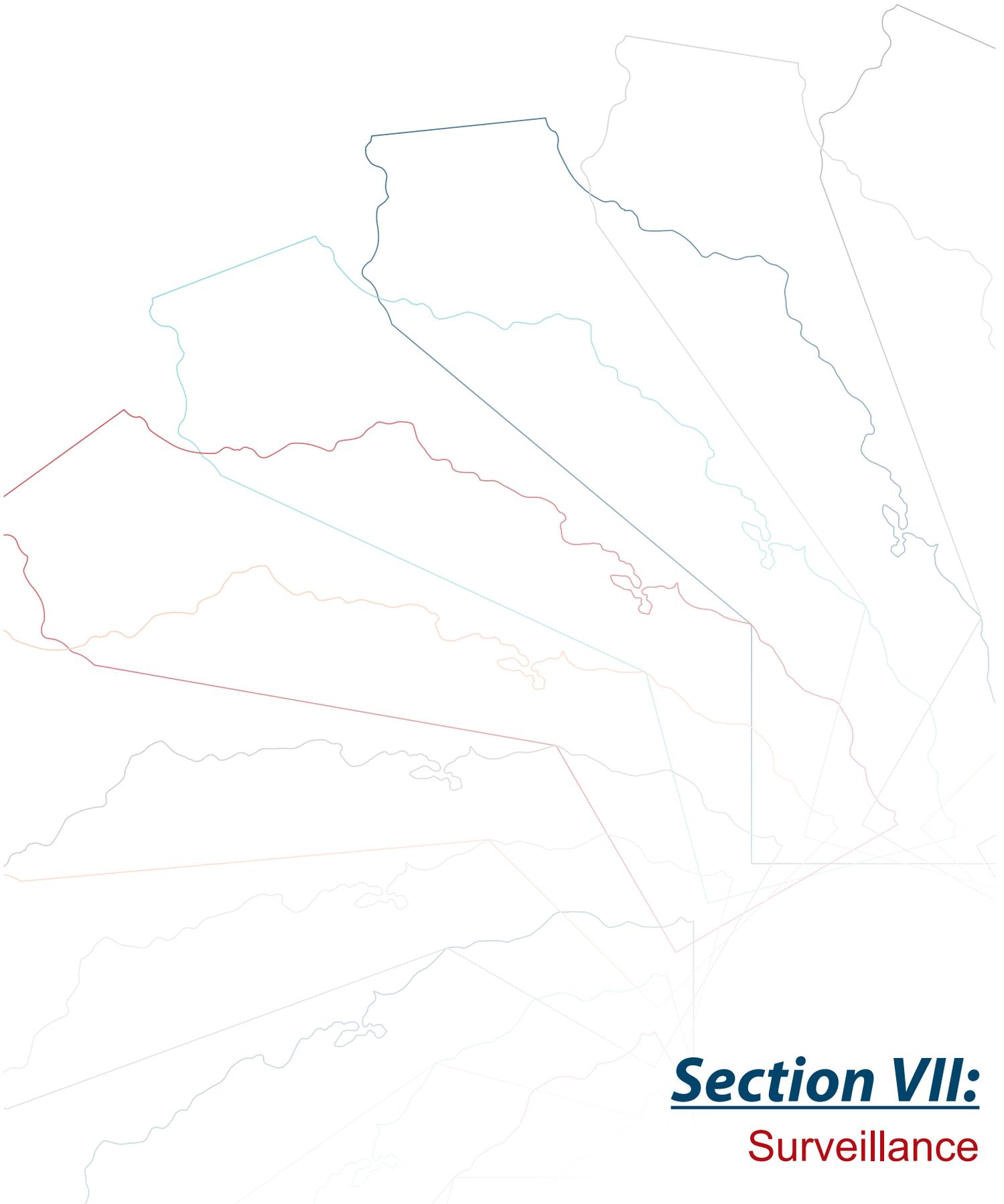
Health Resources and Services Administration (HRSA) funds may be used to fund all aspects

of syringe services for HIV-positive individuals. Substance Abuse and Mental Health Services Administration (SAMHSA) funds may not be used to fund the activity of syringe exchange, but may be used to fund comprehensive SSP services such as outreach to out-of-treatment PWID, counseling, support to enter substance use disorder treatment, and HIV prevention education. SAMHSA funds may also be used to support overdose prevention education and naloxone distribution.

Metrics

Metric*	Metric Source	Data Source	Grantee Responsible for Collecting and Reporting Data Corresponding to Metric as Part of PS18-1802?
Community assessment to determine local capacity for expansion of syringe services completed	PS18-1802 (CDC)	Grantee Semi-Annual Progress Report	Yes
Work plan outlining how HIV prevention and care-related service gaps specific to injection drug users will be addressed	PS18-1802 (CDC)	Grantee Semi-Annual Progress Report	Yes
Number of service providers trained on overdose education and prevention, including provision of naloxone	GTZ PLAN	Grantee Semi-Annual Progress Report	Yes
Number of naloxone trainings provided to SSP clients	GTZ PLAN	Grantee Semi-Annual Progress Report	Yes
Number of SSP clients linked to HIV prevention, care, or PrEP services	PS18-1802 (CDC)	Grantee Semi-Annual Progress Report; copy of Needs Assessment	Yes
Number of OA prevention-funded programs that offer syringe exchange services	GTZ PLAN	Grantee Semi-Annual Progress Report	Yes
Percentage of residents living within 50 miles of a syringe exchange program or pharmacy that sells syringes without a prescription	GTZ PLAN	OA Research	No
Number of Ryan White-funded programs that offer syringe exchange services	GTZ PLAN	OA Research	No

* The metrics list included in this guidance document is preliminary and subject to change



Section VII: **Surveillance**

HIV surveillance is generally defined as the systematic collection, analysis, interpretation, dissemination, and evaluation of population-based information about persons with diagnosed HIV and AIDS. HIV surveillance data include all demographic groups and are the primary source of population-based HIV information available in all U.S. states and territories. HIV cases are defined according to the current CDC surveillance case definitions.

The OA Surveillance Section is responsible for working with LHJs to collect and process HIV surveillance data, including data management, quality assurance, and data analysis. OA collects and reports HIV surveillance data to CDC.

HIV surveillance in clinical settings that involves the reporting of confidential HIV tests and associated clinical information is sometimes called “core” or “case” surveillance. Core surveillance is one of many forms of HIV surveillance that have been funded by CDC to monitor the HIV/AIDS epidemic in the United States. Examples of other HIV surveillance programs funded by CDC include surveillance of new HIV infections (incidence surveillance); HIV risk behaviors (behavioral surveillance); quality of care and clinical outcomes (medical morbidity monitoring); and perinatal HIV transmission (enhanced perinatal surveillance). Core HIV surveillance is the focus of this guide and the term, “HIV surveillance” is used throughout this document to refer to core surveillance activities.

Laboratories are legally required to report laboratory tests indicative of HIV infection to LHJs and CDPH. Health care providers are legally required to report HIV cases to LHJs. Surveillance coordinators at the local health jurisdictions identify and report all cases of diagnosed HIV infection according to the guidelines specified in the OA Guide to HIV Surveillance. Surveillance coordinator activities include:

- Maintaining the infrastructure for HIV surveillance;

- Collecting and submitting accurate, complete, and timely HIV surveillance data to OA;
- Maintaining data security and confidentiality;
- Program management, coordination, and evaluation;
- Collaborating with local health department staff and external partners to respond to the HIV epidemic; and
- Facilitating data dissemination to appropriate staff for data to care, surveillance-based partner services, and other communicable disease control or follow-up activities to reduce new HIV infections and improve care outcomes for PLWH.

HIV/AIDS surveillance systems are routinely evaluated for accuracy, completeness, and timeliness of case reporting, and completeness and accuracy of data collected. These evaluations are used to improve data in the surveillance system, more accurately interpret analyses of data collected, and promote the best use of public health resources. Measuring performance is an important part of promoting complete, accurate, and timely HIV case data, and ensuring a reliable source of HIV surveillance information. Activities described here are necessary to ensure that HIV case reporting meets or exceeds state and national program performance standards for completeness, timeliness, duplication, risk ascertainment, and case ascertainment through death certificates.

California HIV Surveillance Performance Standards

Timeliness and Completeness: LHJs shall complete an Adult or Pediatric Case Report Form for 100 percent of newly reported HIV cases and 100 percent of new HIV Stage 3 (AIDS) cases identified in the jurisdiction and submit those case report forms to the OA **within 45 days** of

the Contractor receiving notification of a new case [as per HSC Section 121023 and California Code of Regulations, Title 17 § 2643.15].

Duplication: No more than 5 percent of HIV/AIDS case reports can be duplicates or involve incorrectly matched case reports (CDC performance standard).

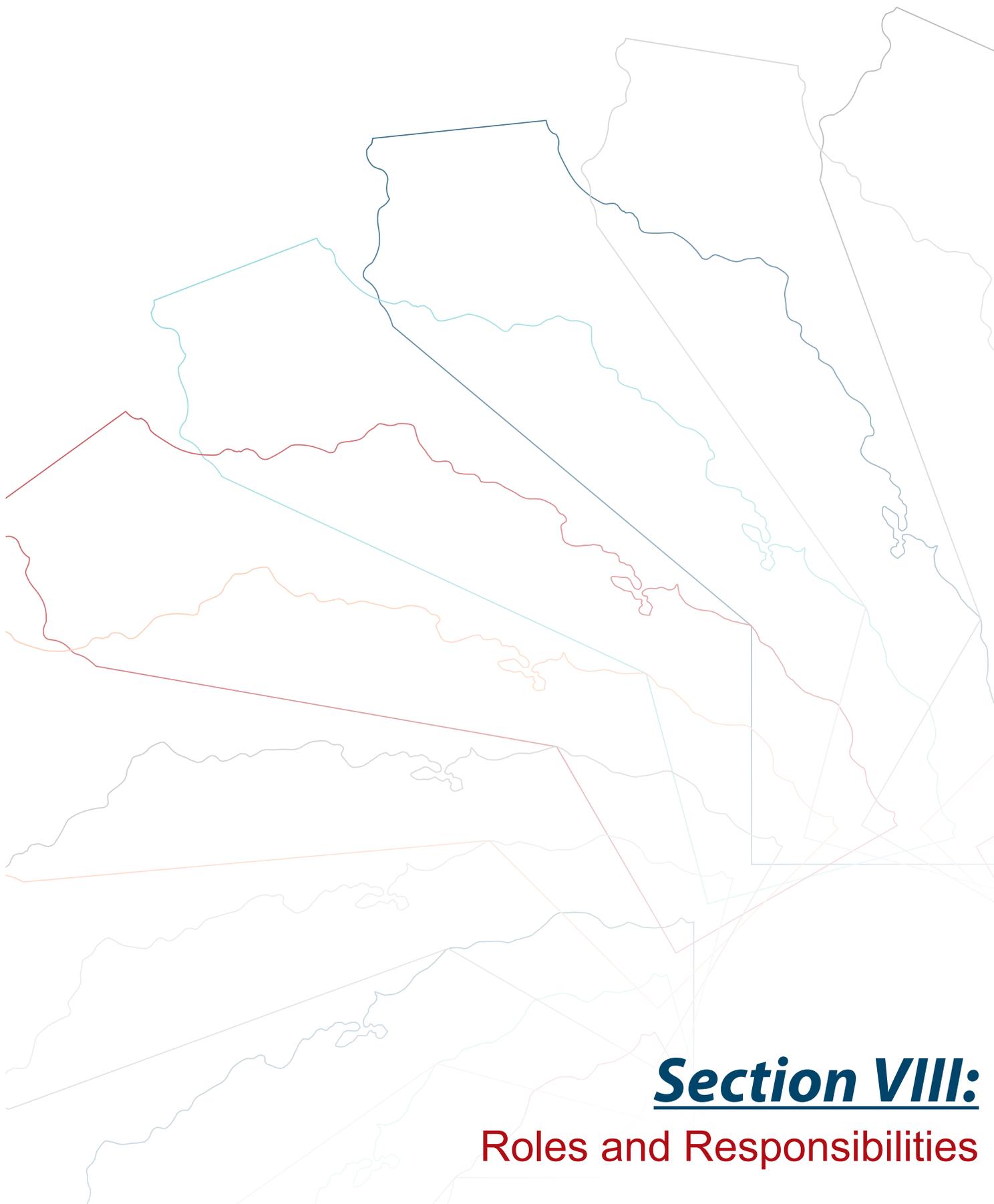
Risk Factor Ascertainment: LHJs shall collect all required data elements on 100 percent of Adult and Pediatric Case Report Forms using all available data sources to the extent permitted by law including, but not limited to, data from medical providers, HIV test sites, laboratories, HIV prevention programs, Ryan White funded programs, STD surveillance programs, STD and HIV partner services programs, and people search software. Required data elements are stated in the OA Guide to HIV Surveillance and

include, but are not limited to, demographic information, contact information, risk behavior, clinical information, and testing and treatment history.

Case Ascertainment Through Death

Certificates: The proportion of cases identified through death certificates alone should be less than 5 percent. If the proportion of such cases exceeds 5 percent, earlier reporting needs to be strengthened through other sources (CDC performance standard).

For more information, please refer to the [Guide to HIV Surveillance in California](#) posted on the CDPH website or to the LHJ scope of work in the LHJ surveillance contract.



Section VIII: **Roles and Responsibilities**

Prevention Coordinators

HIV Prevention Coordinators are responsible for developing, implementing and maintaining HIV programming in their LHJs in order to decrease HIV acquisition. Using HIV surveillance data and their knowledge of their community, Prevention Coordinators should establish relationships with health care providers, CBOs, and other organizations that can influence community attitudes and actions that will decrease HIV transmission and assist with all HIV prevention activities. Within the CPA-funded HIV prevention LHJs, Prevention Coordinators also manage OA-provided funding in accordance with this document.

Surveillance Coordinators

In addition to carrying out the activities outlined in the OA Guide to HIV Surveillance, LHJ surveillance coordinators will also work with LHJ HIV prevention and care staff to share data for programmatic purposes. Surveillance coordinators receive detailed HIV analyses from OA, including detailed HIV continuums, and are responsible for sharing data that assist with HIV prevention and care activities while protecting client information from unauthorized use. LHJ prevention staff and surveillance coordinators should work together to achieve California's Integrated Plan goals and objectives. For example, surveillance coordinators can use surveillance data to identify people newly diagnosed with HIV by a health care provider, and collaborate with HIV prevention and disease investigation staff to coordinate provider outreach and linkage to care activities.

OA ensures the accuracy of HIV surveillance data by de-duplicating records, conducting death ascertainment, and monitoring quantity and completeness of electronic laboratory reporting (ELR). OA produces the following data products:

- Annual HIV surveillance report and supplemental reports which include the

number and rate of new diagnoses of HIV, all persons living with diagnosed HIV infection, and deaths among persons with diagnosed HIV infection. [Reports are available](#) on the Office of AIDS website;

- [Fact sheets available](#) on the Office of AIDS website;
- Detailed continuums of HIV care by LHJ which are shared with LHJ surveillance coordinators. Detailed continuums are for LHJ use and should not be shared outside of the LHJ; and
- During 2018, OA will be developing an interactive report portal which will provide action-oriented dashboards, workflows, and reports for surveillance- and prevention-based activities.

Using Surveillance and Other Data to Facilitate and Coordinate GTZ Activities

Program collaboration and data sharing between local health department HIV surveillance, prevention and care staff, and STD disease intervention staff is essential in order to effectively implement GTZ activities, including surveillance-based HIV and STD partner services, data to care, and cluster investigations. HIV surveillance data should be used to initiate public health action. Knowledge of HIV status prior to client interactions helps better prepare local health department HIV and STD staff to address both HIV testing and care needs, as well as determine whether linkages to HIV care, PrEP, or other services are needed. Previously, the use of surveillance data to inform prevention activities, including partner services efforts, was hampered by non-names reporting and data sharing restrictions. However, current statute, regulation, and data security guidelines allow data sharing between health department HIV and STD programs and between local health jurisdictions. OA strongly encourages the

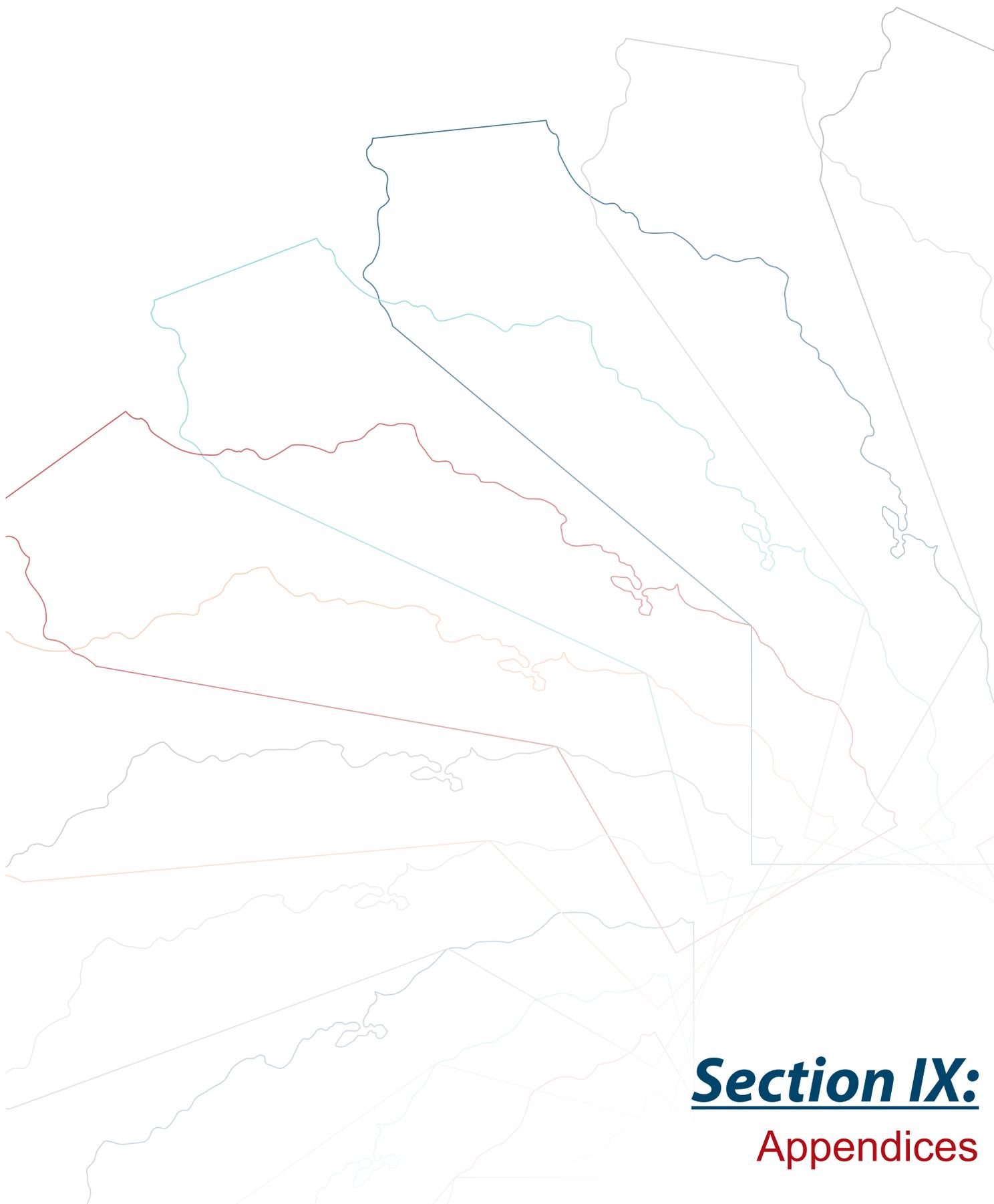
appropriate sharing of data to facilitate program effectiveness and efficiency. Data sharing process should still conform to data security and confidentiality requirements.

Cross program (HIV surveillance and prevention and STD) record searches and data matching are essential in order to enhance local HIV programs' ability to most appropriately focus HIV testing and partner services to clients at greatest need and to facilitate linkage to PrEP and HIV care. HIV surveillance staff should coordinate with HIV and STD surveillance, prevention and disease intervention staff to establish data sharing processes or mechanisms that will support comprehensive, data informed public health follow-up of clients diagnosed with HIV and/or STDs and their partners. LHJs should establish standard operating procedures to conduct HIV and STD surveillance data record searches prior to initiating any client interview, partner services, field notification, or testing activities.

All staff conducting partner services interview/offer, elicitation and partner notification should document interview findings and investigation

outcomes on appropriate CDPH forms (e.g. interview record, partner information form, health department follow-up tab) and/or in CDPH data collection systems (e.g. LEO, AIDS Regional Information and Evaluation System [ARIES], CalREDIE) for data collection and grant reporting purposes. Standardized questions regarding client risk (e.g. substance use—methamphetamines or opiates, exchange of sex for drugs/money, incarceration, etc.) and insight into sexual/social networks (e.g. venues/media where client meets or communicates with sexual partners—Grinder, bathhouse, text messages; geographic locations of interest—homeless encampment; etc.) are valuable data points to inform program interventions. This type of data is useful for identifying potential sexual and social network interventions, particularly during cluster or outbreak investigation.

Please see [Appendix 8](#) for relevant policy letters on HIV reporting. Additional clarification on communication and data sharing between medical providers and local health department program staff regarding HIV testing and LTC status can be found in [Appendix 9](#).



Section IX: **Appendices**

APPENDIX 1: OA Prevention Funded LHJs

There are 20 funded LHJs within the CPA:

- | | |
|----------------|---------------|
| Alameda | San Diego |
| Contra Costa | San Joaquin |
| Fresno | San Mateo |
| Kern | Santa Barbara |
| Marin | Santa Clara |
| Monterey | Santa Cruz |
| Orange | Solano |
| Riverside | Sonoma |
| Sacramento | Stanislaus |
| San Bernardino | Ventura |



APPENDIX 2: Basic Counseling Skills and Alere Training

HIV/HCV Counseling and Testing Training

OA offers training, required by California Health and Safety Code 120917, for non-medical personnel who will be conducting targeted HIV and/or HCV testing. Trainings offered by OA include:

Basic Counselor Skills Training (BCST)

The Basic HIV/HCV Counselor Skills Training (BCST) is a four-day course that introduces participants to the skills necessary to conduct HIV and hepatitis C rapid antibody testing and counseling. These skills include engagement, behavioral risk assessment, harm reduction, and cultural humility. Participants learn how to make appropriate referrals to services that can optimize client and community health, including HIV-related medical care, PrEP navigation, PEP, STD testing and treatment, HCV follow-up testing and care, and Partner Services. Our trainers teach HIV testing procedures using the OraQuick ADVANCE Rapid Test and the OraQuick HCV Rapid Test. The training also discusses OA policy regarding testing and counseling and data collection.

Requirements for completion of this training include successful completion of **1)** an observed role-play; **2)** the post-training quiz; **3)** the rapid test proficiency exam; **4)** the finger stick proficiency exam; and **5)** attendance of the full training.

Please note that people who are already licensed or certified as able to draw blood by finger stick in the state of California need not attend the finger stick portion of the training.

Alere Determine HIV – 1/2 Ab/Ag Combo Proficiency Training

The overall purpose of this one and a half day training is to ensure high standards of care for HIV testing and prevention services at California Department of Public Health, Office of AIDS (OA)-funded testing programs. This standard includes providing accurate, current HIV status information to clients. To implement this standard, OA requires certified HIV test counselors to meet a specified standard of proficiency in running and reading both the OraQuick ADVANCE HIV 1/2 and HCV Antibody Rapid Tests and collecting an adequate blood sample via finger stick. OA requires additional proficiency training for sites integrating the Alere Determine test.

This training ensures that HIV test counselors can adequately explain to their clients the new testing technology, its window period, and its capacity to diagnose HIV infection during the acute infection stage. Additionally, participants will learn to communicate key messages to the client about acute HIV infection, be proficient in performing the Alere Determine test and interpreting its results, and be proficient in collecting an adequate blood sample via finger stick (note that the sample size necessary for the Alere Determine test is ten times that required for OraQuick tests). This training is for participants who have previously completed all components of the BCST.

LHJs interested in more information regarding training for non-medical test providers, or to schedule training in their jurisdiction should contact Karin Hill, HIV Prevention Training Coordinator at karin.hill@cdph.ca.gov or (916) 319-9461.

APPENDIX 3: Capacity Building Assistance (CBA)

The Capacity Building Assistance (CBA) Request Information System (CRIS) is a CDC program that provides information, on-site training and technical assistance to HIV prevention service providers to help them build their skills, plan for and adapt to change, and meet their goals.

PS18-1802 funded LHJs, CBOs, HIV planning groups and health care providers in clinical settings, can make a CRIS request through the California Department of Public Health, Office of AIDS.

CBA services are based on the type of organization that makes the request and by content area. Requesting organizations are linked with a CBA provider with demonstrated expertise in the topic. Organizations seeking CBA may request a provider, or one will be assigned based on the nature of the training requested.

Training components available include but are not limited to:

- Rapid ART;
- HIV, STD and HCV screening;
- Linkage, engagement and retention in care;
- Syringe services programs;
- Patient navigation;
- Cultural competence;
- Referral and linkage to non-HIV medical and social services;
- Organizational development and change management; and
- Strategic planning.

Each topic has a wide array of specialized trainings and technical assistance available.

Funded CBA Providers

- AIDS Project Los Angeles (APLA)
- AIDS United
- Asian & Pacific Islander American Health Forum
- Asian & Pacific Islander Wellness Center
- California Prevention Training Center (PHFE)
- Cicatelli Associates, INC.
- City & County of San Francisco (CBA)
- Denver Health and Hospital Authority/Denver Prevention Training Center
- ETR Associates, INC
- JSI Research and Training Institute, INC.
- Latino Commission on AIDS (LCOA)
- National Alliance of State & Territorial AIDS Directors
- National Community Health Partners (NCHP)
- National Minority AIDS Council, INC. (NMAC)
- New York City Department of Health and Mental Hygiene (NYCDOHMH)
- Primary Care Development Corporation
- Puerto Rico Organization for Community Education (PROCEED)
- UCSF Capacity Building Assistance

Partnership (CAPS, COE, AND AHP)

- University of Missouri Kansas City
- University of Rochester Center for Health & Behavioral Training (CHBT)
- University of Washington

Available training components include, but are not limited to:

- Rapid ART;
- Screening and testing of all patients/clients for HIV;
- Screening and testing of all patients/clients for STD, TB and hepatitis;
- Routine, early HIV screening and testing for all pregnant women;
- Targeted recruitment for HIV testing;
- Partner services;
- Cultural competence for HIV screening, testing and referral;
- Collaboration with laboratory and surveillance programs;
- Syringe services programs (SSP);
- Conducting HIV testing in non-clinical settings;
- Retention in care for HIV-positive individuals;
- Re-engagement in care for HIV-positive individuals;
- Referral and linkage to non-HIV medical and social services;
- Prevention of perinatal transmission;

- Integration of Hepatitis, TB, and STD screening for HIV positive individuals;
- Reporting of CD4 and viral load results to health departments;
- Data to care/use of surveillance data to improve linkage and retention in care, and providing feedback of results to providers and patients;
- Creating HIV/AIDS treatment cascades;
- Navigation services;
- Multi-sectorial partnerships;
- Social marketing, media, and community mobilization;
- Outreach;
- Case management;
- Provider training;
- Routine opt-out testing of pregnant women;
- Rapid testing;
- Preconception care for women living with HIV;
- Monitoring and evaluation;
- Linking HIV-positive women to appropriate services; and
- Perinatal HIV prevention services coordination (PHSC).

Each topic has a wide array of specialized trainings and technical assistance available.

LHJs and CBOs within the CPA should contact OA in order to request CBA through the CRIS system. When requesting CBA, the LHJ or CBO

should contact OA and state the type of training needed, the name or a CBA provider if a specific provider is requested, the organization name and contact information of the person requesting training.

Technical Assistance Contact

To learn more about the types of training available or to make a CRIS request, contact

Matthew Willis, CRIS Specialist for the California Department of Public Health, Office of AIDS at (916) 449-5797 or matthew.willis@cdph.ca.gov. You will be able to receive a consultation to determine what type of CBA would be best for your organization. Please include the specifics of your organization's training needs in your request, as well as a point of contact including contact phone number and email address.

APPENDIX 4: Community Planning Group

The California Planning Group (CPG) is the statewide HIV planning body that enables key stakeholders, communities, and providers to engage in active and ongoing dialogue with the Office of AIDS (OA) to reach the goals of the National HIV/AIDS Strategy and the statewide Integrated Plan. The main functions of this group are to work collaboratively with OA in the development, implementation, and revision of the statewide Integrated Plan; to provide input on new or revised OA allocation formularies, as needed; to participate in review panels for OA's California AIDS Clearinghouse of HIV educational materials; and to provide timely advice on emergent issues identified by OA and/or other key stakeholder parties. CPG is committed to working openly in a group to make decisions and is guided by the principles of equity, fairness, and respectful engagement.

Subcommittees and Work Groups

Subcommittees and Work Groups are established as necessary to facilitate the work of the CPG. These may include members, invited guests (non-voting), and members of the public (non-voting), and are comprised of both OA staff and CPG members. Currently, CPG houses the Membership Subcommittee and the Housing Subcommittee.

The Membership Subcommittee is a standing committee composed of members of the CPG, and is responsible for assessing, monitoring and developing mechanisms necessary to recruit, train and maintain CPG membership at numbers and expertise required to successfully accomplish the work of the group. The Housing Subcommittee will work with OA to develop a statewide housing plan that identifies the most effective housing services, best practices for integrating HIV health and housing providers and encouraging local collaboration, and methods for collaborative funding and service delivery.

Membership

There are 25-30 members on CPG, including two voting Community Co-Chairs as elected by the CPG membership, and two non-voting State Co-Chairs as appointed by OA. Voting members also include 11 Nominated Members who represent eight Ryan White Part A planning bodies and three local HIV planning groups. There are 17 Community/At-Large Members who represent consumers, HIV service providers, and those affiliated with HIV service delivery networks. Non-voting subject matter experts (SMEs) who are appointed by OA also serve on CPG.

The membership supports the planning, development and decision-making processes of the CPG. All CPG members commit to a three- or five-year term of service, and new CPG members are appointed as current member terms expire. Members may apply for a second term (additional 3 or 5 years). All appointed members are selected through an application process, which is conducted as three and five-year member terms expire, or as needed, to replace members who have resigned from the CPG. The Membership Committee engages in monthly teleconferences to review vacancies, assess gaps in members' skills set, and develop recommendations for interim replacement if the Membership Committee deems that critical planning skills are missing from the overall composition of the CPG. The membership review process is designed to identify potential new members in terms of planning skills, knowledge, experience and expertise, areas of interest, and other specific factors as determined annually by the CPG and OA. In addition, CPG strives for at least 25 percent of membership demographic of HIV-positive individuals.

Co-Chairs

The Co-Chair duties are shared between the Community Co-Chairs and State Co-Chairs. Two State Co-Chairs are staff from OA and are appointed by the OA Division Chief, while two Community Co-Chairs are nominated and elected by the CPG members. Election of the CPG Community Co-Chairs takes place each year, and CPG members may nominate themselves or another member. The two candidates with the most votes of the established quorum are elected as the Community Co-Chairs; in the event that this is not achieved due to a tie for one or both of the Community Co-Chair seats, an immediate run-off vote is held between the candidates that have tied, and the candidate(s) receiving the most votes is then elected.

The responsibilities of the State and Community Co-Chairs are to prepare, manage, organize, and facilitate the remote and in-person meetings of the CPG, and review and approve meeting notes; to participate in regular teleconferences to discuss meeting planning, CPG activities, and other CPG-related issues, as needed; collaborate with the Subcommittees and Work Groups; provide leadership and direction on membership recruitment and retention; develop and conduct the new member orientation; provide monthly calls to members; represent

CPG at additional meetings and report back to the CPG; and to perform other duties that are necessary to provide leadership and guidance to the CPG.

Meetings

CPG meets twice a year in-person if allowed by state travel policies; webinars or teleconferences may also be scheduled in order to address specific planning or advisory needs. The meeting agendas typically include presentations on State updates, California's GTZ plan, relevant legislative updates, CPG member and SME announcements, team building activities, and public comment. During these meetings, community feedback is also solicited on important planning documents such as the GTZ plan, California Needs Assessment for HIV, and other documents. Consensus is used in determining actions or recommendations from CPG after full discussion has been completed, and motions and additions to the meeting agendas may come from individual members. Members of the public are welcome and encouraged to attend and observe any of the two face-to-face meetings in a given calendar year; CPG values community input and relies on the full active participation of its members and on organized, well-managed, processes leading to careful deliberations and decisions.

APPENDIX 5: Acronyms

ADAP - AIDS Drug Assistance Program	HRSA - Health Resources and Services Administration
AIDS - Acquired Immune Deficiency Syndrome	IDU - Injection Drug User
ARIES - AIDS Regional Information and Evaluation System	LEO - Local Evaluation Online
ART - Antiretroviral treatment	LHJ - Local Health Jurisdiction
ATS - Alternative Test Site	LTC - Linkage to Care
BCST - Basic Counselor Skills Training	MSM - Men who have Sex with Men
CaIREDIE - California Reportable Disease Information Exchange	MSMWID - Men who have Sex with Men who Inject Drugs
CBA - Capacity Building Assistance	NHAS - National HIV/AIDS Strategy
CDC - Centers for Disease Control and Prevention	NICP - Newly identified confirmed positive
CDPH - California Department of Public Health	NPSS - Nonprescription Sale of Syringes
CHRP - California HIV/AIDS Research Program	OA - Office of AIDS
CPA - California Project Area	PLWDH - People Living with Diagnosed HIV
CPG - Community Planning Group	PLWH - Persons Living with HIV
CRIS - Capacity Building Assistance Request Information System	PrEP - Pre-Exposure Prophylaxis
DHCS - California Department of Health Care Services	PrEP-AP - PrEP Assistance Program
DIS - Disease Intervention Specialist	PS18-1802 - CDC RFA code for Integrated HIV Surveillance and Prevention Programs for Health Departments
eHARS - Enhanced HIV/AIDS Reporting System	PWID - People Who Inject Drugs
ES - Early Syphilis	RR EBI - Risk Reduction Evidence Based Interventions
EBI - Evidence Based Interventions	RRA - Health Education/Risk Reduction
EIS - Early Intervention Services	RWHAP - Ryan White HIV/AIDS Program
ELR - Electronic laboratory reporting	SAMHSA - Substance Abuse and Mental Health Services Administration
GTZ - Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan	SEP - Syringe Exchange Program
HCV - Hepatitis C Virus	SSP - Syringe Services Program
IDU - Injected Drug User	STD - Sexually Transmitted Disease
HAART - Highly active antiretroviral therapy	TA - Technical Assistance
HIV - Human Immunodeficiency Virus	TB - Tuberculosis
HRH - High-Risk Heterosexuals	U = U - Undetectable = Untransmittable

APPENDIX 6: Insurance and Benefits Coverage for PLWH or on PrEP

Funding Source	Funding Type	Features
Medi-Cal	Federal and State-Department of Health and Human Services	Comprehensive medical coverage at little to no cost to the client. For individuals who are unemployed, low income, or disabled. Medi-Cal expansion provides comprehensive medical coverage for individuals under 65 with an annual income lower than 138 percent of the Federal Poverty Level (FPL).
Medicare	Federal- Department of Health and Human Services	For individuals 65 and older. Also for individuals on permanent disability for 2 consecutive years. Comprehensive medical care at little to no cost to the client.
State or County Coverage for Low Income	State and Federal	Basic health services through county clinics, Family PACT, and health centers, etc.
Veteran Benefits Administration Services	Federal – Department of Veterans Affairs	Comprehensive medical coverage and treatment for retired military personnel.
SSI/SSDI	Social Security Administration	The SSI program makes cash assistance payments to aged, blind, and disabled persons (including children) who have limited income and resources. SSDI provides benefits to disabled or blind persons who are “insured” by workers’ contributions to the Social Security trust fund. These contributions are based on a person’s prior earnings.
ADAP	Federal-HRSA and state Special Fund	Covers the costs of HIV-related medications, health insurance premiums, and medical out of pocket costs for uninsured and underinsured PLWH with incomes less than 500 percent of the FPL.
ADAP- PrEP Assistance	State Special Fund	Program will provide clinical services and access to medications related to PrEP. Clients will receive assistance with PrEP-related medical costs and medication on the PrEP-AP formulary for the treatment of STDs. For insured clients, the PrEP-AP will pay for medication copays for PrEP after the manufacturer’s co-payment assistance annual threshold is reached. Uninsured patients can receive PrEP through the manufacturer’s patient assistance plan.
PrEP Manufacturer’s Patient Assistance Program	Private- Pharmaceutical Company	PrEP medication assistance program assists eligible HIV-negative adults in the United States who require assistance paying for medication for PrEP.
Ryan White Part B	Federal- HRSA	Provide medical care and support services for low-income PLWH who do not have another payment source for the service. Benefits include outpatient ambulatory care, case management, dental care, mental health care, transportation support, housing assistance, and many other services.
HOPWA	Federal – Housing and Urban Development	Provide rental subsidies and supportive services for low-income PLWH to prevent homelessness. Benefits include: short-term rental, mortgage and utility subsidy, hotel/motel vouchers, security deposits, first/last months’ rent, case management, food, transportation, housing information services, facility operating costs for transitional housing.

APPENDIX 7: PS18-1802 Logic Model

For a copy of the PS18-1802 Logic Model, please contact: Kolbi Parrish, Research Scientist II: kolbi.parrish@cdph.ca.gov, or (916) 445- 8491.

APPENDIX 8: Method and Timeline for Reporting HIV Data



Methods and Timeline for Reporting HIV Data:
 Overview of Legal Requirements for Providers, Labs, and Local Health Officers¹
Office of AIDS Fact Sheet 2017

California Health and Safety Code (HSC) Section 121022(b)(1) requires health care providers and local health officers (LHO) to report cases of HIV infection, to the Local Health Officer and to the California Department of Public Health, respectively, by courier service, United States Postal Service express mail or registered mail, other traceable mail, person-to-person transfer, facsimile, or electronically by a secure and confidential electronic reporting system established by the department.²

The California Code of Regulations (CCR) provides requirements for reporting HIV in Title 17 CCR sections 2500, 2505, and 2643.5 through 2643.15 as outlined below.³

Sections 2500 and 2505 govern reporting for all reportable diseases:

2500	Health care provider reporting for all reportable diseases
2505	Lab reporting for all reportable diseases

Sections 2643.5 through 2643.15 require reporting for confirmed HIV:

2643.5	Health Care Provider reporting of confirmed HIV to the Local Health Officer
2643.10	Lab reporting of confirmed HIV to the Local Health Officer
2643.15	Local Health Officer reporting of confirmed HIV to the State

For sections 2643.5 to 2643.15, 17 CCR §2641.30 defines “confirmed HIV test” as:

- (a) a procedure which verifies the presence of HIV infection as determined by any clinical laboratory test or HIV Test Algorithm or examination used to detect the presence of HIV, a component of HIV, or antibodies to or antigens of HIV, including the HIV antibody (HIV-Ab), HIV p-24 antigen, Western blot (Wb), and immunofluorescence antibody tests; or
- (b) for the purpose of this Article, all tests used to monitor HIV infection, including HIV nucleic acid detection.

¹ This fact sheet is a generalized view of CA HIV/AIDS surveillance reporting laws and is not intended to address all aspects of HIV/AIDS law or to offer legal interpretation or advice. Although the statutes and regulations referenced are current as of 11/2017, these laws may be amended at any time. Consult your own legal counsel, accordingly.

² http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=121022.&lawCode=HSC

³ <https://govt.westlaw.com/calregs>

Method and Timeline for Reporting HIV Data (*continued*)

Health Care Provider Reporting of HIV to the Local Health Officer:

METHODS FOR REPORTING CONFIRMED HIV: 17 CCR 2643.5(c)

Health care providers shall report HIV to the *LHO in the health provider's jurisdiction* within seven calendar days of receipt from a laboratory of a patient's confirmed HIV test or determination by the health care provider of a patient's confirmed HIV. The report shall consist of a completed copy of the HIV/AIDS Case Report form.

(1) All reports containing personal information, including HIV/AIDS Case Reports, shall be sent to the LHO or his or her designee by:

- (A) Courier service, U.S. Postal Service Express or Registered mail, or other traceable mail, facsimile,⁴ or electronically by a secure and confidential electronic reporting system established by the Department; or
- (B) Person-to-person transfer with the LHO or his or her designee.

(2) The health care provider shall not submit reports containing personal information to the LHO or his or her designee by electronic mail or by non-traceable mail.

TIMELINE: 17 CCR 2500(b), (h), (j), and (k)

- **HIV infection, stage 3 (AIDS):** health care providers shall report to the *LHO for the jurisdiction where the patient resides* by mailing a written report, telephoning, or electronically transmitting a report *within seven (7) calendar days* of the time of identification. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from HIV may make such a report to the LHO for the jurisdiction where the patient resides. 17 CCR 2500(b), (h), and (j).
- **HIV, acute infection:** (k) In addition to routine reporting requirements set forth in section 2643.5, for acute HIV infection reporting, health care providers shall report all cases *within one (1) working day to the LHO of the jurisdiction in which the patient resides by telephone*. If evidence of acute HIV infection is based on presence of HIV p24 antigen, providers shall not wait until HIV-1 RNA is detected before reporting to the LHO. 17 CCR 2500(h) and (k).

Lab Reporting of HIV to the Local Health Officer:

METHODS AND TIMELINE FOR REPORTING CONFIRMED HIV: 17 CCR 2643.10

(a) Labs shall, within seven calendar days of determining a confirmed HIV test, report the confirmed HIV test to the *LHO for the local health jurisdiction where the health care provider is located*.

(b)(1) All reports containing personal information, including laboratory reports, shall be sent to the LHO or his or her designee by:

- (A) Courier service, U.S. Postal Service Express or Registered mail, or other traceable mail; or
- (B) Person-to-person transfer with the LHO or his or her designee; or

⁴ To avoid delivering confidential information into unauthorized hands, Office of AIDS does not fax documents containing directly or indirectly identifying information regarding HIV. [Guidance](https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/GuideToHIV%20Surveillance.pdf) on p. 23: <https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/GuideToHIV%20Surveillance.pdf>

Method and Timeline for Reporting HIV Data (*continued*)

(C) Provided that, commencing July 1, 2009, or within one year of the establishment of a state electronic laboratory reporting system, whichever is later, a report generated pursuant to Section 120130, or Section 121022, by a laboratory shall be submitted electronically in a manner specified by the department.

(2) The laboratory shall not submit reports containing personal information to the LHO or his or her designee by electronic facsimile transmission or by electronic mail or by non-traceable mail.

METHODS AND TIMELINE FOR REPORTING HIV, ACUTE INFECTION: 17 CCR 2505(a), (e)(2), and (j)

(a) Labs shall report acute HIV infection *within one working day to the local health jurisdiction in which the patient resides by telephone (see (j) for specific acute HIV infection reporting requirements)*. If the patient residence is unknown, the laboratory shall notify the health officer of the jurisdiction in which the health care provider is located. 17 CCR 2505(a) and (a)(2).

(e)(2) Acute HIV shall be reported both by telephone and *to the state electronic reporting system within one working day* of identification.

[Office of AIDS plans to include HIV reporting in CalREDIE in 2018.]

(j) In addition to routine reporting requirements set forth in section 2643.10, for acute HIV infection reporting, laboratories shall report all cases *within one business day to the LHO of the jurisdiction in which the patient resides by telephone*. If the patient residence is unknown, the laboratory shall notify the health officer of the jurisdiction in which the health care provider is located. If evidence of acute HIV infection is based on presence of HIV p24 antigen, laboratories shall not wait until HIV-1 RNA is detected before reporting to the LHO. 17 CCR 2505(j).

SPECIMEN REPORTING FROM LABS: 17 CCR 2505(m)

This incidence program has been discontinued by the CDC.

Local Health Officer Reporting of HIV to the State:

METHODS AND TIMELINE FOR REPORTING ALL STAGES OF HIV: 17 CCR 2643.15

(a) The local Health Officer or his or her authorized designee shall match and unduplicate laboratory reports of confirmed HIV tests with the local health department HIV/AIDS registry database and with HIV/AIDS Case Reports received from health care providers and not entered into the database.

(b) The Health Officer or his or her authorized designee shall, within 45 calendar days of receipt of a laboratory report of a confirmed HIV test, submit unduplicated HIV/AIDS Case Reports to the Department.

(1) HIV/AIDS Case Reports shall be sent by Courier service, U.S. Postal Service Express or Registered mail, or other traceable mail, person to person transfer, facsimile, or electronically by a secure and confidential electronic reporting system established by the department to the California Department of Public Health, Office of AIDS, Surveillance Section.

(2) The local Health Officer or his or her authorized designee shall not report confirmed HIV tests for patients of an Alternative Testing Site or other anonymous counseling and

Method and Timeline for Reporting HIV Data (*continued*)

testing program, a blood bank, a plasma center, or for participants of a blinded and/or unlinked HIV seroprevalence study.*

[*If patients are subsequently tested elsewhere, that test should be reported to the local health officer, and that test result must be reported to the state. See Health and Safety Code section 1603.1(c).]

Public Health Reporting of HIV is an Authorized Disclosure under HIPAA & CMIA:

Federal law authorizes a HIPAA covered entity, such as healthcare providers, to "disclose protected health information without written authorization from the individual" to "A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease...including, but not limited to...public health interventions..." (HIPAA, 45 CFR §164.512(b)(1)(i): Uses and disclosures for which an authorization or opportunity to agree or object is not required.)

The California Confidentiality of Medical Information Act (CMIA) authorizes a provider of health care to disclose medical information without first obtaining authorization to a local health department for the purpose of preventing or controlling disease including for the purpose of public health interventions. (CA Civil Code §56.10(c)(18))

CDC and Office of AIDS Guidance on HIV Reporting:

CDC guidance from 2011 on HIV reporting is located [here](#).⁵

Office of AIDS 2014 "Guide on HIV Surveillance in California" (based on 2011 CDC guidance and California Law) is located [here](#).⁶ Office of AIDS guidance differs from the statute and regulations because current guidance discourages the use of facsimile (fax) when transmitting HIV results. Office of AIDS has suspended the use of fax in transmitting documents containing HIV data, see page 23 in the Office of AIDS guidance. Faxing is discouraged due to the high risk of error in typing a fax number and the possibility of received faxes remaining in an area that may not be secure.

⁵ <https://www.cdc.gov/nchhstp/programintegration/docs/pcsidatasecurityguidelines.pdf>

⁶ <https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/GuideToHIV%20Surveillance.pdf>

APPENDIX 9: Legal Authority for Data Sharing



Legal Authority for Provider and Local Public Health Department Staff to Share Patient HIV/AIDS Information for Case Management and Care Coordination [Office of AIDS](#) Fact Sheet 2017

California Health and Safety Code, Section [121025\(c\)\(2\)\(C\)](#) authorizes local public health department staff to communicate with health care providers for the purpose of proactively offering and coordinating care and treatment services, *and so also authorizes health care providers to respond* with relevant patient information to these local public health department staff.

Section [121025\(c\)\(3\)](#) authorizes local public health department STD and TB control staff to communicate with health care providers for the purpose of facilitating appropriate medical care and treatment of persons co-infected with HIV, TB, syphilis, gonorrhea or chlamydia. This section *also authorizes health care providers to respond* with relevant patient information to these local public health department staff.

Section [121025\(b\)](#) authorizes a local public health department, or an agent of that department, to disclose personally identifying information to other local health departments when necessary for disease investigation, control, or surveillance, as determined by the disclosing local health department.

Section [121025\(c\)\(3\)](#) states that for the purpose of facilitating appropriate medical care and treatment of persons coinfecting with HIV and tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal infection, *local public health agency sexually transmitted disease control, communicable disease control, and tuberculosis control staff may further disclose the information to state or local public health agency sexually transmitted disease control, communicable disease control, and tuberculosis control staff, the HIV-positive person who is the subject of the record, or the health care provider who provides his or her HIV, tuberculosis, hepatitis B, hepatitis C, meningococcal infection, and sexually transmitted disease care.*

Federal law authorizes a HIPAA covered entity, such as healthcare providers, to "disclose protected health information without written authorization from the individual" to "A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease...including, but not limited to...public health interventions..." (HIPAA, [45 CFR §164.512\(b\)\(1\)\(i\)](#): Uses and disclosures for which an authorization or opportunity to agree or object is not required.)

The California Confidentiality of Medical Information Act (CMIA) authorizes a provider of health care to disclose medical information without first obtaining authorization to a local health department for the purpose of preventing or controlling disease including for the purpose of public health interventions. ([CA Civil Code §56.10\(c\)\(18\)](#).)

APPENDIX 10: Requirements for Focused HIV Testing Sites

LHJs and their testing sites must provide services in accordance with California Health & Safety Code 120917, which sets out requirements for both medical and non-medical HIV test operators. A test kit operator must either be a medical provider engaged in direct client care, or an HIV test counselor who has received the Basic Counselor Skills Training (BCST) from OA or its training partners using an OA-approved training curriculum. All individuals tested with OA funds in non-health care settings should be given the results of their test in person.

Written quality assurance plans are required by sites conducting point-of-care rapid HIV tests waived under the Federal Clinical Laboratory Improvement Act. The Focused Specialist from each testing site submits for comprehensiveness and compliance with State and Federal requirements these plans to OA for review. Please submit updated plans anytime there are significant changes, such as the addition of HCV testing.

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

Additionally:

- The test site must maintain signed statements of confidentiality for employees and volunteers who have access to individual client files;
- Client records containing personally identifying information developed or acquired by the agency relating to any program activity or services are confidential and shall not be disclosed, except as otherwise provided by law for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by their guardian or conservator; and
- Information collected during HIV testing, such as the Client Assessment Questionnaire, Client Information Form, invoices, etc., must be retained by the test site for three years in addition to the current year. All confidential client information must be stored in a locked filing cabinet.

APPENDIX 11: Ordering Condoms

Once a LHJ from within the California CPA (all counties except Los Angeles and San Francisco) has identified a venue for condom distribution, the LHJ must fill out the Participating Venue Information (PVI) form (available from CACOrders@cdph.ca.gov) for each participating venue, keep a copy and send a copy to OA via e-mail at CACOrders@cdph.ca.gov or FAX at (916) 449-5800. OA staff will review the PVI form to ensure eligibility and register the venue into the program. Once registered, a condom order sheet will be e-mailed to the venue's contact, copying the LHJ's contact.

There is no limit to how many eligible venues each LHJ can have participating in a condom distribution program. LHJs are encouraged to maintain collaborative relationships with their participating venues in order to provide clients/patrons additional services (e.g. HIV testing, HIV/AIDS/STD information, partner services, risk-reduction counseling, etc.) as needed.

Participating venues can choose from two male condoms (a regular-sized lubricated latex and a large-sized lubricated latex), the FC2 female condom, and personal lubricant packets. The condom order sheet provides detailed instructions for filling it out. Participating venues can place their orders by e-mailing the order sheet to CACOrders@cdph.ca.gov, or faxing it to (916) 449-5800. While there is no limit on how many times a venue can order per month, they are asked to place their orders on an "as-needed" basis.

Participating venues can also use the "This is a Condom Zone" signage (downloadable below) to encourage their clients to use condoms, if

they choose to be sexually active, and to contact their local health jurisdiction or CBO if they need information on HIV/AIDS/ STDs, or where to get tested for HIV and/or STDs.

["This is a Condom Zone" – English version](#)

["Esta es una Zona de Condonos" – Spanish version](#)

Since the condom distribution program is venue-based, condom orders should not be placed by an LHJ for distribution at a one-time event unless the event specifically targets one or more of the targeted populations (e.g. Gay Pride Festival, etc.).

OA prevention funds can't be used by an LHJ to purchase additional types of condoms or lubricant because the prevention budget already purchases them to be disseminated through this targeted condom distribution program. It's important to appreciate the intent of this CDC structural intervention, which is to recruit and expand the number of venues who provide free condoms in the locations and places the targeted populations routinely frequent. The program is not intended to provide for the diverse preferences for specific condoms for every individual, but rather to reduce condom stigma, encourage increased condom usage for those people who are having sex, and to encourage active partnerships between LHJs and their local venues should clients/patrons of those venues need HIV/AIDS/STD services.

Technical assistance contact: CACOrders@cdph.ca.gov

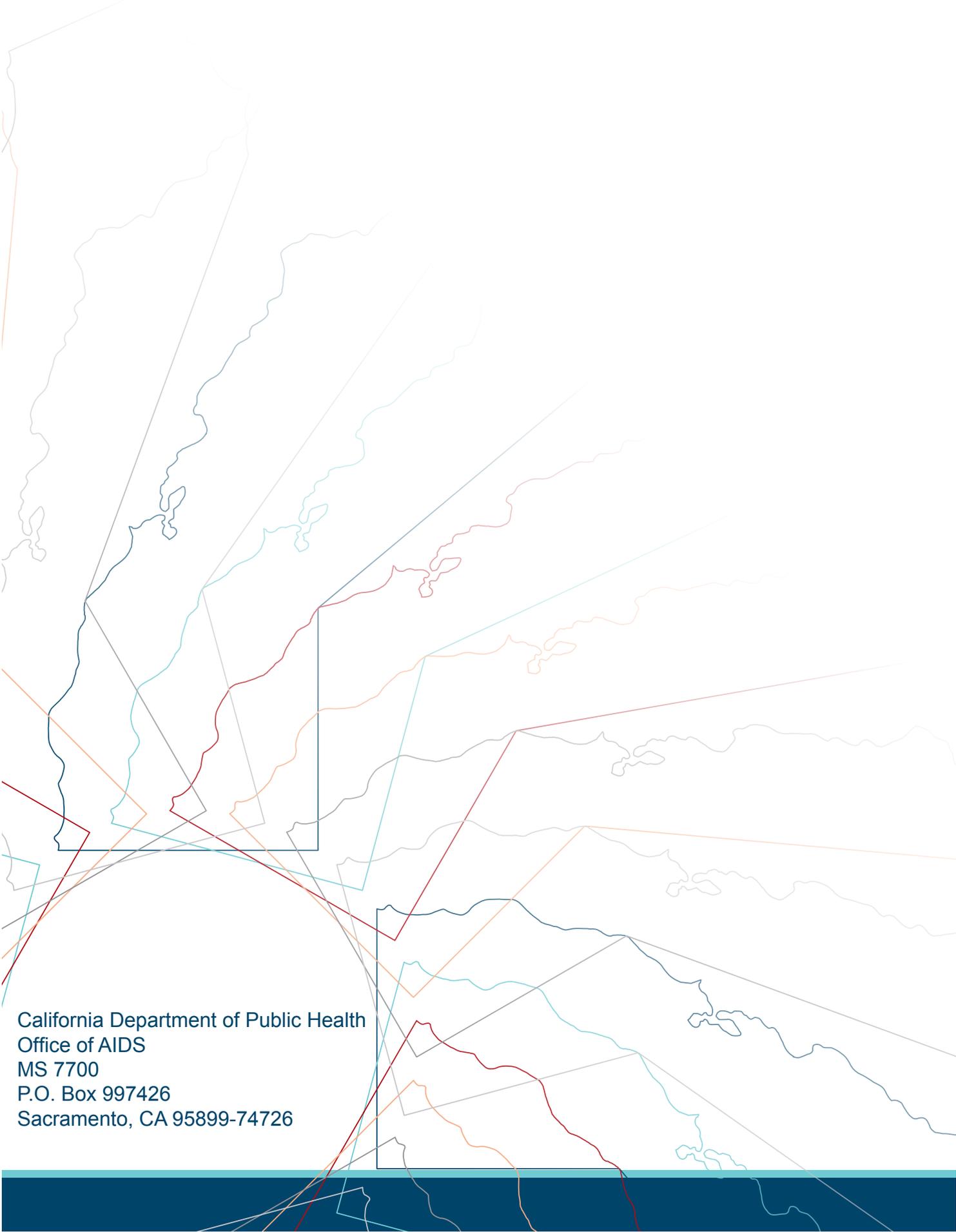
APPENDIX 12: Summary of Requirements

STRATEGY	CENTRAL APPROACHES	REQUIRED ACTIVITIES*	NON-FUNDABLE
<p><u>A: Improve PrEP Utilization</u></p>	<ul style="list-style-type: none"> • Provider engagement and education • Client navigation to PrEP/PEP 	<ul style="list-style-type: none"> • At least one activity supported through these CDC funds, other funding sources, or through the use of combining funding 	<ul style="list-style-type: none"> • Purchase or supplement cost of medications • New large-scale PrEP public education or media campaigns (see page 19 for more details on fundable social media and PrEP education activities)
<p><u>B: Increase and Improve HIV Testing</u></p>	<ul style="list-style-type: none"> • Routine, opt-out testing • Use of laboratory-based Fourth Generation HIV Testing Algorithms • Focused testing of priority populations 	<ul style="list-style-type: none"> • Collaborate to establish at least one new routine, opt-out testing site 	<ul style="list-style-type: none"> • Focused HIV testing locations that have not had any newly-identified confirmed positive results since January 1, 2016 • Medical care provider staff time related to routine opt-out testing • Costs associated with HIV testing in routine opt-out testing, including specimen collection or laboratory test processing, without prior discussion with OA • Purchase or upgrade electronic medical record systems • Prescription or over-the-counter medications • Orders for condoms intended for distribution at a one-time event unless the event specifically involves one or more of the priority populations (e.g. Gay Pride Festival, etc.). • Purchase additional types of condoms or lubrication for distribution

Summary of Requirements (continued)

STRATEGY	CENTRAL APPROACHES	REQUIRED ACTIVITIES*	NON-FUNDABLE
<p><u>C: Expand Partner Services</u></p>	<ul style="list-style-type: none"> Systems, procedures, and protocols to routinely share personally identifying information about individuals reported to be HIV positive with LHJ staff responsible for partner services activities Linkage of partners to care (if HIV positive) or PrEP (if HIV negative) 	<ul style="list-style-type: none"> Develop a Surveillance-Based Partner Services Program plan 	
<p><u>D: Improve Linkage to Care</u></p>	<ul style="list-style-type: none"> Systems and protocols for rapid linkage to care Patient/client navigation programs 	<ul style="list-style-type: none"> Establish a written protocol for a rapid linkage to care system (10 days or less) 	
<p><u>K: Increase and Improve HIV Prevention and Support Services for People Who Use Drugs</u></p>	<ul style="list-style-type: none"> Build capacity of SSPs to deliver comprehensive HIV prevention services for PWID Establish SSPs and/or expand non-prescription syringe sales in pharmacies 	<ul style="list-style-type: none"> LHJs with no authorized SSP must conduct a community capacity assessment to determine capacity for syringe access expansion LHJs with authorized SSPs provide ongoing capacity building to those SSPs to deliver comprehensive HIV prevention and other necessary services for PWID LHJs allocated \$170,000 or less develop or enhance collaboration with local SSPs LHJs requesting to opt out submit written justification to OA 	<ul style="list-style-type: none"> Purchase of needles or syringes (authorized California SSPs can obtain needles, syringes and other supplies from the California Syringe Exchange Supply Clearinghouse) Any activities designed to influence legislative change at the local, state, and federal level

* LHJs are required to have at least one activity associated with or related to each strategy in their work plan. Activities associated with each strategy may be supported through other funding sources or through the use of combining funding from other sources, e.g., utilizing Ryan White funding, or state general fund, or local funds.



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