Enhanced Integration: 2020 Guide to HIV Prevention and Surveillance

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OFFICE OF AIDS
California Department of Public Health

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Section I: General Overview/Executive Summary

Purpose

The purpose of this document, *Enhanced Integration: 2020 Guide to HIV Prevention and Surveillance* (2020 guidance), provides the California Department of Public Health (CDPH), Office of AIDS (OA) guidance to local health jurisdictions (LHJs) implementing the US Centers for Disease Control and Prevention (CDC) PS18-1802 funding opportunity, *Integrated HIV Surveillance and Prevention Funding for Local Health Departments*.

PS18-1802 began January 1, 2018 and ends December 31, 2022. The first year of the grant was designated as a transition year for prevention activities, dedicated to planning and preparing for changes. In 2019, OA's guidance, *Strengthening Our Foundation Through Integration: 2019 Guide to HIV Prevention and Surveillance*, aligned with the five core prevention strategies outlined in the *Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan* (GTZ Plan). This year's guidance builds on the 2019 guidance, and streamlines the core prevention strategies into three required prevention activities: strengthening disease investigation infrastructure, strengthening navigation services, and expanding access to syringe services. A summary of all required activities, unallowable activities, and recommended activities is found in Appendix B.

Rationale

Ultimately, our shared goals are: zero new human immunodeficiency virus (HIV) infections, zero HIV-related deaths, and zero stigma. Yet, as we review our progress, it becomes clear that if we continue to expend our HIV and sexually transmitted diseases (STD) prevention resources in the same ways, we will not achieve these goals.

To arrive at the required activities, we stepped back to envision what we would need to see in order to say "we've made it." From there, we envisioned what would be happening in the near future – "tomorrow" - that would indicate to us that we are on our way to zero. After defining the near future state, we asked what reality we need to see in the very near future - "today" - in order to get there. Figure 1 below describes this vision:

WE'VE MADE IT

- No new HIV infections
- No HIV-related deaths
- No stigma

Figure 1

TOMORROW

- Medical settings routinely test for HIV
- All new cases of HIV and STDs are swiftly investigated and linked to care
- Medical settings are accessible and welcoming to all, including people with histories of trauma
- All people living with HIV achieve viral suppression with medical homes where they are treated with dignity and respect

TODAY

- Robust DIS workforce that can appropriately prioritize and work HIV and STD cases
- Navigation services that link people to necessary services: medical care, health benefits, social support services
- Enhanced prevention services/programs for those people who are not served by mainstream Prevention and other health system services or a history of trauma/stigmatized treatment within those systems

Section II: What Does the Data Tell Us?

How do we know where we are on our path towards ending the HIV epidemic and reaching our vision of zero? Our HIV and STD surveillance data describe both where we are, and where we must focus our efforts

Where Are New Cases of HIV Being Diagnosed?

About 200 newly-identified confirmed positives are diagnosed in prevention funded focused testing (non-healthcare) settings each year, which represents about 4.5 percent of new HIV diagnoses statewide, and about 10 percent of new HIV diagnoses among prevention funded counties.

The majority of newly-identified confirmed positives are diagnosed in non-prevention funded settings including hospitals/medical centers and community health centers/ clinics. Among new HIV diagnoses in prevention funded counties for which a facility was listed, almost half were diagnosed in hospitals/medical centers. About 20 percent were diagnosed in community health centers/clinics, 8 percent at Planned Parenthood, 7 percent at counties/public health departments, and 4 percent were diagnosed at detention facilities.

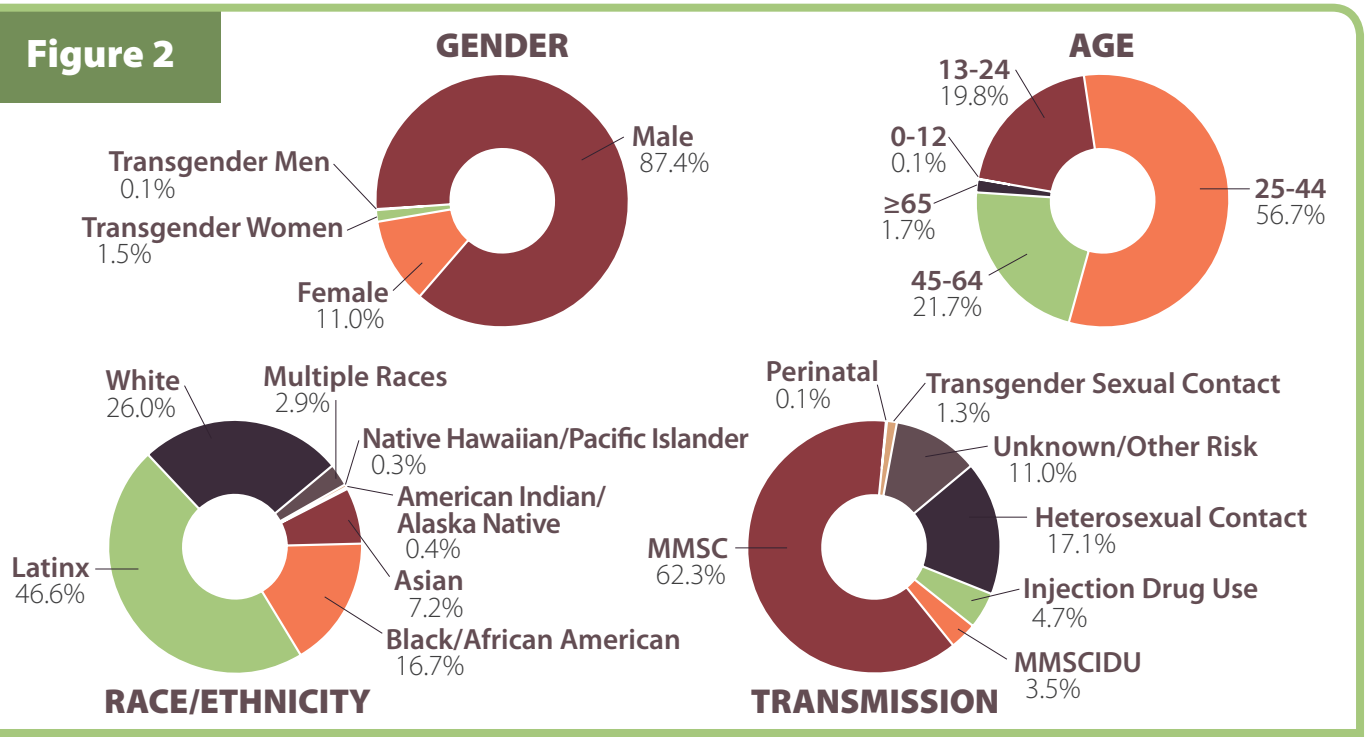
Prevention takeaway: Most people learn their HIV status in medical settings, not through focused testing.

Who is Being Diagnosed with HIV?

In 2017, there were 4,791 people newly diagnosed with HIV in California. Among new HIV diagnoses 87.4 percent were cisgender men, 11 percent were cisgender women, and 1.6 percent were transgender individuals.

More than 56 percent of new diagnoses were individuals between 25-44 years of age. Latinxs made up the largest racial/ethnic group among new HIV diagnoses, accounting for 47 percent of all new diagnoses. Transmission by male-to-male sexual contact (MMSC), including male-to-male sexual contact and injection drug use (MMSCIDU), accounted for 66 percent of new HIV diagnoses. See figure 2.

Figure 2



From 2010 through 2017, both the annual number and rate of new HIV diagnoses have declined in California. The number of new diagnoses declined by 10 percent from 5,321 in 2010 to 4,791 in 2017, while the rate of new diagnoses per 100,000 population declined by 15 percent, from 14.3 to 12.1 during the same time period. Although HIV has declined overall, certain populations continue to be disproportionately affected by HIV. See figure 3.

The majority of the HIV epidemic remains concentrated in gay men and other men who have sex with men (MSM). Almost 90 percent of new HIV diagnoses in 2017 were among cisgender men. Two-thirds (66 percent) of new HIV diagnoses were transmitted by MMSC, including 3.5 percent MMSCIDU. The subpopulations with the largest number of new diagnoses were Latinx MMSC (31 percent of all new diagnoses), followed by White MMSC (16 percent), and Black/African American (AA) MMSC (9 percent). See figure 4.

Figure 3 Number and Rate of New HIV Diagnoses by Year of Diagnosis in California, 2010-2017

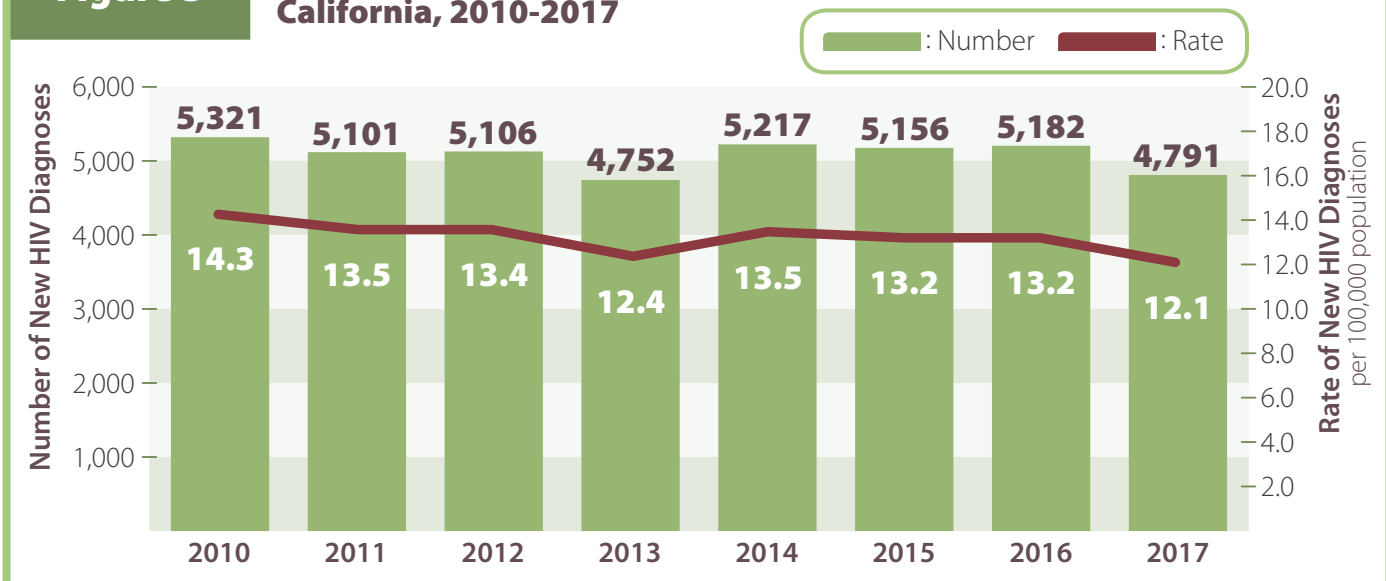
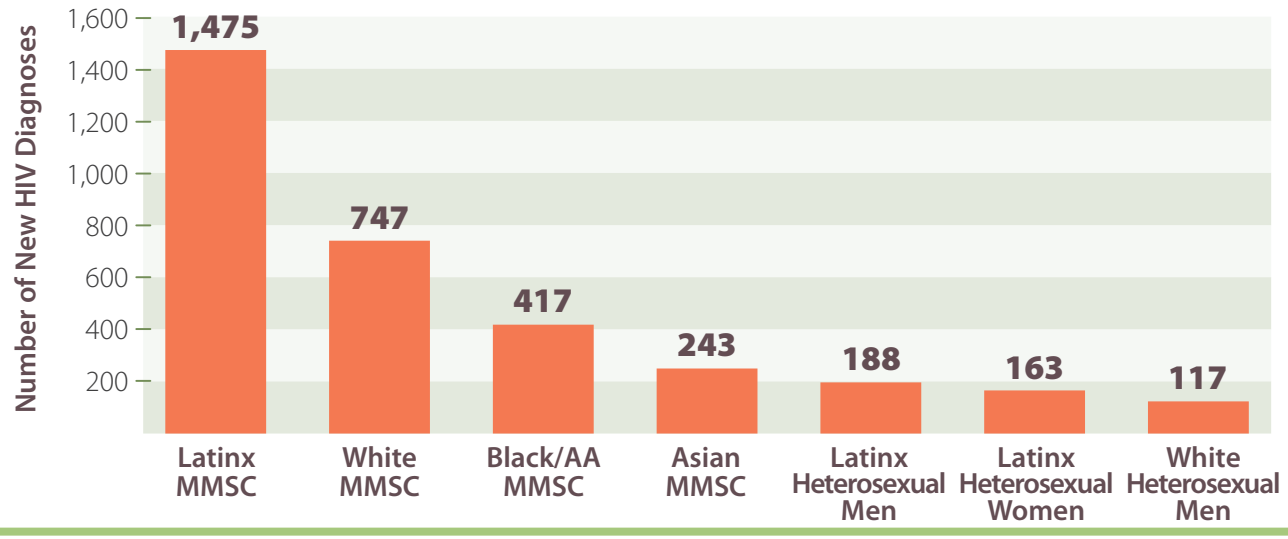


Figure 4 California Subpopulations with the Largest Numbers of New HIV Diagnoses by Race, Transmission Category, and Gender



Prevention takeaway: While total numbers of new diagnoses are slowly declining, HIV continues to be concentrated in gay men and other MSM. Latinx MSM make up the largest percentage of newly diagnosed MSM.

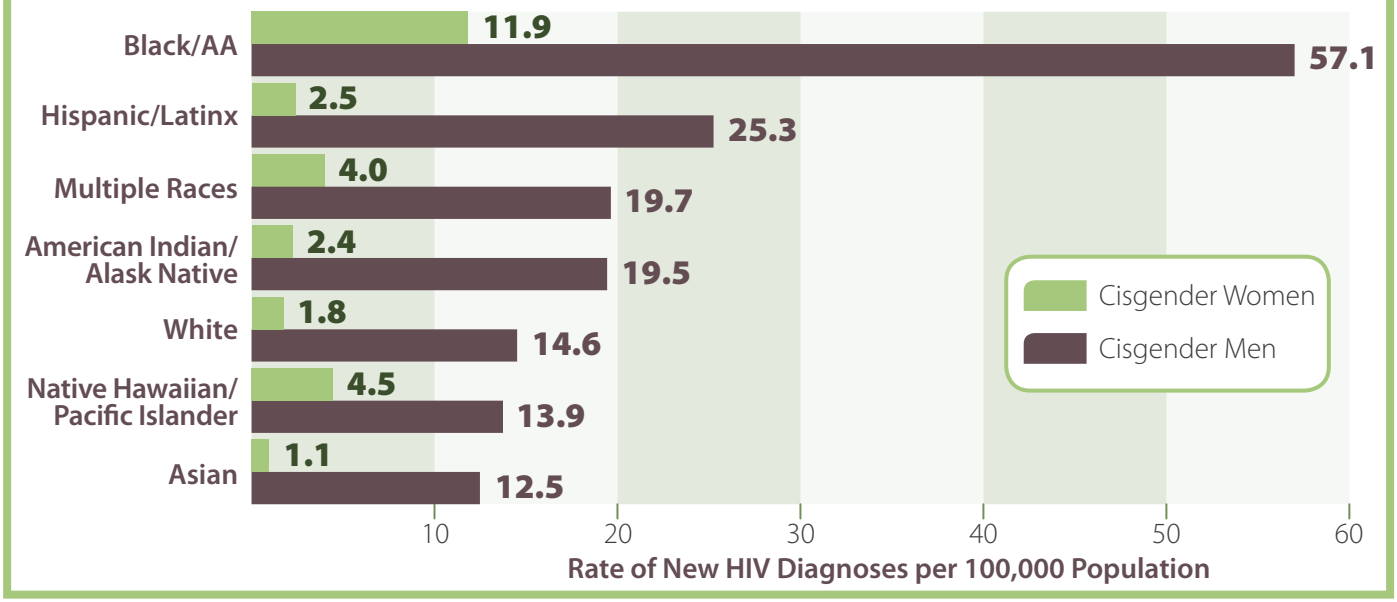
Black/AA are the most disproportionately affected by HIV in California, accounting for approximately 6 percent of California's population, but almost 17 percent of new HIV diagnoses. In 2017, the rate among Black/AA men was 3.9 times more than White men and for Black/AA women, 6.6 times more than White women. From 2010 to 2017, the annual number of new HIV diagnoses among Black/AA has decreased by 21 percent, while the rate of new diagnoses declined by 24 percent. Although rates of new HIV diagnoses for Black/AA have decreased, the disparity gaps remain large.

Latinxs are also disproportionately affected by HIV. In 2017, Latinxs made up about 40 percent of California's population and accounted for almost half of all new HIV diagnoses. The rate of new HIV diagnoses among Latinx men is 1.7 times more than White men and 1.4 times more among Latinx women compared to White women. From 2010 through 2017, the annual number and rate of new HIV diagnoses among Latinxs declined by 5 percent. However, among Latinxs 13-24 years of age the rate of new HIV diagnoses has increased by 5 percent since 2010, and among Latinxs 25-34 years of age by 11 percent. See figure 5.

Prevention takeaway: New HIV diagnoses among Black/AA, both cisgender men and women, are severely disproportionate. Cisgender Latinx men and women are also disproportionately diagnosed with HIV, when compared to Whites.

Although rates for transgender people are not available due to difficulty in estimating population denominators, evidence suggests that transgender people are disproportionately affected by HIV. According to an analysis conducted by CDC, HIV prevalence among transgender people in the U.S. is estimated to be 9.2 percent overall, and higher among transgender women (14.1 percent) than transgender men (3.2 percent). In California, 94 percent of transgender people who received an HIV diagnosis in 2017 were transgender women. Latinxs made up the largest racial/ethnic group among newly diagnosed transgender people (51 percent), followed by Black/ AA (29 percent), and Whites (9 percent).

Figure 5 **Rate of New Diagnoses by Race and Gender, California 2017**



Prevention takeaway: Latinx and Black/AA transgender women nationwide have the highest rates of new cases of HIV, and data suggests similar outcomes in California.

From 2010 to 2017, the rate of new HIV diagnoses among all age groups has declined, except for people 25-34 years of age. The 25-34 age group has the highest rate of new HIV diagnoses and has had an 8 percent rate increase since 2010. The 55 and older age group has had the largest rate decrease, 28 percent since 2010. See figure 6.

Prevention takeaway: The rate of new HIV diagnosis among people 25-34 years of age have increased since 2010. Rates have decreased among all other age groups.

Who is Being Diagnosed Late?

Among persons newly diagnosed with HIV in 2017, 22 percent were diagnosed with Stage 3 acquired immune deficiency syndrome (AIDS) within 12 months of their HIV diagnosis. California's Getting to Zero (GTZ) goal is to decrease the percentage of persons with new HIV diagnoses that are diagnosed with Stage 3 (AIDS) within 12 months of HIV diagnosis (i.e. late diagnosis) to less than 17 percent by 2021. Early HIV diagnosis is crucial as treatment is most effective when initiated before the disease progresses, and prompt treatment and viral suppression reduces the time period of infectiousness.

In 2017, cisgender women were more likely to have a late diagnosis (24 percent) compared to cisgender men (22 percent). By transmission category, heterosexual contact and injection drug use (IDU) had the highest percentage of late diagnosis at 28 percent. People 35 years of age and older were more likely to have a late diagnosis compared to younger age groups. The highest percentage of late diagnosis was 36 percent among people 55 years of age and older. Among all racial/ethnic groups, American Indian/Alaska Natives had the highest percentage of late diagnosis at 28 percent. Latinxs, Asians, and Native Hawaiian/Pacific Islanders also had above average percentages of late diagnosis ranging from 23 to 25 percent.

From 2010 to 2017, the percentage of late diagnoses has decreased substantially. Although Black/AAs and Whites had the same percentage of late diagnoses in 2010, Black/AAs have had a

Figure 6 **Rate of New HIV Diagnoses by Age and Year of Diagnosis in California, 2010-2017**

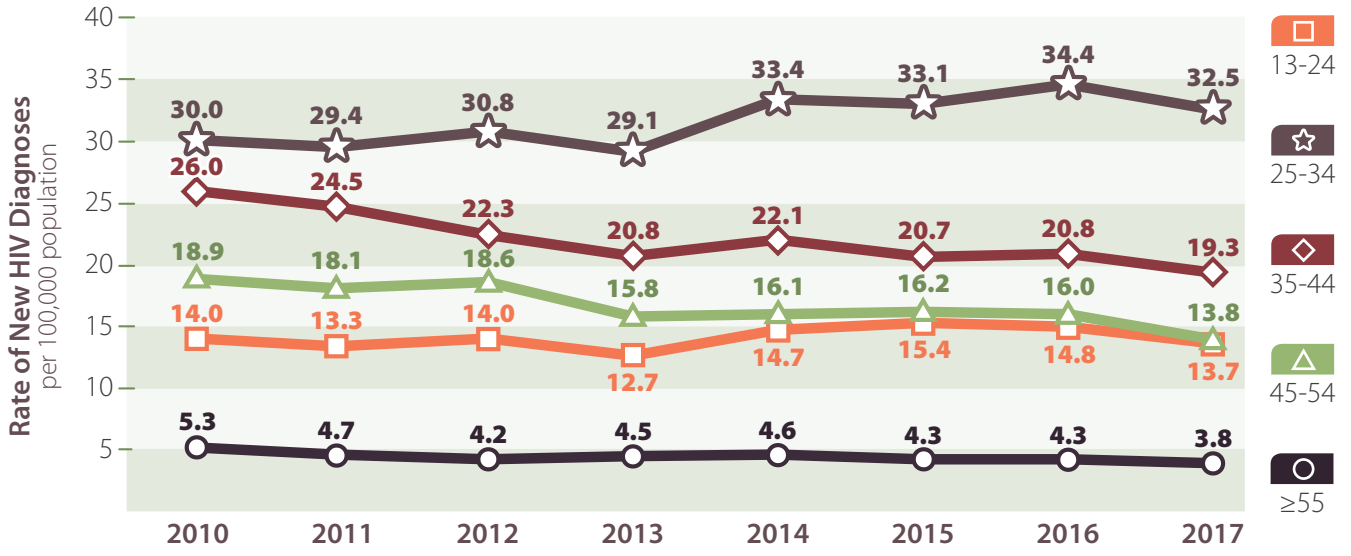
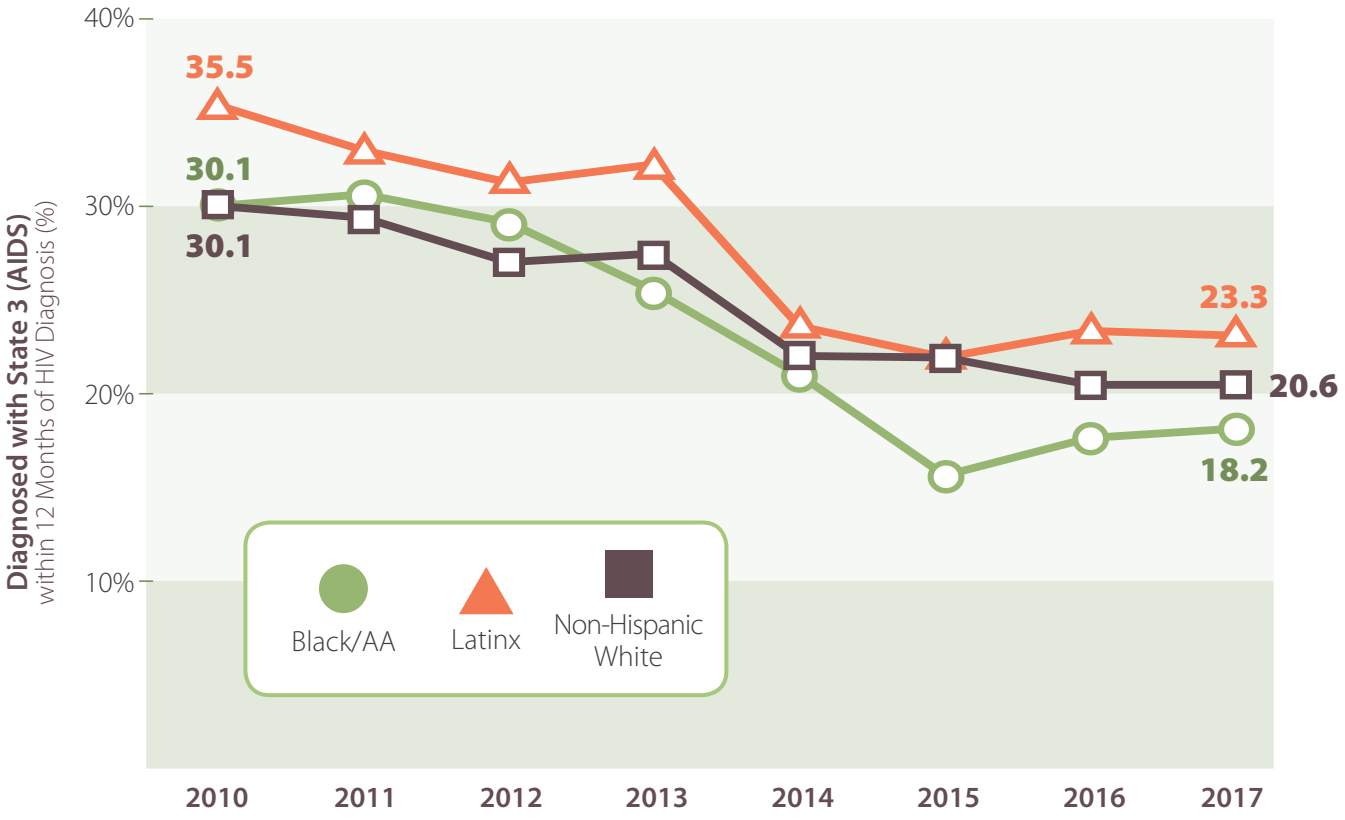


Figure 7 **Stage 3 (AIDS) Diagnoses within 12 Months of HIV Diagnosis by Race/Ethnicity in California, 2010-2017**



larger decrease in late diagnoses, a 40 percent decrease since 2010. Latinxs have had a 34 percent decrease since 2010 and have a higher percentage of late diagnosis compared to Whites and Black/AAs. See figure 7.

Prevention takeaway: The percentage of people newly diagnosed with HIV who were diagnosed with AIDS within 12 months of their HIV diagnoses has declined since 2010, most steeply among Black/AA. Cisgender women, heterosexual contact and IDU, people 35 years of age and older, and American Indian/Alaska Natives have some of the highest percentages of late diagnoses.

Continuum of HIV Care

Statewide in 2017, 76 percent of newly diagnosed cases were linked to care within one month of diagnosis, and 61 percent of newly diagnosed cases achieved viral suppression within 6 months. California's GTZ objectives for 2021 include linking 85 percent of newly diagnosed persons into care within one month of their HIV diagnosis and increasing the percentage who achieve viral suppression within 6 months to 75 percent.

In 2017, linkage to care (LTC) within 30 days of diagnosis was similar across transmission categories, but viral suppression varied widely. Overall, MMSC, heterosexual women, and transgender sexual contact (TGSC) transmission categories had the highest viral suppression rates. Although LTC within 30 days of diagnosis was high for MMSCIDU at 78.2 percent, only 54.7 percent achieved viral suppression within 6 months of diagnosis. A similar pattern was observed for both cisgender men and women who report IDU, with LTC percentages near the statewide average, but viral suppression much lower. For women reporting IDU, viral suppression was an alarmingly low 33 percent; further analysis revealed that

Latinx women had viral suppression of 4.5 percent, despite linkage to care of 63.6 percent. See figure 8.

Among all racial/ethnic groups, Native Hawaiians/ Pacific Islanders, Black/AAs, and Latinxs had the lowest viral suppression within six months of diagnosis at 50.0 percent, 54.6 percent, and 59.7 percent respectively. LTC within 30 days of diagnosis was high across racial/ethnic groups, with the exception of Black/AAs who had the lowest linkage at 68.5 percent. See figure 9.

HIV related health outcomes were similar across age groups, with the 13-24 age group having slightly worse HIV related health outcomes than other groups. People 55 years of age and older had the best HIV related health outcomes and

Figure 8

LTC in 30 Days and Viral Suppression in 6 Months from Diagnosis by Transmission Category, California 2017

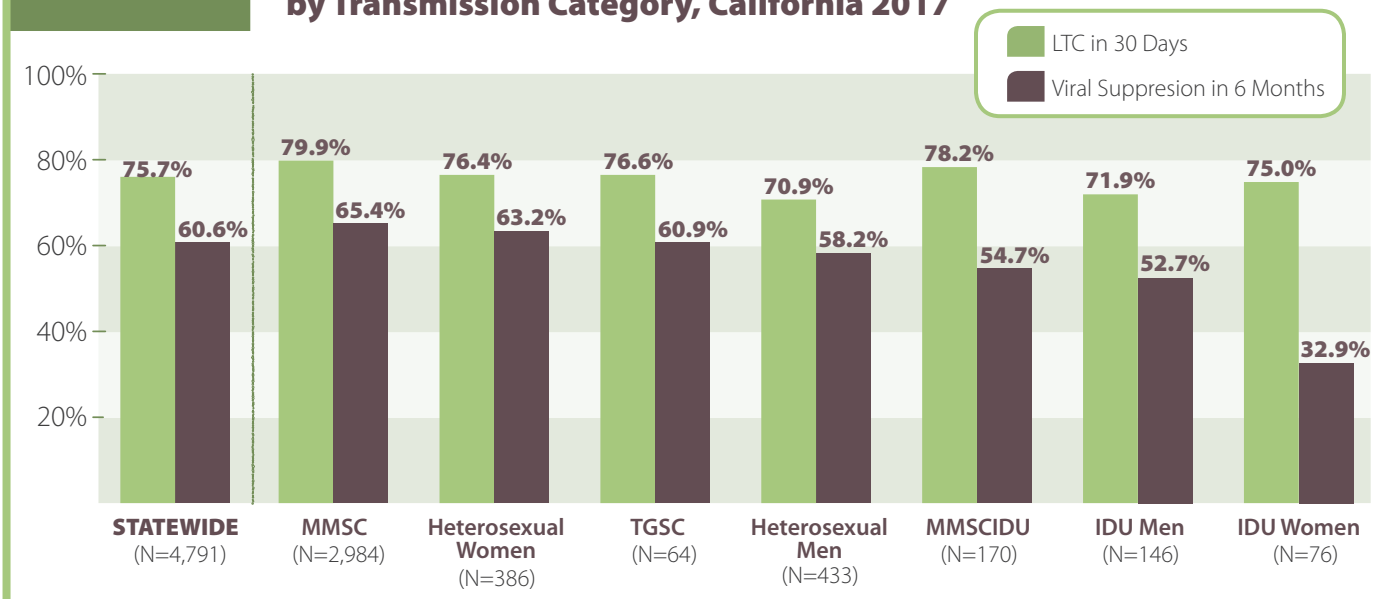
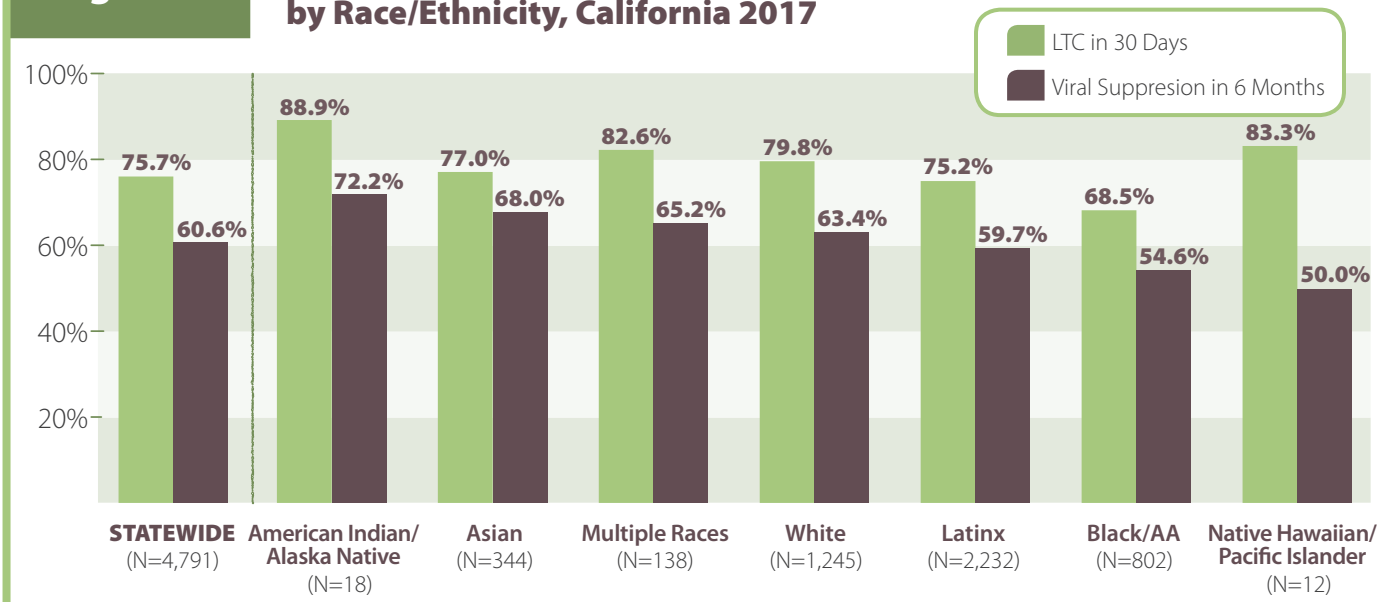


Figure 9

LTC in 30 Days and Viral Suppression in 6 Months from Diagnosis by Race/Ethnicity, California 2017



achieved 63.6 percent viral suppression within six months of diagnosis. See figure 10.

Cisgender men were more likely to be virally suppressed than cisgender women (61.1 percent versus 57.2 percent) within six months of diagnosis. Transgender women had the lowest linkage to care within 30 days of diagnosis and achieved the lowest viral suppression within six months of diagnosis. See figure 11.

Prevention takeaway: Gaps between LTC and viral suppression across all groups indicate that many people newly diagnosed with HIV are unable to stay in care and achieve viral suppression. Certain groups appear to face especially significant barriers to achieving viral suppression: cisgender men and women who inject drugs, Latinx women, Native Hawaiians/Pacific Islanders, Latinx, Black/AA, and transgender women.

Figure 10

LTC in 30 Days and Viral Suppression in 6 Months from Diagnosis by Age, California 2017

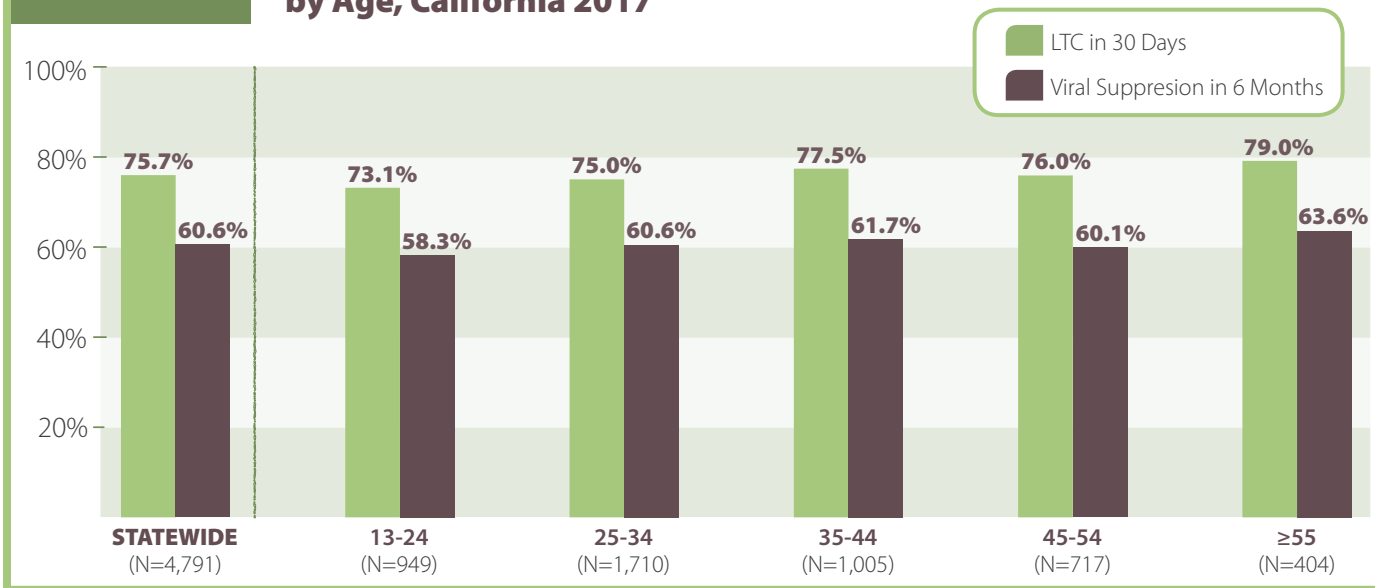
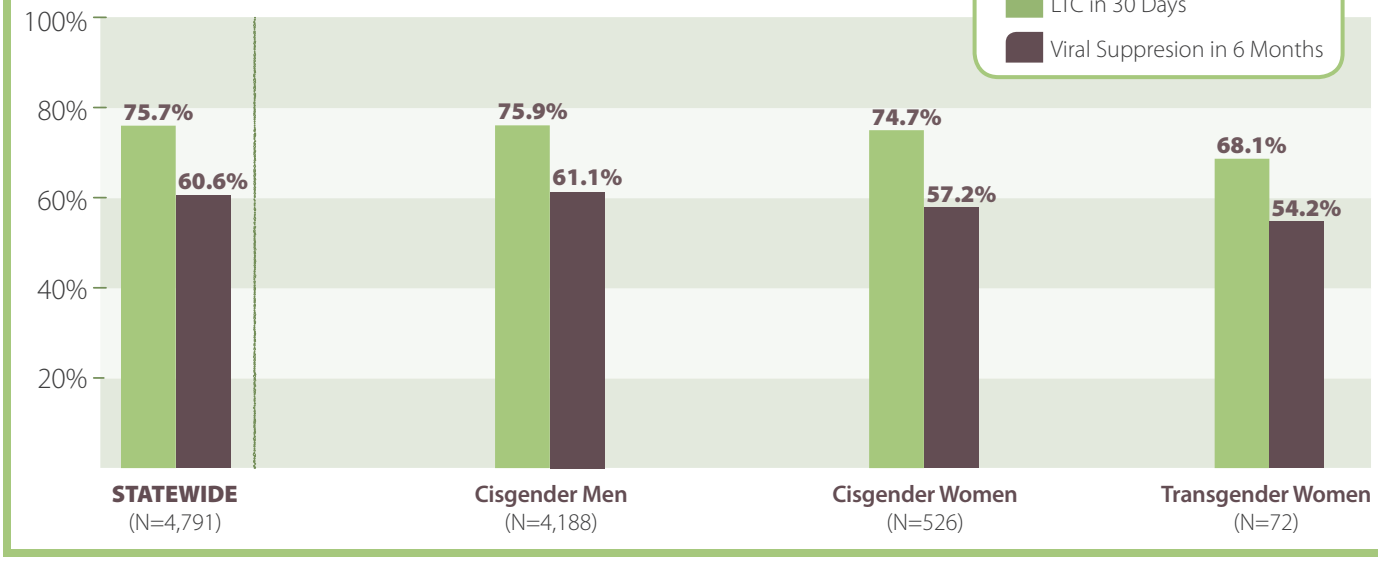


Figure 11

LTC in 30 Days and Viral Suppression in 6 Months from Diagnosis by Gender, California 2017



Who are Candidates for PrEP?

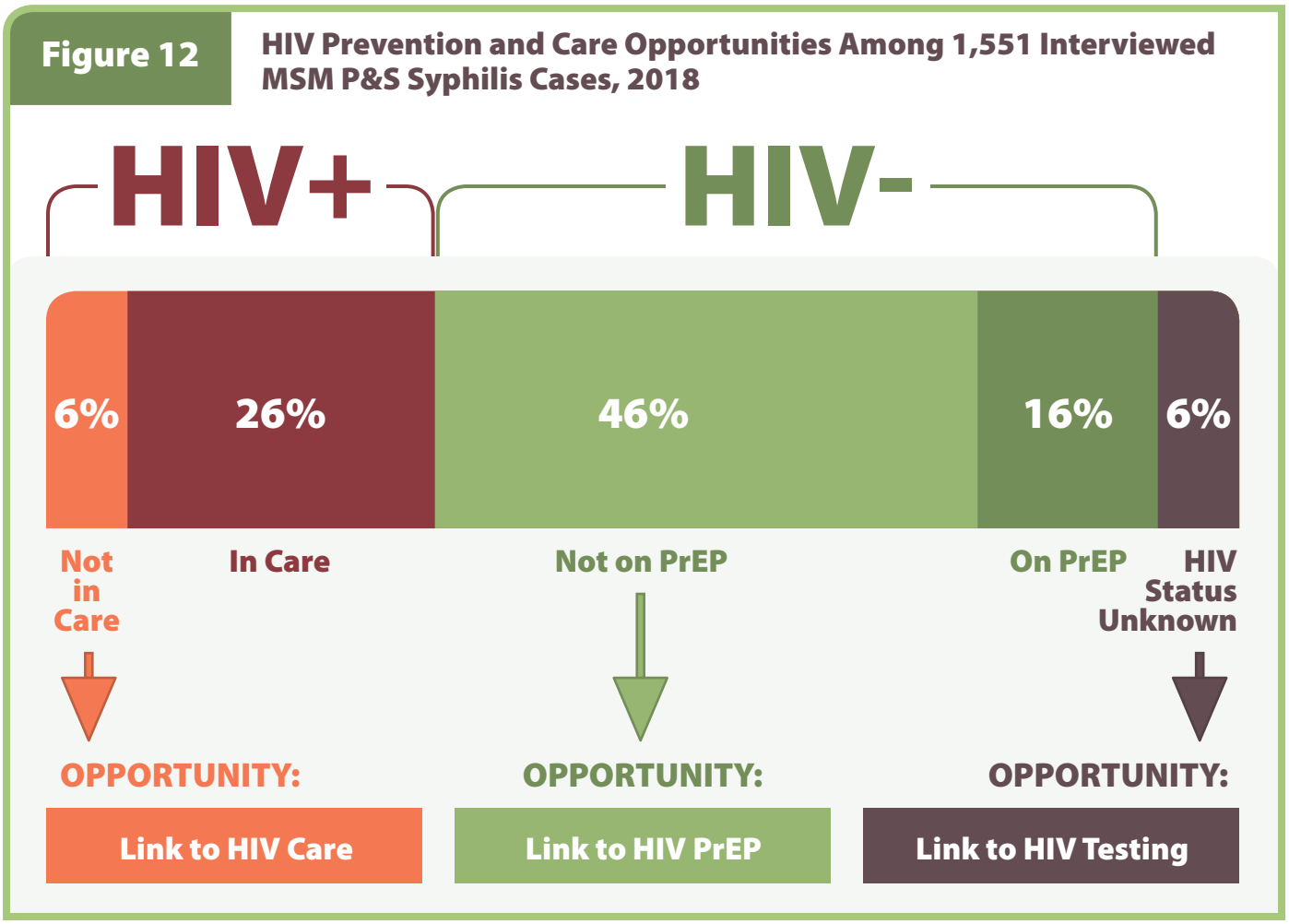
HIV diagnosis data, which show that Latinx MSM, Black/AA MSM, Black/AA cisgender women, and transgender women are diagnosed at higher numbers and disproportionate rates in California, indicate that individuals from these populations are candidates for Pre-Exposure Prophylaxis (PrEP).

California's STD surveillance data also illuminate candidates for PrEP. From 2014 through 2018, sexually transmitted bacterial infections have significantly increased in California. Both the annual number and rate of primary and secondary (P&S) syphilis have increased, especially among gay men and other MSM. The number of P&S syphilis cases increased by 98 percent from 3,853 in 2014 to 7,621 in 2018, while the rate of P&S syphilis per 100,000 population increased by 93 percent, from 9.9 to 19.1 during the same time period.

Gay men and other MSM who are HIV-negative and diagnosed with P&S syphilis are more likely to be diagnosed with HIV making them ideal candidates for PrEP. Among gay men and other MSM diagnosed with P&S syphilis and interviewed for partner services in 2018, almost half were HIV-negative and not on PrEP. This presents an opportunity to link a large proportion of HIV-negative gay men and other MSM to PrEP. In 2018 among those interviewed for partner services, there was an opportunity to link 74 percent of HIV-negative individuals to PrEP.

The proportion of HIV-negative gay men and other MSM P&S syphilis cases reporting PrEP use increased from 2016 to 2018 among all racial/ethnic groups. Among gay men and other MSM diagnosed with P&S syphilis and interviewed for partner services in 2018, Whites and Asians reported the highest PrEP use while Latinxs and

Figure 12 **HIV Prevention and Care Opportunities Among 1,551 Interviewed MSM P&S Syphilis Cases, 2018**



Blacks/AA reported the lowest at 19 percent and P&S 18 percent, respectively. See figure 13.

Gonorrhea is the second most commonly reported sexually transmitted bacterial infection in California after chlamydia, and continues to disproportionately impact gay men and other MSM. Although PrEP use may be higher among gay men and other MSM rectal cases, there is an opportunity to link those who are HIV-negative and not yet on PrEP. Among a subset of male rectal cases interviewed for partner services in 2018, there was an opportunity to link 32 percent to HIV PrEP.

Prevention takeaway: In addition to those populations with the highest numbers and rates of new HIV infection, including Black/AA and Latinx MSM, people who inject drugs (PWID), and transgender women, gay men and other MSM diagnosed with P&S syphilis and/or rectal gonorrhea are candidates for PrEP.

Figure 13 Trends in Reported PrEP Use by Race/Ethnicity Among HIV-/Unknown Interviewed MSM P&S Syphilis Cases, 2016-2018

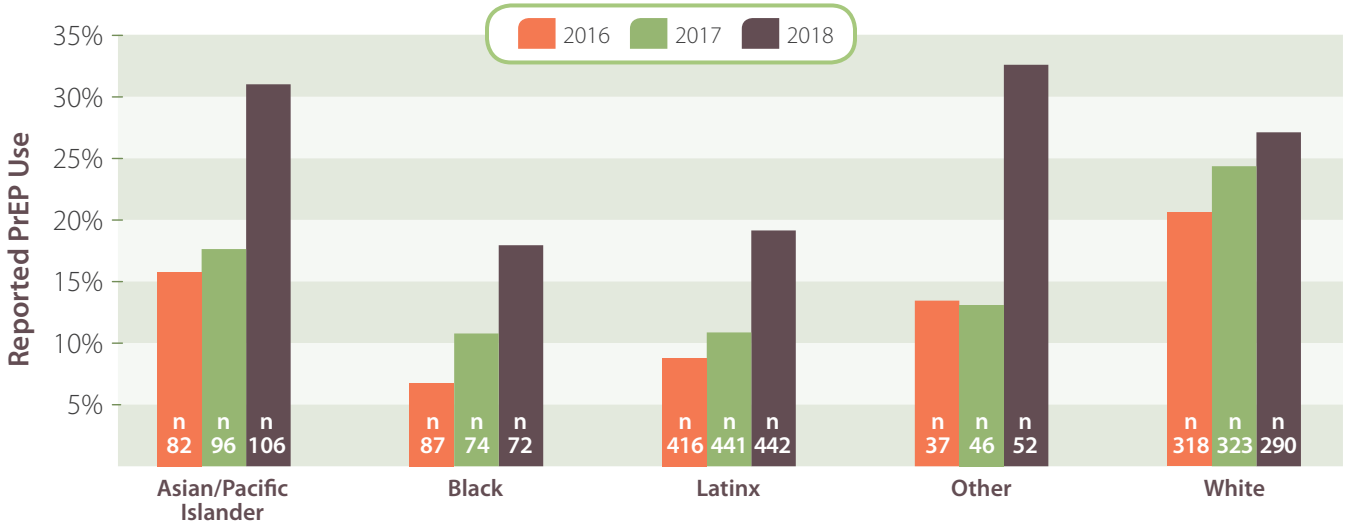
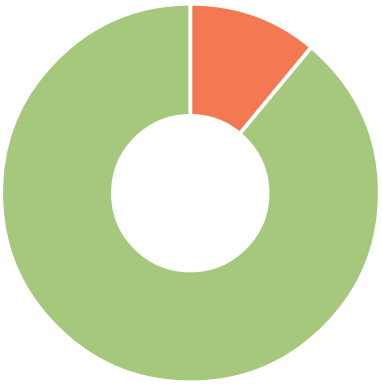
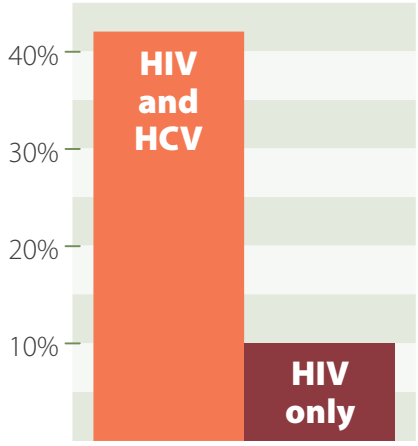


Figure 14 Shared Risk Behaviors: Hepatitis C Virus (HCV) and HIV



Of people in California with diagnosed HIV infection at the end of 2016, **11%** were known to be coinfected with HCV.



Injection drug use* was the most common risk factor among those with known HIV and HCV, reported by **42%** of persons with coinfection compared to **10%** of persons with HIV monoinfection at the end of 2016.

* MSM/IDU or IDU Use

Prevention takeaway: Preliminary data suggests about only half of people in care for HIV have been evaluated for HCV and linked to care; this is a missed opportunity for whole person care and for early identification and treatment of HCV among PLWH. Additionally, given the HIV and HCV coinfection among PWID, further opportunities for Hepatitis A and B vaccination can support PWID health.

Indications for Prevention

Taken together, California's HIV surveillance outcomes highlight that, while new cases of HIV are slowly declining, the slope is not steep enough to see a California with zero new infections, zero stigma, and zero HIV-related deaths on the horizon. In addition, getting to zero appears to be further away for Black/AA, Latinx, transgender, and PWID in California than for White, cisgender men.

Prevention Takeaways	Programmatic Indication
Most people learn their HIV status in medical settings, not through focused testing.	Shift resources previously allocated to focused testing towards navigating people to HIV testing in medical settings and PrEP. Bolster disease investigation infrastructure in order to ensure that all newly identified cases of HIV are investigated, provided partner services, and linked to care.
While total numbers of new diagnoses are slowly declining, HIV continues to be concentrated in gay men and other MSM. Latinx MSM make up the largest percentage of newly diagnosed MSM.	Prevention efforts must continue to prioritize gay men and other MSM, especially Latinx MSM.
New HIV diagnoses among Black/AA, both cisgender men and women, are severely disproportionate. Cisgender Latinx men and women are also disproportionately diagnosed with HIV, when compared to Whites.	Current prevention efforts are not sufficiently addressing the needs of Black/AA individuals and communities. Navigation services (to HIV testing, HIV care, and PrEP) should prioritize serving Black/AA and Latinx individuals.
Latinx and Black/AA transgender women nationwide have the highest rates of new cases of HIV, and data suggests similar outcomes in California.	Current prevention efforts are not sufficiently addressing the needs of transgender women. Navigation services (to HIV testing, HIV care, and PrEP) should prioritize transgender women, especially Black/AA and Latinx individuals.

Prevention Takeaways *(cont.)*	Programmatic Indication *(cont.)*
The rate of new HIV diagnosis among people 25-34 years of age have increased since 2010. Rates have decreased among all other age groups.	Current prevention efforts are not sufficiently addressing the needs of young people. Navigation services (to HIV testing, HIV care, and PrEP) should prioritize serving younger people.
The percentage of people newly diagnosed with HIV who were diagnosed with AIDS within 12 months of their HIV diagnoses has declined since 2010, most steeply among Black/AA. Cisgender women, heterosexual contact and IDU, people 35 years of age and older, and American Indian/Alaska Natives have some of the highest percentages of late diagnoses.	More people are being diagnosed earlier. This is a win! Resources should continue to be allocated towards routine testing of cisgender women, PWID, people over 35, and American Indian/Alaska Natives.
Gaps between linkage to care and viral suppression indicate that many people newly diagnosed with HIV are unable to stay in care and achieve viral suppression. Certain groups appear to face especially significant barriers to viral suppression: cisgender men and women who inject drugs, Latinx cisgender women, Native Hawaiian/Pacific Islanders, Latinx, Black/AA, transgender women, and youth.	All new cases of HIV require public health action, namely disease intervention activities, in order to ensure linkage to care. Disease investigation processes should link PLWH to navigation services that inquire about barriers to staying in care, and link to services that address those barriers.
Gay men and other MSM diagnosed with P&S syphilis and/or rectal gonorrhea are candidates for PrEP.	Status neutral public health action should include linkage to PrEP for MSM diagnosed with P&S syphilis and/or rectal gonorrhea. These individuals should be prioritized for PrEP Navigation services.
Preliminary data suggests about only half of people in care for HIV have been evaluated for HCV and linked to care; this is a missed opportunity for whole person care and for early identification and treatment of Hepatitis C among PLWH. Additionally, given the HIV and HCV coinfection among PWID, further opportunities for Hepatitis A and B vaccination can support PWID health.	Access to sterile syringes are key to preventing new cases of HIV and HCV. Disease investigation and navigation services should include HCV evaluation and linkage to care as part of their processes.

Section III: PS18-1802 Funding Requirements

Requirements for PS18-1802 funding are directed towards reaching our future state. The following section describes required and unallowable uses of PS18-1802 funds, which are also summarized in Appendix B. Additionally, LHJs should review and aim to adopt the approaches described in Appendix A across implementation of all HIV prevention activities.

#1. Strengthen Disease Investigation Infrastructure

Effective HIV prevention necessitates investment in the communicable disease investigation model for public health action. This model of surveillance-based work begins with receipt of laboratory or provider reports at the health department, which is then used to identify HIV/STD/HCV cases for public health follow up, including patient interview, partner elicitation and notification, linkage to HIV/STD/HCV care for both the patient and their partner(s), and case analysis. The disease investigation model incorporates proven HIV prevention interventions, including data to care, partner services, and HIV/STD integration.

LHJs funded under PS18-1802 must use funds to support and develop disease investigation infrastructure. As the nature of disease investigation requires the use of surveillance data, this work can only be carried out by local health department personnel and cannot be subcontracted.

Activity Goals:

- Increase number of HIV cases investigated
- Increase number of people who participate in HIV partner services among persons:
  - With newly diagnosed HIV infection
  - Reinvestigated for PS
- Increase number of partners elicited through HIV partner services interviews of index patients with:
  - With newly diagnosed HIV infection
  - Reinvestigated for PS
- Increase the percentage of index patients who provide names for partner services follow up
- Increased notification and HIV testing of partners identified through HIV partner services
- Increase the number of partners of clients who test positive for syphilis that are tested for HIV and referred or navigated to services (PrEP or HIV care)
- Increased notification and HIV testing of partners identified through syphilis partner services
- Increase the number of partners of PLWH who test negative for HIV referred to PrEP
- Increase the number of partners of clients who test positive for rectal gonorrhea/chlamydia that are tested for HIV and referred to services (PrEP or HIV care)
- Increase the percentage of newly diagnosed PLWH that are linked to HIV care
- Increase the percentage of previously diagnosed out-of-care PLWH re-linked to care
- Increase the percentage of PLWH retained in HIV medical care

- Increase HIV viral load suppression among PLWH
- Increase HIV viral load suppression among PLWH within 6 months

Allowable Costs:

Allowable costs for disease investigation infrastructure at the local health department include:

- Personnel, including:
  - Surveillance clerks
  - Communicable disease investigators(CDIs)/ Disease intervention specialists (DIS)/Disease Intervention Technicians (DITs) and other staff conducting surveillance-based disease investigation activities
  - DIS Supervisors/Frontline managers
  - Data entry staff
  - Other disease investigation support staff
    - No minimum requirement. OA and the Sexually Transmitted Disease Control Branch (STDCB) have conducted preliminary analyses that suggest a minimum number of DIS full-time employees (FTE) to provide surveillance-based partner services for HIV and syphilis cases. These estimates will be provided to individual LHJs upon request. LHJs should tailor their staffing plan to meet local needs and position classifications necessary to implement a robust surveillance-based HIV and syphilis partner services program.
- Investigative tools, including but not limited to:
  - LexisNexis Accurint® licenses
  - Equipment: computers, cell phones, tablets
  - Transportation: transportation vouchers, mileage reimbursement for DIS
- Training for DIS and other support staff, including but not limited to:
  - CDC's disease intervention training course(s)
  - Motivational interviewing
  - Cultural humility
  - Statewide meetings and associated travel and per diem
    - ***Minimum requirement: travel and per diem for at least one staff to attend the CDPH DIS summit. Ideally all LHJ disease investigation staff should attend the DIS Summit in 2020, in order to support consistency in training/capacity building.***

Prioritization of Disease Investigation Activities:

The intention of PS18-1802 is to support surveillance-based HIV disease investigation, including: timely linkage to care for persons with newly identified HIV; identification of sexual, needle sharing and social network partners who may be exposed or at risk for HIV in order to facilitate testing and linkage to care or PrEP; and return to care for PLWH who are not engaged in care or virally suppressed. The pathways to

facilitate these activities rely on the use of HIV and STD surveillance data to initiate public health action.

The emphasis of PS18-1802 funds should be to support LHJ activities specific to:

- **New HIV diagnosis, including, acute HIV and new HIV or AIDs diagnosis**
  - Public health follow-up should include:
    1) LTC, initiation of Anti-retroviral treatment (ART), and STD testing of the index client;
    2) Client interview to clarify disease information, assess risk, and facilitate elicitation/notification/confirmation of testing of sexual, needle sharing and social network partners—ensuring facilitating preventative treatment (e.g., PrEP, syphilis prophylaxis) or LTC as appropriate; and
    3) PWID, both index clients and partners, should receive testing for Hepatitis B & C and be offered Hepatitis A & B vaccine.
- **HIV prevention opportunities among persons diagnosed with new STD, specifically syphilis and rectal gonorrhea (GC)**
  - Public health follow-up should include:
    1) HIV testing and linkage to care or PrEP for persons diagnosed with early syphilis and rectal GC;
    2) PLWH diagnosed with syphilis or rectal GC, who are currently not engaged in care or are no longer virally suppressed should be linked to a health care provider;
    3) Client interview of early syphilis cases among MSM and transgender people in order to clarify disease information, assess risk, and facilitate elicitation/notification/confirmation of testing of sexual, needle sharing and social network partners—ensuring facilitating preventative treatment (e.g., PrEP, syphilis prophylaxis) or linkage to care as appropriate; and
    4) Index clients and partners who are PWID should receive testing for Hepatitis B & C and be offered Hepatitis A & B vaccine.
  - Special attention should be directed to syphilis cases among persons who are pregnant and female syphilis cases with risk factors such as methamphetamine use, PWID, homelessness, exchange of sex for drugs/money/housing/etc. in order to seize opportunities to prevent HIV (e.g., HIV testing and PrEP-as indicated) and prevent perinatal transmission (e.g., prompt initiation of ART, return to care).
- **Molecular Cluster Investigation and Outbreak Response**
  - For Molecular Cluster Investigation, public health follow-up should include:
    1) Prioritize cluster investigation where new HIV infection may suggest links to growing cluster; and
    2) Pursue additional client interview and sexual/needle sharing/social network investigation where prior public health efforts may not have been sufficient for clients identified in a molecular cluster.
  - For outbreak response, public health follow-up should include:
    1) Communication with OA surveillance/prevention designees if there is suspicion of outbreak,

cluster of HIV in a particular venue (e.g. homeless encampment), or unusual or sustained increase of HIV in a particular location (e.g. city/town) or population (e.g. young MSM);

2) Collaboration with CDPH in verification of increase or outbreak and creation of action plan; and
3) Mobilization of resources to support outbreak response action plan.

CDPH recognizes that many LHJs are faced with a large burden of HIV and STDs that need investigation and follow up, relative to local staffing resources. OA and STDCB are collaborating to develop a prioritization schematic to assist LHJs in triage and assignment of STD and HIV investigations for public health action.

Expectations of HIV/STD Disease Investigation:

Each LHJ has a unique local structure and may have different work flows and staff to support surveillance-based HIV disease investigation. That said, the core expectations of the communicable disease investigation model are as follows:

- **Intake and processing of laboratory tests and provider reports (e.g., confidential morbidity report (CMR)):**

  Conduct a record search for previous diagnosis (e.g., reported HIV tests are matched to Enhanced HIV/AIDS Reporting System (eHARs) by CDPH and those without a match—previous diagnosis are transmitted to LHJs for further investigation, syphilis history report is available in California Reportable Disease Information Exchange (CalREDIE) data distribution portal (DDP) to assess whether the report is from a new case or the result of follow-up tests). Once a determination of a new case is made for HIV or STD, an additional s record search should be conducted to confirm co-infection (e.g., new HIV diagnosis should include a record search in CalREDIE for confirmation of STD/HCV status [e.g., review of history and/or assessment of current infection]), and treatment, confirmation of HCV status, new diagnosis with syphilis should include a record search of local interventional surveillance access – Local Interventional Surveillance Access (LISA) to confirm HIV status and linkage to care.

- **Contact reporting medical provider(s) to verify information:**

  Disclosure of test result(s) to patient, clinical diagnosis, signs/symptoms, treatment initiated, linkage to HIV care, ascertain testing for potential co-morbidity (e.g. STD, Hepatitis B & C), hepatitis A & B vaccination, client demographic and locating information, emergency contact information, pregnancy status, gender of sex partners, additional clinical or risk information required for disease reporting, and needs identified or linkages facilitated to other supportive services.

- **Ensure linkage to HIV and STD care, other medical care and supportive services:**

  Clients diagnosed with HIV or STD without confirmation of linkage to care for HIV or appropriate STD treatment should receive public health assistance to facilitate linkage to or re-engagement in care. Confirmation of initial or return HIV care visit is an essential step in getting to zero. Local health department verification of syphilis treatment is a standard of care for all newly diagnosed syphilis cases. This is particularly important for females as an essential step in congenital syphilis prevention. And also important to prevent future complications from syphilis, such as neurosyphilis and ocular impairment. Clients should also be assessed for the need for other medical services

(e.g., STD testing for HIV positive persons, HIV testing for those with STD infection-linking to PrEP and PrEP AP if HIV negative, Hepatitis B & C testing for PWID, Hepatitis A & B vaccination for PWID, prenatal care for pregnant people) and appropriate linkage facilitated. Additional supportive services, such as transportation to treatment visits, housing, PrEP-AP, etc., may also be provided.

- **Interview index clients:**

  Provide education about the disease(s) diagnosis; obtain enhanced surveillance information-including risk factors, locations (e.g., homeless encampments, apps, websites, bars/clubs, hotels, etc.) where clients met partners or had sex, and other pertinent factors; elicit sexual and needle-sharing partners, and social network contacts who may be at increased risk of infection; linkage to care or other supportive services should be offered as appropriate.

- **Partner notification, evaluation and treatment:**

  Locate and notify partners of possible exposure to HIV/STD/HCV **and ensure referral to testing, treatment**, and other services as appropriate. Comprehensive "field investigation" should be conducted to locate and notify partners. LHJs should facilitate HIV, STD and HCV testing for sexual, needle sharing and social network partners. Field-based testing is encouraged for people who may have barriers to care. If tested in a medical setting, confirmation of testing and test results with the medical provider is essential. People who test positive with a new diagnosis should receive support from public health to ensure linkage to HIV, STD, and/or HCV care, as relevant. Sexual and needle sharing partners who test negative for HIV should be linked to PrEP and/or Post Exposure Prophylaxis (PEP), and partners of STD cases should receive prophylactic treatment (e.g., bicillin for syphilis, expedited partner therapy for chlamydia), per CDC recommendations. Infants exposed to HIV or syphilis, in-utero, who test negative at delivery, should receive preventative treatment and follow up testing, per CDC guidelines. PLWH who are currently not engaged in care should be linked to a health care provider. PWID should receive Hepatitis B & C testing and Hepatitis A & B vaccination.

- **Investigative tools:**

  A number of resources are available to provide additional demographic and locating information for index clients and their sexual, needle sharing and social network partners. These tools include but are not limited to: people search programs (e.g., LexisNexis Accurint®), the Department of Motor Vehicles database, local social services program databases. Additionally, the use of google street view can be helpful in discussion with clients who "know how to get to their partner's house" or "know the cross streets, but not the actual address".

- **Communication techniques:**

  Initial contact with clients may take place in person (e.g., clinical setting, health department setting or face to face in the field at their home or other location) or via phone. Email and text messages may also be used to initiate contact and are aimed to establish a phone or in-person discussion. Do not disclose disease-specific, confidential information via text as that may compromise confidentiality – communications should be framed as 'an urgent health matter.' Interviews of index clients and notification of potential exposure for sexual or needle sharing partners or encouragement for testing for social network partners potentially at risk for disease should be conducted in person or via phone, after verifying client identity and ensuring a confidential environment to discuss sensitive material. Tools for technology-based partner notification can be found at www.cdc.gov/std/program/ips/default.htm.

Where to Start?

OA recommends HIV prevention programs begin building upon their existing disease investigation infrastructure by:

- Assessing the surveillance and disease intervention systems in your local health department, looking for strengths and gaps for implementation of a surveillance-based HIV partner services program.
- Identifying the disease intervention infrastructure and other resources (e.g., LexisNexis Accurint®) that your health department has in place. The HIV Partner Services Plan template completed as a requirement of the 2019 fiscal year will provide a starting place for taking an inventory, which can then be built upon.
- Reviewing local epidemiology for newly diagnosed HIV, syphilis and other STDs. Consider prioritization recommendations, listed above, along with local priorities and workload(s) to develop a local prioritization scheme. Identifying gaps to build the program that you want and need. Consider the tools, technology, human resources, training and skills that are necessary to meet those needs, and establish a plan for achieving that.
- Engaging in capacity building activities (e.g., monthly CDPH local capacity building webinars; disease intervention mentorship for local staff).

#2. Expand and Provide Navigation Services

Navigation services link people to necessary services: medical care, health care benefits, and social support services. 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. This includes linking a person to the HIV care or prevention system and referral, linkage or assistance with insurance enrollment, transportation, and other supportive services that dismantle barriers to timely and consistent care and treatment.

Navigation program should 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.

LHJs funded under PS18-1802 must support and develop services that navigate:

- People newly diagnosed with HIV to HIV care and other services;
- People previously diagnosed with HIV and out of care to care and other services; and
- People vulnerable to HIV, particularly black/AA and Latinx MSM, young MSM, transgender women, Black/AA cisgender women, MSM with earl syphilis, and MSM with rectal gonorrhea, to PrEP.

Navigation services may be subcontracted, however LHJs should consider how people identified through surveillance data, both newly diagnosed and previously diagnosed out of care, will be effectively referred and linked to these services, as well as how subcontracted navigation programs will be integrated into disease intervention processes.

Activity Goals:

- Increase the percentage of newly diagnosed PLWH that are linked to HIV care
- Increase the percentage of previously diagnosed out-of-care PLWH re-linked to care
- Increase the percentage of PLWH retained in HIV medical care
- Increase HIV viral load suppression among PLWH
- Increase HIV viral load suppression among PLWH within 6 months
- Increase the number of newly identified PLWH that initiate ART within ≤ 5 days of HIV positive test event
- Increase the number of eligible patients who are referred to PrEP prescriber
- Of PrEP eligible clients assisted through 18-1802 funding, increase linkage to PrEP prescriber
- Of PrEP eligible clients assisted through 18-1802 funding, increase initiation of PrEP

Allowable Costs:

Allowable costs for navigation services include, but are not limited to:

- Personnel, including:
  - Navigators (position titles may vary by county)
  - Program managers
  - Program coordinators
  - Case managers, nurses, or social workers conducting strength-based case management
  - Support staff
- Training for navigators and other support staff, including but not limited to:
  - Cultural humility
  - AIDS Drug Assistance Program (ADAP), Covered CA, Medi-Cal enrollment
  - Statewide meetings and associated travel and per diem
- Navigation services subcontracts
- Incentives and enablers: vouchers, gift cards, transportation, and other small costs that encourage and allow PLWH to attend medical appointments and access other services

Expectations of Navigation Services Programs:

Although navigation services programs vary from LHJ to LHJ, depending on disease burden, the availability of services, demographics, and local need, the core expectations for these programs are as follows:

- **Navigation to health care providers**

  Navigation programs assist PLWH who are currently not engaged in care to link to a health care provider. Navigation programs should be designed to rapidly link people to care, whenever

possible. Rapid linkage to care is defined as linking a patient with HIV into care with an HIV provider within 10 days of HIV diagnosis to begin antiretroviral therapy (ART) immediately in order to achieve viral suppression as quickly as possible.

Programs navigating people to PEP and PrEP should link those seeking PrEP to a prescribing provider and determine eligibility for the CDPH PrEP Assistance Program. 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 offered whenever possible.

- **Navigation to health care benefits**

  Navigation programs include benefits navigation, both for PLWH and people vulnerable to HIV. Successful benefits navigation programs help individuals understand their health insurance enrollment options, link people to health care insurance and/or provide assistance with completing health insurance enrollment applications. Link to and assist with enrollment in Medi-Cal and Medicare plans, and Covered California. Successful programs will also assist individuals with determining eligibility for and enrolling in one of the CDPH OA Health Insurance Premium Payment Assistance programs (OA-HIPP), if possible. Navigations should also link all eligible individuals to Ryan White Services.

- **Navigation to drug assistance programs**

  In addition to navigating to overall health care benefits, navigation programs link individuals to third-party payers for medication, including ADAP, PrEP-AP and drug manufacturer patient assistance programs. See Appendix C for ADAP programs and eligibility requirements.

- **Navigation to supportive services**

  Barriers to accessing and remaining in care, both for HIV care and PrEP, are often unrelated to medical care itself. Navigation programs link individuals to essential support services available in the LHJ: social services, housing assistance, food assistance, substance use disorder treatment, harm reduction and other available services that meet basic needs.

Navigating the Navigators

PleasePrEPMe.org (PPM) provides online resources and support for PrEP implementation in California. In addition to the searchable PrEP provider directory, PPM can support LHJs & their partners with PrEP implementation via:

- Online chat navigation services in English and Spanish. Chat is answered live M-F 9 a.m.—5 p.m. with an offline message option during other hours. Chat primarily serves potential PrEP users and frontline & navigation staff seeking support for resources or complicated cases.
- Support for how to pay for PrEP, including the CA PrEP-AP.
- Links to PrEP implementation resources on the California webpage.
- Information on PrEP, PEP, U=U for potential PrEP users.
- PrEP Navigation Manual in English & Spanish—this is a living document, sign up to be notified for updates.
- Online PrEP Navigation Training – 8 self-paced modules

LHJs and their partners are encouraged to link or refer to PPM resources.
Questions or queries: contact@pleaseprepme.org

please PrEPme .org

Where to Start?

OA recommends HIV prevention programs begin expanding upon their existing navigation services by:

- **Hiring, reassigning, and training staff**
  - Careful selection of navigators - hire or reassign staff who have professional experience in service navigation (prior experience with local health care system and social service providers) and know the geographical and/or racial/ethnic community they will be serving.
- **Develop protocols for recruitment and initial contact**
  - Share information about navigation services with clients;
  - Assess eligibility for assistance programs (ADAP, PrEP-AP, OA-HIPP);
  - Assess eligibility for Ryan White Services; and
  - Assess readiness to engage in navigation services.
- **Strengthen relationships and linkage resources**
  - Establish professional relationships with outside sources;
  - Maintain easy to access inventory of resources; and
  - Gain support from medical personnel (involve medical personnel in project planning; find a physician "champion").
- **Ensure that staff provide supportive and client-focused navigation services that can**
  - Easily identify and address knowledge gaps and barriers to care, support the client to be engaged in care, elicit and understand clients' questions and concerns regarding treatment, and successfully develop individualized adherence and support plans (such as motivational interviewing);
  - Identify client barriers beginning at intake – client intake forms should identify many possible barriers (transportation, employment, financial, health insurance, child care, unstable housing); and
  - Be tailored to meet the needs of those who have a history of experiencing trauma/and or stigma within social support systems, starting with cultural humility and trauma informed care trainings for staff.
- **Develop guidelines for intensive client follow up after initial visit**
  - 6 – 12 month client – navigator engagement
- **Develop performance and success measures (client outcome data)**
  - Data should show linkage to and retention in care, treatment adherence, and health status.

#3. Expand Access to Syringe Services for People who Inject Drugs

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). 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.

In 2017, 6.9 percent of cumulative HIV infections in California were among people who report injection drug use as a risk factor. Nationally, outbreaks of HIV and HCV in Massachusetts, Seattle, Indiana and elsewhere underscore the importance of access to prevention services for PWID, "even in [areas]…with shrinking HIV epidemics."[1] In California, the CDPH Office of Viral Hepatitis Prevention has documented an alarming increase in the cases of chronic HCV among people aged 15-29, likely due to increases in injection drug use among young people. PWID have limited access to medical and social services: one study of syringe exchange participants found that 76% of SSP participants received all of their preventive services from the SSP, making the SSP their sole contact with the health care system.[2]

Activity Goals:

- Increase the number of SSPs operating in the LHJ
- Increase funding available to SSPs operating in the LHJ
- Increase the number of pharmacies that sell syringes without prescriptions

Guidance:

LHJs funded under PS18-1802 must:

- Fund SSPs, or support the development of new SSPs, if none exist within the jurisdiction; and
- Expand non-prescription syringe sales in pharmacies.

LHJs' responsibilities depend on their PS18-1802 funding level, in recognition of the fact that many LHJs in the California Project Area (CPA) are funded at a baseline level that precludes subcontracting of any of their HIV prevention-related services. However, any LHJ that wishes to subcontract to conduct any of the activities listed below may do so.

- **LHJs funded at more than $350,000 with SSPs** must strengthen the capacity of SSPs to deliver comprehensive HIV prevention and other necessary services for PWID by funding them to do so.
- **LHJs funded at more than $350,000 with No Authorized SSP** must develop a plan and timeline for establishing an SSP in the jurisdiction
- **LHJs funded at $350,000 or less** may fund their SSP, if they have one, or work to increase the number of pharmacies that sell syringes without a prescription. Work to improve NPSS must include baseline measures (how many pharmacies currently offer the service), target numbers (what percentage increase will the LHJ seek) and how they will alert PWID where NPSS is available.

Activity Opt-Out Requirements

LHJs that do not plan to use their PS18-1802 allocations to support all three required activities, as demonstrated in both their work plan and budget, must submit a signed letter from the LHJ Public

[1] Golden MR, Lechtenberg R, Glick SN, et al. Outbreak of Human Immunodeficiency Virus Infection Among Heterosexual Persons Who Are Living Homeless and Inject Drugs — Seattle, Washington, 2018. MMWR Morb Mortal Wkly Rep 2019;68:344–349. DOI: http://dx.doi.org/10.15585/mmwr.mm6815a2.

[2] Heinzerling KG, Kral AH, Flynn NM, et al. Unmet need for recommended preventive health services among clients of California syringe exchange programs: Implications for quality improvement. Drug and Alcohol Dependence 2006;81:167-178. DOI: https://doi.org/10.1016/j.drugalcdep.2005.06.008.

Health Director or Local Health Officer. The letter must explain why the activity cannot be conducted based on need, resource constraints, and/or policy restrictions. Local epidemiological data, references to specific policy restrictions, and budget information, must be provided to support the justification. This justification will be due by **March 30, 2020**.

Upon review of the justification, OA will work with the LHJ to determine next steps. For example, next steps may include, redirecting a portion of the LHJ's grant to another eligible entity in order to fund the SSP activities and meet the PS18-1802 deliverables for the jurisdiction. If funding is redirected, the amount of the funding reduction to the LHJ would be based on proportion of injection drug-use related HIV infection in the jurisdiction, and would be reviewed and approved by the OA Division Chief. Any such redirection in funding would be designed to serve PWID, and would serve PWID within the jurisdiction.

Section IV: Recommended Activities

The three required components of PS18-1802-funded HIV prevention programs may be complemented by other proven prevention activities. OA recommends and approves the following activities, **given that the three required activities are implemented.**

Health Care Provider Engagement

Provider Detailing:

PS18-1802 funds may support LHJ coordination of having trained Infectious Disease/Specialty Providers visit medical practice sites (HIV or non-HIV) to meet with providers and site staff members, to encourage changes in clinical practice, policy and/or behavior. Provider detailing can focus on, but is not limited to, comprehensive sexual health, Routine Opt-Out Testing (ROOT), and PrEP/PEP.

Activity Goals:

- Increase the number of providers engaged by LHJs though education, provider detailing, or training that apply engagement subject (i.e. if the detailing is PrEP prescribing, did the detailing cause the provider to start prescribing PrEP?)

Grand Rounds and Provider Education:

LHJs may use funds to coordinate medical education in order to help HIV or non-HIV providers and other healthcare professionals and staff to keep up to date in important evolving areas regarding HIV/STD prevention, care and treatment.

Learning Collaborative:

LHJs may support learning collaborative that are used to engage groups, partners, providers and navigators working toward the same goal to learn from and assist one another during implementation or improvement of programmatic activities within or outside your jurisdiction.

Conduct HIV Testing

Activity Goals:

- Increase number of sites conducting ROOT for HIV
- Increase the number of sites that conduct ROOT for HIV and syphilis
- Increased number of persons living with HIV infection who are aware of their HIV status
- Increase the number of PS18-1802-funded HIV tests administered to people from priority populations
- Increase the number of persons with newly diagnosed HIV infection identified through PS18-1802-funded testing
- Increase the number of newly identified PLWH identified through PS18-1802-funded testing that are linked to medical care
- Increase the number of persons with newly diagnosed HIV infection identified throughout 18-1802 linked to HIV medical care within ≤ 5 days of HIV positive test event
- Increase the number of persons with newly diagnosed HIV infection identified throughout 18-1802 linked to HIV medical care within ≤ 14 days of HIV positive test event
- Increase the number of persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing linked to HIV medical care within ≤ 30 days of HIV positive test event
- Increase HIV viral load suppression among PLWH who are engaged through 18-1802 focused testing
- Increase HIV viral load suppression among PLWH who are engaged through 18-1802 focused testing within ≤ 6 months of HIV positive test event
- Increase the number of newly identified PLWH engaged through 18-1802 focused testing that initiate ART within ≤ 5 days of HIV positive test event

Focused Testing:

Focused testing, previously referred to as targeted testing, best serves individuals who face barriers in accessing testing in medical settings. **LHJs that choose to fund focused testing must meet the following requirements:**

- Funded testing sites must have identified at least one newly identified confirmed positive (NICP) since January 1, 2018
- Test counselors must have passed an OA-approved test counselor training. Information on OA's Basic Counselor Skills Training (BCST) is found in **Appendix D**.

- Subcontractors conducting focused testing must have and follow linkage to care protocols and protocols for partner services

- Focused testing data must be collected and entered into the Local Evaluation Online (LEO) system

- LHJs and their subcontractors must interview index clients and elicit partner information, and subcontractors must develop mechanisms for sharing partner names with LHJ staff. This is particularly advantageous when community based organizations (CBOs) have a long-term relationship with a client in case management or care navigation, and discussion of the benefits of notification for sexual and needle sharing partners has become part of a menu of items discussed as part of comprehensive case management. Subcontractors conducting focused testing must also inform clients with a positive test result that they will be contacted by a county health department staff, who will verify that they are in care and work with them to ensure they are accessing any other needed services. When partner information is elicited by CBO staff, partner demographic and locating information must be shared with the LHJ to initiate partner notification and linkage to testing and care. LHJs must establish communication systems with CBOs doing partner elicitation to ensure that these activities are complimentary and not redundant to surveillance-based partner services activities, to prevent duplicative contact by the health department and CBO staff.

- PS18-1802 funds may **NOT** be used to purchase HIV or HCV test kits. Information on how to order HIV or HCV test kits is found in **Appendix G**.

Additionally, OA recommends that LHJs review data to understand where focused testing is successful and which demographics are accessing focused testing in their jurisdiction. PS18-1802 funds may be used to support staff time and processes for reviewing HIV surveillance data to understand where NICPs are being tested. The OA LEO data system should be used to generate testing reports to better understand who is accessing current focused testing sites, and whether sites are reaching individuals and communities most in need of focused testing services. 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 identify sites that maximize resources (staffing, time, and materials) to identify newly diagnosed HIV-positive individuals, and to track linkage to care rates.

Routine Opt-Out Testing:

Expanding the number of medical settings that conduct routine, opt-out testing (ROOT) may be supported with PS18-1802 funding. Support may take two forms:

- **Facilitating the Introduction or Expansion of ROOT**

  LHJ staff may work with hospitals, primary care providers, jails, and other settings that routinely provide medical services within the county, to introduce or expand ROOT. OA encourages LHJs to review surveillance data to identify locations that diagnose HIV and STIs, in order to focus ROOT efforts. In this context, support for ROOT takes the form of conversations between LHJ staff and facility staff to develop ROOT testing protocols and procedures. CBA support is also available to help LHJ efforts to expand the number of locations that routinely test for HIV, HCV, and STIs in their jurisdiction. LHJs are not required to submit ROOT data for this activity.

- **ROOT at County Clinics**

  LHJs using PS18-1802 to support HIV prevention activities in categorical STD clinics, county clinics, or subcontracting to clinics to provide HIV prevention medical services, should routinely screen patients for HIV per CDC guidelines. Clinics supported in any way with PS18-1802 funds (staff salaries, laboratory test processing, materials and supplies, outreach activities) must:

  - Screen for HIV and syphilis if a blood draw is performed. All patients tested for syphilis must also be tested for HIV, and vice versa; and
  - Submit ROOT data for any facilities receiving PS18-1802 funding.

Linkage to Care Coordinator

LHJs may fund or assign a linkage to care coordinator to facilities, such as emergency departments, conducting routine, opt-out testing to assist with linking people diagnosed with HIV or STIs to care.

Condom Distribution

LHJs and subcontracted agencies may partner with venues (e.g., CBOs, community health centers/clinics, Lesbian, Gay, Bi-sexual, and transgender [LGBT] centers, bars, dance clubs, sex clubs, bathhouses, barber shops/hair salons, etc.) to distribute free condoms to clients/patrons. Each OA-funded LHJ should use local knowledge and local surveillance data to identify and recruit venues in their jurisdiction that specifically serve one or more of the below-mentioned populations[3] (which 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 F**.

In alignment with the National HIV/AIDS Strategy, the CDPH condom distribution program targets HIV-positive people and those people California data show to be most vulnerable for acquiring HIV infection. Those people are:

- Partners of people living with HIV (PLWH);
- Transgender individuals with an emphasis on African Americans/Blacks and Hispanics/Latinos/as;
- Gay men and MSM with an emphasis on AA/Blacks and Latinx;
- PWID;
- Sexual and needle-sharing partners of gay men, MSM and PWID; and
- Women at risk for HIV via their sexual partners (who are in one or more of the above-mentioned populations), injection drug use and/or commercial sex work.

Venues that specifically serve one or more of these populations are eligible to participate in the program by providing free condoms to their clientele.

[3] Please note that youth are not considered at high-risk for HIV infection unless they specifically fall into one or more of the above-mentioned key 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).

Strengthen Community Engagement

Activity Goals:

- Increased linkage to PrEP prescriber by persons from priority populations engaged through 18-1802 and for whom PrEP is indicated
- Increased initiation of PrEP by persons from priority populations engaged through 18-1802 and who are eligible for PrEP
- Increase the percentage of newly diagnosed PLWH from priority populations that are linked to HIV care
- Increase the percentage of previously diagnosed out of care PLWH from priority populations re-linked to care
- Increase the percentage of PLWH from priority populations retained in HIV medical care

Conduct Community Assessment:

LHJs may conduct a community assessment to better understand the needs of their priority populations in order to create a strategic plan to reduce disparities among those most vulnerable to HIV.

Stigma and Discrimination:

LHJs may support stigma and discrimination reducing activities that focus on:

- How to collect data around stigma to strategically map out and address change;
- Identifying relevant stakeholders;
- Planning and hosting stigma conversations. For additional information on facilitating stigma conversations, access National Alliance of State and Territorial AIDS Directors (NASTAD) toolkit; and
- Developing action plans for future programming around stigma reduction.

Advisory Committee:

LHJs may use PS18-1802 funding to support local or collaborative advisory committees, including with other LHJs, that are used for program planning, implementation and evaluation of program effectiveness. Advisory committee members must reflect the priority population in that jurisdiction.

Feedback From Clients on Service Delivery:

Client level feedback is critical to understand and improve the quality of care and services being provided. LHJs may use PS18-1802 funds to support the development, collection and analysis of client level feedback tools.

Strengthen Structural/System-Level Interventions

Activity Goals:

- Increased linkage to PrEP prescriber by persons from priority populations engaged through 18-1802 and for whom PrEP is indicated
- Increased initiation of PrEP by persons from priority populations engaged through 18-1802 and who are eligible for PrEP
- Increase the percentage of newly diagnosed PLWH from priority populations that are linked to HIV care
- Increase the percentage of previously diagnosed out of care PLWH from priority populations re-linked to care
- Increase the percentage of PLWH from priority populations retained in HIV medical care

Cultural Competency/Cultural Humility:

Marginalized communities often experience inadequate access to culturally competent services. LHJs may support training as well as monitoring and implementation of cultural competence and cultural humility practices by front line staff and medical providers during service delivery.

Social Determinants of Heath:

LHJs may use PS18-1802 to develop and strengthen relationships with local and community partners, in order to address social determinants of health for people vulnerable to HIV, with the aim of improving health outcomes.

- **Example:** Memorandum of understanding (MOU) with local victim services to place individuals experiencing domestic violence, into safe housing
- **Example:** Referral system with local food bank to provide fresh, nutritious foods for those unstably housed and wouldn't seek services on their own

Quality Improvement:

LHJs may support activities that utilize quality improvement models to improve client outcomes.

- **Example:** Improving wait times for clients waiting for services within a STD clinic
- **Example:** Improving HIV and syphilis co-infected case investigation processes

Section V: Unallowable Uses of PS18-1802 Funding

Unallowable uses of PS18-1802 funds:

- Focused testing sites with less than 1 newly identified confirmed positives (NICP) in the past year;
- New large-scale social media and social marketing campaigns
- HIV test kits, unless as approved by OA in writing
- Purchase of needles or syringes (authorized California SSPs can obtain needles, syringes and other supplies from the California Syringe Supply Clearinghouse)
- Any activities designed to influence legislative change at the local, state, and federal level
- Condoms/lube (condoms and lube may be ordered through OA)
- Electronic health record systems or system upgrades

Section VI: Next Steps

Work Plan and Logic Model Submissions

An LHJ work plan and logic model template for calendar year 2020 will be distributed to all funded LHJs to complete by **April 13, 2020** LHJs should submit their completed work plans/logic models to PS18-1802@cdph.ca.gov.

Submitting Required Budget Documents

LHJs should submit completed budget documents to the assigned Prevention Business Analyst (see below and next page), and cc: PS18-1802@cdph.ca.gov and Karin Hill, karin.hill@cdph.ca.gov by **April 13, 2020**. LHJ budgets will be reviewed alongside work plans and logic models to ensure that budgeted costs are reflective of planned activities.

Prevention Business Analysts	PS18-1802 Grants
Cheryl Austin (916) 449-5810	Monterey Santa Barbara Santa Clara Santa Cruz Ventura Marin Stanislaus

Prevention Business Analysts *(cont.)*	PS18-1802 Grants *(cont.)*
Katrina Gonzales (916) 552-9823	Alameda Sacramento Fresno San Joaquin Solano Contra Costa Sonoma
Andrea "Dre" Vazquez (916) 650-0170	Kern San Bernardino San Diego Riverside San Mateo Orange

Section VII: Technical Assistance and OA Resources

Capacity Building Assistance (CBA) Technical Assistance (TA)

The CBA Tracking System (CTS) is a Centers for Disease Control and Prevention (CDC) program that provides information, on-site training and TA to HIV prevention service providers to help them build skills, plan for and adapt to change, and meet their goals.

Organizations that are directly funded by the CDC may make a CBA request directly to CDC. Other organizations, including health departments, community-based organizations (CBOs), HIV planning groups and health care providers in clinical settings, can make a CBA request through the CDPH/OA. See **Appendix E** for details on CBA providers, training/TA opportunities, and how to request training/TA.

OA/STD PS18-1802 Local Capacity Building Assistance

Keshia Lynch - Keshia.Lynch@cdph.ca.gov
Local Capacity Building/Quality Improvement Coordinator

Matt Willis - Matthew.Willis@cdph.ca.gov
HIV/STD Program Coordinator

Brett AugsJoost - Brett.AugsJoost@cdph.ca.gov
HIV Partner Services Coordinator

ADAP Assistance

For questions regarding ADAP or any of the related programs, contact: **CDPH call center** (844) 421–7050, **Fax number** (844) 421-8008, or visit the ADAP webpage for additional program details. To locate an ADAP enrollment site utilize the ADAP Enrollment Site Locator.

Appendices

Appendix A: OA-Supported Approaches

CDPH/OA supports the following approaches to HIV prevention program planning and development:

Involvement of the Priority Population in Service Delivery

OA recommends that LHJs involve PLWH and HIV negative individuals who are disproportionately impacted by HIV, in the planning, design, and implementation HIV prevention programs. LHJs are expected to maintain the priority population's ongoing involvement in an advisory capacity.

Safe and Secure Program Environment

Community input and recommendations regarding best practices emphasize the need for programs serving priority populations to create environments where clients feel safe and supported, both physically and psychologically and where their differences are respected and appreciated. **Cultural competence** is the ability of an organization to effectively deliver services that meet the social, cultural and linguistic needs of its constituents. **Cultural humility** is a respect for the unique cultural experience of the individual, or an openness to what an individual has determined is his or her personal expression of heritage and culture.

CDPH/OA recognizes that individuals from some priority populations are often hesitant and/or unable to access services due to **HIV related stigma, medical mistrust, and systemic/ institutional oppression**. OA recommends that LHJs develop and maintain an easily accessible "safe space" where clients can discuss health, social and emotional issues, as well as receive services (e.g. housing, mental health, legal services). A key component to creating a safe program environment is hiring staff and peers who are not only welcoming and who will work with clients in a respectful manner, but are also representative of the priority populations they serve.

Trauma-Informed Approach

OA recommends that LHJs adopt the principles and practices of a trauma-informed approach to care, especially with respect to the program delivery as well as for in the workplace. OA defines **trauma-informed** as an approach to administering services in care and prevention that acknowledges that traumas may have occurred or may be active in clients' lives, and that those traumas can manifest physically, mentally, and/ or behaviorally. A trauma-informed approach is expected to be understood and adopted by agency staff at multiple points of service delivery. By adopting this approach, LHJs understand the importance of recognizing and addressing an individual's underlying mental health issues/needs that may influence their coping skills and self-protective behaviors. This approach recognizes historical and communal trauma, which can be a key factor in clients' decision-making. Ultimately, clients will be supported to become safer emotionally, physically, and socially.

Many individuals in priority populations served are disproportionately impacted by trauma. The 2016 National Survey of Children's Health found that 61% of Black/African American (AA) children and 51% of Latinx children have experienced at least one adverse childhood experience. Black/ AA and Latinx persons are disproportionately vulnerable to acquiring HIV or are PLWH who are victims of violence and/or may have a history of childhood sexual abuse, rape, incest. These same populations have experienced physical or emotional abuse when disclosing their HIV status to partners or family members. Co-factors such as

substance use and mental health issues may also be present, further emphasizing the importance of providing comprehensive and integrated services with a trauma-informed lens. Providers should have an understanding of the challenges these populations face and should effectively engage these populations with past and current experiences of trauma and violence so that they are not further stigmatized but instead are linked to appropriate care, treatment and support services.

Intersectionality recognizes that the more devalued identities an individual has including race, class, disability and gender, increases the risk of adverse outcomes, such as homelessness, assault, depression and drug use. OA encourages LHJs to take into account an individual's intersectional identities when providing services. As HIV and health inequities continue to disproportionally impact individuals in populations, it is essential to ensure that medical providers, frontline staff and navigators use an intersectional approach to understand trauma.

Comprehensive Sexual Health Education

Comprehensive sexual health education addresses the root issues that help young individuals from priority populations make informed decisions to keep themselves safe and healthy. Programs are encouraged to use a holistic approach to provide youth with accurate sexual health education that helps them reduce their vulnerability to HIV/STD and unintended pregnancies.

Comprehensive sexual health education includes age and developmentally appropriate, medically-accurate information on a broad set of topics related to sexuality, including human development, healthy relationships, decision making, abstinence, contraception and disease prevention. It affords opportunities for developing skills as well as learning. Programs that work with youth should provide youth, particularly, with the tools to make informed decisions, build healthy relationships, and prepare them for when/if they become sexually active. Programs should provide medically accurate information; encourage family communication about sexuality with parents/guardians; and teach youth the skills to make responsible decisions about sexuality.

Harm Reduction

CDPH/OA promotes a harm reduction framework to support the health and safety of people who use drugs. Harm reduction accepts, without judgement, that people use drugs for many reasons; that risk and behaviors related to drug use occur across a spectrum, and that everyone has the capacity to make positive changes without requiring abstinence. Harm reduction also seeks to challenge the circumstances by which people's experiences of drug use and its relationship to HIV risk or other health outcomes are deeply shaped by stigma and discrimination – including within the health care system – and by policies that target and exclude people from care related to drug use based on race or ethnicity, gender, housing status, poverty, and other factors.

LHJs incorporating harm reduction strategies in their programs may use a variety of tools depending on the needs of the people they intend to serve, including syringe services for PWID, counseling and health education designed to promote safer drug use (including for opioids, stimulants, alcohol, or polydrug use) and safety for people who use drugs during sex, integration of mental health and substance use disorder care, or overdose prevention services, and/or other strategies as appropriate.

Health and Wellness Approach

CDPH/OA encourages programs serving the priority population to integrate the concepts of health and wellness into their HIV/STD prevention services. The health and wellness model promotes comprehensive approaches that address the physical, psychological, and environmental impacts on an individual's overall health.

In the context of an HIV/STD prevention program, a health and wellness approach would enable a program to recognize and address how various health related factors interact and increase a person's vulnerability for HIV infections and STD's.

Programs that incorporate a health and wellness approach into their HIV/STD programs will be better prepared to facilitate access to healthcare services, thus enhancing their strength-based model of care, and empower their clients to become primary agents of change for themselves.

LHJs are also encouraged to incorporate wraparound services that address the **social determinants of health**. CDPH/OA defines social determinants of health as the range of social, economic and environmental factors that determine the health status of individuals or populations. Social determinants of health play a role in HIV infection and the ability of people vulnerable to, or living with HIV to seek treatment, care and support.

Social Networks

CDPH/OA encourages the use of social network strategies to enlist persons who are HIV/STD positive or vulnerable to HIV in order to recruit peers in their social, sexual and drug/alcohol using networks to seek HIV/STD testing. Members of the LHJs prevention program can be recruited and trained to work with members of their networks to:

- Provide education and connections to supportive services;
- Distribute safer sex supplies and information on obtaining sterile syringes; and
- Locate HIV/STD testing sites, help link those who test positive to care and services.

Required/ Recommended	Activity	Requirements	Allowable	Unallowable
REQUIRED	Strengthen Disease Investigation infrastructure	• Travel and per diem for at least one DIS staff to attend the Annual CDPH DIS Summit	• Personnel/staff • Investigative tools • Training	• DI services cannot be subcontracted • Equipment over $5000 per unit
REQUIRED	Expand and provide navigation services		• Navigation personnel/ staff • Staff training • Navigation subcontracts • Small incentives	• Prescription or over-the-counter medications
REQUIRED	Expand access to syringe services for people who inject drugs	• LHJs funded at more than $350,000 with SSP: fund SSP(s) • LHJs funded at more than $350,000 with no SSP: develop plan and timeline for establishing an SSP • LHJs funded at $350,000 or less: fund SSP, or work to increase number of pharmacies that sell syringes without a prescription		• Purchase of needles or syringes (authorized California SSPs can obtain needles, syringes, and other supplies from the California Syringe Exchange Supply Clearinghouse)

Required/ Recommended	Activity	Requirements	Allowable	Unallowable
Recommended	Healthcare provider engagement		• Healthcare provider detailing • Healthcare provider grand rounds • Learning collaborative	
Recommended	HIV Testing, focused	• Test counselors have passed OA-approved test counselor training • Subcontractors must have linkage to care and partner services protocols • Data entered into LEO • Interview index clients, elicit partner information, and develop mechanism to share partner names with LHJ (if subcontracted)		• Sites with less than one NICP since 1/1/17 • Purchase of HIV or HCV test kits • Testing incentives
Recommended	HIV Testing, routine opt-out	• Patients tested for syphilis must also be tested for HIV • Patients tested for HIV must also be tested for syphilis • Data submitted to OA	• Facilitating introduction or expansion of ROOT • Supporting ROOT at county clinics • Linkage to care coordinator at ROOT site	• Medical care provider staff time • Cost associated with ROOT including specimen collection or laboratory test processing, without prior OA discussion

Required/ Recommended	Activity	Requirements	Allowable	Unallowable
Recommended	HIV Testing, routine opt-out *(continued)*			• Purchase or upgrade to electronic medical record systems • Prescription or over-the-counter medications
Recommended	Condom distribution			• Purchase of condoms or lube • Orders for condoms intended for distribution at a one-time event that is not specifically serving groups vulnerable to HIV
Recommended	Community engagement	• Community assessment • Stigma and discrimination reducing activities • Client surveys		• Risk-reduction evidence based behavioral interventions (RR EBIs) or locally-developed behavioral interventions
Recommended	Structural/system-level interventions	• Cultural competency/ cultural humility trainings, monitoring, service delivery • Activities aimed at addressing social determinants of health • Quality improvement activities		

Program	Overview	Eligibility Requirements	Program Benefit
AIDS Drug Assistance Program (ADAP)	ADAP helps ensure that people living with HIV and AIDS in California who are uninsured or under-insured have access to medication. ADAP pays the prescription costs for medication on the ADAP Formulary for eligible individuals.	• Be a resident of California; • Have a positive HIV/AIDS diagnosis; • Be at least 18 years old; • Have an annual Modified Adjusted Gross Income (MAGI) that does not exceed 500% Federal Poverty Level based on household size and income; and • Not be fully covered by Medi-Cal or any other third-party payers.	• Covers the cost of medications on the ADAP formulary.
Office of AIDS Health Insurance Premium Payment Assistance (OA-HIPP) Program	Subsidy program that helps pay an ADAP client's monthly health insurance premiums for clients enrolled in ADAP.	• Be enrolled in ADAP (see ADAP eligibility requirements above); • Be enrolled in comprehensive health care coverage; and • Not be fully covered by Medi-Cal.	• Pays up to $1,938 per month for health insurance premiums • Covers multiple plan types • Covers outpatient medical out-of-pocket expenses
Employer Based Health Insurance Premium Payment (EB-HIPP) program	Subsidy program helps pay an ADAP client's share of their employer-based health insurance premiums.	• Be enrolled in ADAP (see ADAP eligibility criteria above); • Be employed by an employer that offers comprehensive health care coverage; • Be enrolled in an employer-based insurance policy; and • Employer must sign an EB-HIPP Participation Agreement form.	• Pays up to $1,938 of the client's portion of their employer-based health insurance premium • Covers outpatient medical out-of-pocket expenses

Program	Overview	Eligibility Requirements	Program Benefit
Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)	Subsidy program that helps cover medical costs associated with getting PrEP.	• Be a resident of California; • Have a negative HIV/AIDS diagnosis; • Be at least 18 years old; • Have an annual MAGI that does not exceed 500% Federal Poverty Level based on household size and income; • Not be fully covered by Medi-Cal or any other third-party payers; and • Be enrolled in a PrEP drug manufacture's assistance program, if applicable.	• Uninsured clients: o Pays for approved PrEP-related medical costs through a provider in the PrEP-AP Provider Network; and o Covers the cost of medication on the PrEP-AP formulary for the prevention of HIV and sexually transmitted infection treatment, excluding Truvada® and Descovy®. • Medicare clients without drug coverage: o Pays for allowable PrEP-related medical out-of-pocket costs; and o Covers the co-pay costs for medication on the PrEP-AP formulary, excluding Truvada® and Descovy®. • Medicare clients with drug coverage: o Pays for allowable PrEP-related medical out-of-pocket costs; and o Covers the co-pay costs for medication on the PrEP-AP formulary. • Insured clients (must see a provider in their health plan network): o Pays for approved PrEP-related medical out-of-pocket costs; o Covers the co-pay costs for Truvada and Descovy *after* the drug manufacturer program benefit is exhausted; and o Covers the co-pay costs for medication on the PrEP-AP formulary.

Program	Overview	Eligibility Requirements	Program Benefit
Medicare Part D Premium Payment (MDPP) program	Pays Medicare Part D and Medigap insurance premiums for clients enrolled in ADAP and a Medicare Part D prescription drug plan.	• Be enrolled in ADAP; • Be enrolled in a Medicare Part D prescription plan; and • Not be receiving 100% assistance from Medicare's Extra Help/Full Low Income Subsidy.	• MDPP without Medigap: o Pays for Medicare Part D premiums, and o Covers medical out-of-pocket expenses. • MDPP program with Medigap: o Pays for Medicare Part D premiums, o Covers medical out-of-pocket expenses; and o Pays for Medigap premiums.

Appendix D: Basic Counselor Skills Training (BCST)

California Health and Safety Code allows non-medical personnel to conduct CLIA waived rapid HIV and HCV tests, provided they are trained through an OA-sponsored training provider. The BCST allows participants to build skill in client centered counseling techniques, talking about PrEP and PEP with clients, risk assessments and risk reduction strategies, preliminary positive and negative HIV test results delivery, and reactive or non-reactive HCV results delivery. This course also includes certification in the OraQuick Advance Rapid HIV and HCV tests, certification in the Alere Determine HIV test, as well as finger stick blood collection for these testing technologies.

The BCST is a 5 day in-person training course with a required online pre-training prerequisite. In order to successfully complete the training, participants must attend all 5 days of training and successfully pass all evaluative components.

During the training, trainers will provide individualized observation opportunities and give direct and immediate feedback to participants as they practice and prepare for skill competencies. Participants with an active phlebotomy license (or other medical licensure that included phlebotomy training) are exempt from the finger stick portion of training.

Training locations are determined at the request of the local health jurisdictions funded by PS PS18-1802. Local health jurisdictions may host a BCST provided there is a minimum of 8 participants registered and confirmed, with a maximum of 16 participants. OA will provide the training at no cost for registration.

OA contracts with UCSF Alliance Health Project to conduct training. For more information or to schedule a BCST, please contact ahptraining@ucsf.edu.

Appendix E: Capacity Building Assistance (CBA)

The CBA Tracking System (CTS) is a Centers for Disease Control and Prevention (CDC) program that provides information, on-site training and TA to HIV prevention service providers to help them build skills, plan for and adapt to change, and meet their goals.

Organizations that are directly funded by the CDC may make a CBA request directly to CDC. Other organizations, including health departments, community-based organizations (CBOs), HIV planning groups and health care providers in clinical settings, can make a CBA request through the CDPH/OA.

The Denver Prevention Training Center, San Francisco Department of Public Health, and the California Prevention Training Center are contracted by the CDC to provide TA tailored to meet the capacity-building needs and preferences of CDC-funded health departments, CBOs, and their partners. Personalized TA services and products can be accessed to assist in addressing programmatic challenges to effectively plan, integrate, implement and sustain HIV prevention programs and services. Below is additional information about each of the TA providers.

Denver Prevention Training Center	***Clinical HIV Testing and Prevention for Persons with HIV*** • Routine and focused HIV testing as a part of integrated normative care in clinical settings • Referrals to prevention and essential support services • Linkage to, and retention and reengagement in care; early antiretroviral treatment (ART); medication adherence; perinatal HIV prevention • Behavioral interventions for persons with HIV
San Francisco Department of Public Health	***Nonclinical HIV Testing and Prevention for HIV Negative Persons*** • Routine and focused HIV testing as a part of integrated normative care in clinical settings • Referrals to prevention and essential support services • Referrals to HIV medical care for persons with positive HIV test results • Behavioral interventions for persons with HIV
California Prevention Training Center	***Integrated HIV Activities and Structural Interventions*** • Structural interventions to address social determinants of health; condom distribution; Syringe Services Programs (SSPs) • Social marketing campaigns and social media strategies • Partner Services and Data to Care activities • Integrated HIV Prevention and Care Planning • HIV/HCV Transmission Clusters and Outbreak Response

For more information about CBA, visit: https://effectiveinterventions.cdc.gov/. For a list of types of available CBA at a glance, visit: https://wwwn.cdc.gov/CTS/Pages/Main/TAAtAGlance.

To learn more about the types of training available or to make a Capacity Building Assistance Request Information System (CRIS) request, email CBA@cdph.ca.gov.

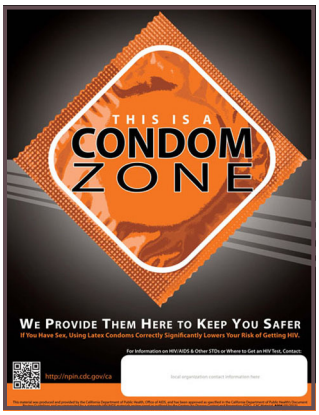
Appendix F: Condom Distribution

Once an LHJ from within the California Project Area (CPA) (all counties accept 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 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 Condones" – 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 G: HIV/HCV Test Kit Ordering

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 Program Advisors). The form should be submitted electronically to OraQuickTestKits@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.

Please note: once test kit orders have been received by the LHJ, a PDF copy of the "OraSure Technologies, Inc. Packing Slip" must be submitted to OraQuickTestKits@cdph.ca.gov to ensure that future orders are shipped without delay.

Abbott Determine HIV – 1/2 Ab/Ag Combo: OA will provide Abbott Determine rapid test kits and external controls to funded LHJs. LHJs must have certified test counselors receive training from OA on the Abbott Determine rapid test. Determine HIV test kits may be ordered by the LHJ coordinators using the HIV test kit order form (available from OA Program Advisors). The form should be submitted electronically to DetermineTestKits@cdph.ca.gov. Allow 15 business days to process an order. LHJs interested in receiving training to use the Determine test kit, please contact UCSF Alliance Health Project at ahptraining@ucsf.edu for more information.

Please note: once test kit orders have been received the by LHJ, a PDF copy of the "Abbott Packing List" must be submitted to DetermineTestKits@cdph.ca.gov to ensure that future orders are shipped without delay.

Appendix H: Resources Provided by Office of AIDS

OA's Syringe Access and Harm Reduction web page includes a directory of California SSPs, fact sheets on legal and other issues, information about CDPH and local authorization of SSPs, CDPH guidance for syringe services programs, and links to other tools and resources. It also includes the Non-Prescription Syringe Sale Toolkit for health departments.

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.

Free online training for staff in harm reduction principles and practices is available at the Harm Reduction Coalition's website; use code CASSP100.

For technical assistance in conducting community assessments for establishing SSPs and/or nonprescription syringe sales contact Matt Curtis, Harm Reduction Specialist at matt.curtis@cdph.ca.gov.

For information and assistance related to state authorization of an SSP, contact Marjorie Katz, Health Program Specialist, at marjorie.katz@cdph.ca.gov.

For technical assistance with questions related to policy and law governing syringe exchange and nonprescription syringe sale contact Alessandra Ross, Injection Drug Use Specialist at alessandra.ross@cdph.ca.gov or 916-449-5796.

Appendix I: PS18-1802 Data Collection Tools, Systems, and Data Security and Confidentiality

The Office of AIDS (OA) uses multiple data systems to collect quantitative client-level HIV program data from local health jurisdictions, providers, and contractors. These systems are secure and maintained to ensure the confidentiality of the data collected. Additionally, OA collects qualitative data via grantee logic models/work plans and progress reports. Data are collected to meet funding and regulatory requirements, as well as to guide program implementation and improvement. All grantees are required to maintain data security and confidentiality.

A summary of core PS18-1802 data collection tools and systems is provided below.

Data Collection Tool/Mechanism	Data Collection System	Information Documented	Type of Data
• **Adult Case Report Form (ACRF)**	• California Reportable Disease Information Exchange (CalREDIE)	• HIV and AIDS reporting at the time of diagnosis or if HIV progresses to AIDS for people 13 or older	• Quantitative • Client-level
• **Pediatric HIV/AIDS Case Report Form**	• N/A - Paper submission. Provider contact LHJ HIV surveillance coordinator. LHJ contact designated OA surveillance staff.	• HIV and AIDS reporting at the time of diagnosis or if HIV progresses to AIDS for people under the age of 13	• Quantitative • Client-level
• **STD / HIV Field Investigation Incident (SHFII)** • **Client Encounter Form (CEF)** • **Supplemental Client Encounter Form (SCEF)**	• CalREDIE • Local Evaluation Online (LEO)	• Health department follow-up activities for reported cases of syphilis and HIV • PS18-1802 funded: o Focused HIV testing activities o Routine opt-out HIV testing (ROOT) activities (preliminary or confirmed HIV-positive test events only) o PrEP navigation activities o Referral to and provision of support services activities (preliminary or confirmed HIV-positive test events only) o PrEP navigation activities o Referral to and provision of support services	• Quantitative • Client-level
• **CSV file (formatted per requirements outlined in the PS18-1802 ROOT Negative CSV File Data Dictionary)**	• N/A - CSV file submitted via Secure File Transfer (SFT) site	• ROOT activities (HIV-negative, inconclusive, or invalid test events only)	• Quantitative • Client-level
• **Grantee progress report**	• N/A – progress report sent via email to PS18-1802@cdph.ca.gov, cc'ing your program advisor.	• Program successes, challenges, changes, and lessons learned, and aggregate programmatic data.	• Quantitative • Aggregate quantitative

Contact David Webb (David.Webb@cdph.ca.gov) for a copy of the PS18-1802 ROOT Negative CSV File Data Dictionary.

Data Collection System Details:

CalREDIE

CalREDIE is a secure system implemented by the California Department of Public Health (CDPH) for electronic disease reporting and surveillance. Local Health Jurisdictions must enter HIV and syphilis incidents into CalREDIE, in addition to other infectious diseases.

New in 2020, CalREDIE also contains a module for capturing follow-up activities for both HIV and STD incidents, including co-infected cases. The STD/HIV field investigation incident (SHFII) captures data to document follow-up activities including partner services and linkage to care for reported cases of syphilis and HIV (beginning in calendar year 2020). The SHFII will also be used to capture outcomes relating to molecular surveillance, out of care follow up activities, and other activities that trigger health department follow up. Note that HIV partner services activities will no longer be entered into LEO.

To inquire about general CalREDIE trainings and access, contact: CalREDIEHelp@cdph.ca.gov. For additional information about CalREDIE, visit: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/CalREDIE.aspx.

ACRF

The ACRF is a form used for HIV surveillance adult case reporting. Additional information about HIV surveillance case reporting can be found here: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.aspx.

STD/HIV Field Investigation Incident (SHFII)

New in 2020, CalREDIE also contains a module called the STD/HIV Field Investigation Incident (SHFII) for documenting integrated follow-up activities, including partner services and linkage to care, treatment, or PrEP, for people with HIV and/or an STD.

Follow-up activities for which SHFII collects data include :

- Linkage to Care/Services:
  - HIV linkage/re-engagement in care;
  - HIV/STD/Hepatitis C testing & treatment;
  - HIV pre-exposure prophylaxis (PrEP); and
  - Additional services.
- Partner elicitation and follow-up
- HIV cluster investigation activities
- Client interviews

The SHFII is needed because of the overlap in populations affected by syphilis and HIV. The SHFII facilitates prevention and care opportunities, and supports coordinated follow-up for individuals who are co-infected. The SHFII will also be used to capture outcomes relating to HIV cluster investigations, out of care follow up activities, and other activities that trigger health department follow up. Note that HIV data relating to partner services activities will no longer be entered into LEO.

Office of AIDS and STD Control Branch will be disseminating SHFII specific documentation as the SHFII rolls out at the beginning of 2020.

A template including the SHFII data elements will be available by request; to request a copy of the SHFII template, email PS18-1802@cdph.ca.gov.

Local Interventional Surveillance Access (LISA)

The LISA data portal has been implemented by OA in partnership with STDBC as a nimble, two-way local/state data exchange solution. LISA is designed to provide:

- Real-time client-level and agency level actionable information;
- Cross-jurisdictional person data linked across relevant OA/STD data systems;
- A tool to overcome technical and statutory barriers; and

- An interface for administrative and programmatic feedback.

LISA provides data recorded in HIV and STD surveillance, prevention, and follow-up data systems including line lists of Californians living with HIV and/or STDs who require health department follow-up for linking to care, treatment, and other supportive services. LISA also provides real-time agency and staff-level outcome indicators, and interactive dashboards and visualizations for internal and external audiences.

LISA is a browser-based tool that provides LHJ staff access to data from eHARS, the primary HIV surveillance data system in California, and CalREDIE which collects surveillance and disease investigation/case management data for reportable HIV and STD conditions. In the near future, LISA will also link with data fromLEO (OA's prevention program data system), ARIES (OA's HIV care management data system), and AES (OA's ADAP enrollment System). LISA is being developed on an RStudio Connect platform supported by CDPH Information Technology Services Division (ITSD) in the CDPH extranet environment. The extranet environment ensures secure data access for only approved, authenticated users.

LEO

LEO is a secure system that OA has implemented for OA-funded HIV prevention service delivery (e.g., HIV testing, PrEP navigation, referral to and provision of support services) reporting. PS18-1802-funded LHJs and their subcontractors are responsible for presenting clients with the LEO Client Consent and Privacy Notice (CDPH 8650 and 8650 SP) as part of standard service delivery, and for documenting service delivery activities and outcomes included on the Client Encounter Form (CEF) and Supplemental Client Encounter Form (SCEF); this information must be entered into LEO on a continuous basis, at least weekly.

In addition to fulfilling reporting requirements, grantees are also responsible for monitoring PS18-1802 service delivery activities, outcomes, and data quality/completeness, and for verifying the "State number (eHARS) *(LHJ use only)*," "CalREDIE STD/HIV field investigation ID *(LHJ use only)*," and "CalREDIE person ID *(LHJ use only)*" fields for all clients with an HIV-positive test result that was entered into LEO as a result of PS18-1802 funded activities. These monitoring and verification activities should occur on a continuous basis, and at least monthly.

Monitoring and verification tools currently available in LEO include:

- **The HIV Testing Monitoring Report**
  Helpful for monitoring HIV testing volume, linkage to care through testing, referral to PrEP through testing, and characteristics of persons tested for HIV (e.g., age group, race/ethnicity, population group)

- **The PrEP Monitoring Report**
  Helpful for monitoring outcomes along the PrEP cascade, including PrEP referral, linkage, and initiation

- **View All Encounters screen**
  Helpful for monitoring data entry activity and completeness of encounters

- **eHARS and CalREDIE ID Verification Screen** *(LHJ use only)*
  Helpful for identifying and updating encounters for which eHARS and CalREDIE IDs need to be verified

To inquire about LEO training, request a copy of quick start guides (e.g., Client Search and Data Entry, Reports), and/or request electronic copies of the CEF or SCEF, contact the LEO Helpdesk: LEOHelp@cdph.ca.gov.

Client Encounter Form (CEF)

The CEF must be completed for all client encounters.

Supplemental Client Encounter Form (SCEF)

The SCEF must be completed in addition to the CEF if the client tests HIV-positive (preliminary or confirmed) or reports a previous HIV-positive (preliminary or confirmed) test result.

LEO Privacy and Consent

Grantees must integrate the LEO Client Consent and Privacy Notice (CDPH 8650 and 8650 SP) into standard service delivery processes; the LEO Client Consent and Privacy Notice is available in English (CDPH 8650) and Spanish (CDPH 8650 SP). Copies of the LEO Client Consent and Privacy Notices can be requested through the LEO Helpdesk (LEOHelp@cdph.ca.gov).

Although clients are not required to consent to having their personal and medical information entered into LEO in order to receive PS18-1802-funded services, they do need to be presented with the LEO Client Consent and Privacy Notice as part of standard service delivery. Client consent forms must be reauthorized every three years, and must be kept with the client's record. Programmatic data for clients who choose not to sign the LEO Client Consent and Privacy Notice must be entered into LEO utilizing either the "Client WITHOUT Consent Form", or "Anonymous Testing Client" data entry option (whichever is appropriate); these data entry options disable fields like name, street address, and social security number. A LEO Client Search and Data Entry Quick Start Guide providing additional information on data entry options can also be obtained through the LEO Helpdesk (LEOHelp@cdph.ca.gov).

Data Security and Confidentiality

Grantees are responsible for protecting client privacy and confidentiality by ensuring that protected health information is stored and disclosed only in a manner consistent with California and federal laws and regulations, and OA policies and procedures.

These responsibilities include ensuring all health department staff, including contract staff embedded at the health department, do the following at the time of hire and annually: (1) complete the HIV surveillance data security and confidentiality training and (2) sign the HIV/AIDS Confidentiality Agreement Form (CDPH 8689) . In addition to fulfilling Data Security and Confidentiality requirements outlined in the Surveillance Scope of Work, grantees must retain a copy of training certificates and signed HIV/AIDS Confidentiality Agreement Forms on-site, and make them available to OA upon request. Note that non-health department staff (i.e. staff at CBOs or other subcontracted agencies) may not access identifiable HIV surveillance data.

An electronic copy of the HIV/AIDS Confidentiality Agreement Form (CDPH 8689) can be found at: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8689.pdf. For a copy of the security and confidentiality training, contact: Melanie.Droboniku@cdph.ca.gov.

Appendix J: Logic Model + Work Plan

Instructions: The Logic Model + Work Plan lists required and recommended activities and sub-activities for PS18-1802 2020, along with corresponding goals and metrics. Using the template sent out with this guidance document, please check any planned sub-activities. Activities already checked are required and may not be unchecked. List any additional sub-activities in the space provided. Any additional sub-activities must meet the stated goals of the activity under which the sub-activity is added. If your LHJ plans to conduct a main activity not included in the required or recommended activities, please email your program advisor and cc PS18-1802@cdph.ca.gov.

Completed Logic Model + Work Plan is due to ps18-1802@cdph.ca.gov by **April 13, 2020.** See example of template below.

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
Strengthen Disease Investigation Infrastructure (Required)	Increase number of HIV cases investigated	CalREDIE	# of HIV cases investigated/ # of HIV cases eligible for investigation	Hire/reassign personnel	☐
	Increase number of people who participate in HIV partner services among persons: • with newly diagnosed HIV infection • reinvestigated for PS	CalREDIE	# of newly identified PLWH who undergo partner services interview / # of newly identified PLWH # of eligible previously identified PLWH who undergo partner services interview / # of previously identified PLWH eligible for interview	Train DIS and/or other support staff (e.g. HIV investigation, partner services, interviewing techniques, cultural competency)	☐
	Increase number of partners elicited through HIV partner services interviews of index patients with: • with newly diagnosed HIV infection • reinvestigated for PS	CalREDIE	# of partners elicited / # of newly identified PLWH who undergo partner services interview # of partners elicited /# of eligible previously identified PLWH who undergo partner services interview	Implement investigation tools	☐
	Increase the percentage of index patients who provide names for PS follow up	CalREDIE	# of clients who provide names during PS elicitation interview /# of clients interviewed for PS	Conduct disease investigation	☒
	Increased notification and HIV testing of partners identified through HIV partner services	CalREDIE	# of named partners notified / # of total partners elicited # of named partners tested for HIV / # of total partners elicited	Additional DIS strengthening sub-activities that meet activity goals? *Please list below.*	

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
	Increase the number of partners of clients who test positive for syphilis that are tested for HIV and referred or navigated to services (PrEP or HIV care)	CalREDIE/ Surveillance	# of syphilis partners who test positive for syphilis that are tested for HIV / # of partners who test positive for syphilis # of syphilis partners who are linked to HIV medical care that test positive for syphilis and HIV / # of partners who test positive for syphilis that are tested for HIV # of syphilis partners who test negative for HIV and positive for syphilis that are referred to a PrEP prescriber / # of partners who test positive for syphilis that are tested for HIV		
	Increased notification and HIV testing of partners identified through syphilis partner services	CalREDIE	# of named syphilis partners notified / # of named syphilis partners # of named syphilis partners notified and tested for HIV / # of total named syphilis partners # of named syphilis partners notified and tested for syphilis / # of total named syphilis partners		
	Increase the number of partners of PLWH who test negative for HIV referred to PrEP	CalREDIE	# of HIV negative partners of PLWH who are referred to a PrEP prescriber/ # of HIV negative partners of PLWH		
	Increase the number of partners of clients who test positive for rectal gonorrhea/ chlamydia that are tested for HIV and referred to services (PrEP or HIV care)	CalREDIE	# of rectal gonorrhea/ chlamydia partners who test negative for HIV and positive for rectal gonorrhea/ chlamydia that are referred to a PrEP prescriber / # of partners who test positive for rectal gonorrhea/chlamydia that are tested for HIV		
	Increase the percentage of newly diagnosed PLWH that are linked to HIV care	Surveillance	# of newly diagnosed PLWH linked to HIV care / # of newly diagnosed PLWH		

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
	Increase the percentage of previously diagnosed out-of-care PLWH re-linked to care	Surveillance	# of out-of-care PLWH linked to HIV care / # of out-of-care PLWH		
	Increase the percentage of PLWH retained in HIV medical care	Surveillance	# of PLWH retained in HIV care / # of PLWH		
	Increase HIV viral load suppression among PLWH	Surveillance	# of PLWH who are virally suppressed / # of PLWH		
	Increase HIV viral load suppression among PLWH within 6 months	Surveillance	# of newly diagnosed PLWH who are virally suppressed within 6 months of initial positive test / # of newly diagnosed PLWH # of out-of-care PLWH linked to HIV care who are virally suppressed within 6 months of initial re-engagement test / # of out-of-care PLWH		
Expand and provide navigation services (Required)	Increase the percentage of newly diagnosed PLWH that are linked to HIV care	Surveillance	# of newly diagnosed PLWH linked to HIV care / # of newly diagnosed PLWH	Hire/reassign personnel	☐
	Increase the percentage of previously diagnosed out-of-care PLWH re-linked to care	Surveillance	# of out-of-care PLWH linked to HIV care / # of out-of-care PLWH	Train navigators and other support staff (ex: cultural humility, benefits enrollment)	☐
	Increase the percentage of PLWH retained in HIV medical care	Surveillance	# of PLWH retained in HIV care / # of PLWH	Navigate people living with HIV to HIV support services	☒
	Increase HIV viral load suppression among PLWH	Surveillance	# of PLWH who are virally suppressed / # of PLWH	Navigate HIV negative clients to PrEP	☒
	Increase HIV viral load suppression among PLWH within 6 months	Surveillance	# of newly diagnosed PLWH who are virally suppressed within 6 months of initial positive test / # of newly diagnosed PLWH # of out-of-care PLWH linked to HIV care who are virally suppressed within 6 months of initial re-engagement test / # of out-of-care PLWH	Additional sub-activities that support expanding navigations services and meet activity goals? *Please list below.*	

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
	Increase the number of newly identified PLWH that initiate ART within ≤ 5 days of HIV positive test event.	CalREDIE	# of newly diagnosed PLWH who initiate ART within ≤ 5 days of positive test event / # of newly diagnosed PLWH		
	Increase the number of eligible patients who are referred to PrEP prescriber	CalREDIE	# of people who test positive for syphilis, or rectal gonorrhea, or rectal chlamydia, or are a named partner of PLWH and test negative for HIV that are referred to PrEP prescriber / # of people who test positive for syphilis, or genital gonorrhea, or genital chlamydia, or are a named partner of PLWH and test negative for HIV		
	Of PrEP eligible clients assisted through 18-1802 funding, increase linkage to PrEP prescriber	LEO	# of eligible people linked to PrEP prescriber / # of PrEP eligible people		
	Of PrEP eligible clients assisted through 18-1802 funding, increase initiation of PrEP	LEO	# of eligible people linked to PrEP prescriber, those who initiate PrEP / # of PrEP eligible clients		
Expand access to syringes for people who inject drugs (Required)	Increase the number of SSPs operating in the LHJ	Progress Report	# of SSPs in operation in LHJ	Support the development of new SSPs	☐
	Increase funding available to SSPs operating in the LHJ	Progress Report/Budget	# of dollars subcontracted to SSP(s) / # of dollars allocated to LHJ	Fund existing SSP(s)	☐
	Increase the number of pharmacies that sell syringes without prescriptions	Progress Report	# of NPSS pharmacies in LHJ	Expand non-prescription syringe sales in pharmacies	☐
				Additional sub-activities that support expanding navigations services and meet activity goals? *Please list below.*	

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
Health care Provider Engagement (Recommended)	Increase the number of providers engaged by LHJs though education, provider detailing, or training that apply engagement subject (i.e. if the detailing is PrEP prescribing, did the detailing cause the provider to start prescribing PrEP?)	Progress Report	# of providers applying engagement subject / # of providers engaged and type of engagement	Conduct provider detailing (on ROOT, PrEP, or sexual health)	☐
			# of providers engaged and type of engagement / of providers providing engagement topic services	Conduct grand rounds and/ or provider education	☐
				Establish learning collaboratives	☐
				Maintain learning collaboratives	☐
				Additional sub-activities that support expanding navigations services and meet activity goals? *Please list below.*	
Conduct HIV Testing (Recommended) **- Focused Testing** **- Routine Opt-out Testing**	Increase number of sites conducting ROOT for HIV	Progress Report	# of new sites implementing ROOT for HIV	Facilitate the introduction of ROOT	☐
	Increase the number of sites that conduct ROOT for HIV and syphilis	Progress Report	# of new sites implementing ROOT for HIV and syphilis	Support ROOT at county STD clinics	☐
	Increased number of persons living with HIV infection who are aware of their HIV status	LEO/EvalWeb/ CalREDIE	# of people tested who are informed of their test result / total number of people tested for HIV	Embed Linkage to Care Coordinator at health care facilities	☐
	Increase the number of PS18-1802-funded HIV tests administered to people from priority populations	LEO	# of PS18-1802-funded HIV test events conducted with people from priority populations / # of PS18-1802-funded HIV test events	Conduct focused testing	☐
	Increase the number of persons with newly diagnosed HIV infection identified through PS18-1802-funded testing	LEO	# of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH / # of PS18-1802-funded people tested for HIV	Additional sub-activities that support expanding navigations services and meet activity goals? *Please list below.*	

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
	Increase the number of newly identified PLWH identified through PS18-1802-funded testing that are linked to medical care	LEO	# of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH that are linked to care / # of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH		
	Increase the number of persons with newly diagnosed HIV infection identified throughout 18-1802 linked to HIV medical care within ≤ 5 days of HIV positive test event	LEO/ Surveillance	# of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH that are linked to care within ≤ 5 days of positive test event / # of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH		
	Increase the number of persons with newly diagnosed HIV infection identified throughout 18-1802 linked to HIV medical care within ≤ 14 days of HIV positive test event	LEO/ Surveillance	# of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH that are linked to care within ≤ 14 days positive test event / # of PS18-1802-funded people tested for HIV who are newly diagnosed PLWH		
	Increase the number of persons with previously diagnosed HIV infection identified through PS18-1802-funded HIV testing linked to HIV medical care within ≤ 30 days of HIV positive test event	LEO/ Surveillance	# of PS18-1802-funded people tested for HIV who are previously diagnosed PLWH that are linked to care within ≤ 30 days of positive test event / # of PS18-1802-funded people tested for HIV who are previously diagnosed PLWH		
	Increase HIV viral load suppression among PLWH who are engaged through 18-1802 focused testing	LEO/ Surveillance	# of PS18-1802-funded PLWH identified through focused test event that are linked to care and virally suppressed after date of test event / # of PS18-1802-funded PLWH identified through focused test event		

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
	Increase HIV viral load suppression among PLWH who are engaged through 18-1802 focused testing within ≤ 6 months of HIV positive test event	LEO/ Surveillance	# of PS18-1802-funded PLWH identified through focused test event that are linked to care and virally suppressed within ≤ 6 months of initial test event / # of PS18-1802-funded PLWH identified through focused test event		
	Increase the number of newly identified PLWH engaged through 18-1802 focused testing that initiate ART within ≤ 5 days of HIV positive test event	LEO/CalREDIE	# of PS18-1802-funded newly diagnosed PLWH who initiate ART within ≤ 5 days of test event / # of PS18-1802-funded newly diagnosed PLWH		
Strengthen Community Engagement	Increased linkage to PrEP prescriber by persons from priority populations engaged through 18-1802 and for whom PrEP is indicated	LEO	# of PS18-1802-funded people from priority population linked to PrEP prescriber / # of PS18-1802-funded people from priority population who are eligible for PrEP	Conduct community assessment	☐
	Increased initiation of PrEP by persons from priority populations engaged through 18-1802 and who are eligible for PrEP	LEO	# of PS18-1802-funded people from priority population who initiate PrEP / # of PS18-1802-funded people from priority population who are eligible for PrEP	Conduct stigma and discrimination reduction activities (stigma data collection, holding stigma conversations, identifying stakeholders, stigma action plans)	☐
	Increase the percentage of newly diagnosed PLWH from priority populations that are linked to HIV care	CalREDIE	# of newly diagnosed PLWH from priority population linked to HIV care / # of newly diagnosed PLWH from priority population	Support an advisory committee	☐
	Increase the percentage of previously diagnosed out of care PLWH from priority populations re-linked to care	CalREDIE	# of previously diagnosed PLWH from priority population who are out-of-care linked to HIV care / # of previously diagnosed PLWH from priority population who are out-of-care	Create a process for gathering client feedback	☐

Activity	Activity Goals	Data Source	Metrics (Numerator/denominator)	Sub-Activity	Check for yes
	Increase the percentage of PLWH from priority populations retained in HIV medical care	CalREDIE	# of PLWH from priority population retained in HIV care / # of PLWH from priority population	Additional sub-activities that support expanding navigations services and meet activity goals? *Please list below.*	
Strengthen Structural/ System-level interventions	Increased linkage to PrEP prescriber by persons from priority populations engaged through 18-1802 and for whom PrEP is indicated	LEO	# of PS18-1802-funded people from priority population linked to PrEP prescriber / # of PS18-1802-funded people from priority population who are eligible for PrEP	Conduct activities to address social determinants of heath	☐
	Increased initiation of PrEP by persons from priority populations engaged through 18-1802 and who are eligible for PrEP	LEO	# of PS18-1802-funded people from priority population who initiate PrEP / # of PS18-1802-funded people from priority population who are eligible for PrEP	Train staff in cultural humility	☐
	Increase the percentage of newly diagnosed PLWH from priority populations that are linked to HIV care	CalREDIE	# of newly diagnosed PLWH from priority population linked to HIV care / # of newly diagnosed PLWH from priority population	Conduct quality improvement initiatives	☒
	Increase the percentage of previously diagnosed out of care PLWH from priority populations re-linked to care	CalREDIE	# of previously diagnosed PLWH from priority population who are out-of-care linked to HIV care / # of previously diagnosed PLWH from priority population who are out-of-care	Additional sub-activities that support expanding navigations services and meet activity goals? *Please list below.*	
	Increase the percentage of PLWH from priority populations retained in HIV medical care	CalREDIE	# of PLWH from priority population retained in HIV care / # of PLWH from priority population		

Appendix K: Acronyms

ACRF	Adult Case Report form
ADAP	AIDS Drug Assistance Program
AA	African American
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
BCST	Basic Counselor Skills Training
CalREDIE	California Reportable Disease Information Exchange
CBA	Capacity Building Assistance
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CDI	Communicable Disease Investigator
CMR	Confidential Morbidity Report
CPA	California Project Area
CRIS	Capacity Building Assistance Request Information System
CTS	CBA Track System
DHCS	California Department of Health Care Services
DIS	Disease Intervention Specialist
DIT	Disease Intervention Technician
DDP	Data Distribution Portal
eHARS	Enhanced HIV/AIDS Reporting System
EBI	Evidence Based Interventions
FTE	Full-Time Employee
GC	Gonorrhea
GTZ	Laying a Foundation for Getting to Zero: California's Integrated HIV Surveillance, Prevention, and Care Plan
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injection Drug User
LEO	Local Evaluation Online
LGBT	Lesbian, Gay, Bi-sexual, and Transgender
LISA	Local Interventional Surveillance Access
LHJ	Local Health Jurisdiction
LTC	Linkage to Care
MMSC	Male to male sexual contact
MMSCIDU	Male to male sexual contact and inject drug use

Appendix K: Acronyms *(cont.)*

MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
NICP	Newly identified confirmed positive
NPSS	Nonprescription Sale of Syringes
OA	Office of AIDS
PVI	Participating Venue Information form
PEP	Post Exposure Prophylaxis
PLWDH	People Living with Diagnosed HIV
PLWH	Persons Living with HIV
PrEP	Pre-Exposure Prophylaxis
PrEP-AP	PrEP Assistance Program
PWID	People Who Inject Drugs
ROOT	Routine Opt-Out Testing
RR EBI	Risk Reduction Evidence Based Interventions
SHFII	STD/HIV Field Investigation Incident
SSP	Syringe Services Program
STD	Sexually Transmitted Disease
STDCB	Sexually Transmitted Disease Control Branch
TA	Technical Assistance
TGSC	Transgender sexual contact
U = U	Undetectable = Untransmittable

California Department of Public Health
Office of AIDS
MS 7700
P.O. Box 997426
Sacramento, CA 95899-74726
www.cdph.ca.gov/programs/cid/doa