2017

Los Angeles County
Commission on HIV

PUBLIC COMMENT PERIOD:
JUNE 8-JULY 7, 2017
PLEASE EMAIL COMMENTS TO:
hivcomm@lachiv.org

PROPOSED HIV PREVENTION SERVICE STANDARDS-FOR PUBLIC COMMENT

The development of service standards is one of the core functions of the Commission on HIV. The public is invited to review the proposed Prevention Service Standards.

HIV PREVENTION SERVICE STANDARDS: Background

PURPOSE of SERVICE STANDARDS: Service standards outline the essential elements of service delivery a provider agency must adhere to when implementing HIV prevention services. The purpose of the service standards is to ensure consistent high-quality service delivery throughout Los Angeles County. Service standards establish the minimal level of service delivery. Providers are encouraged to exceed this minimal level if able to, given their capacity and scope.

A multitude of factors at the structural-, environmental-, interpersonal-, and individual-level impact the risk of HIV infection. Therefore, a multitude of services (e.g. housing, employment, social marketing, counseling, condom distribution, etc.) may also serve to prevent the acquisition of HIV. Because it is not feasible to create standards for every potential prevention service, the HIV Prevention Service Standards described in this document focus on ensuring that every HIV-negative individual at risk of HIV infection is successfully connected to and retained in the prevention service(s) that are appropriate for them at any given point in time.

Also, because there are so many different types of organizations that may provide prevention services, and so many different types of services that may be considered "prevention services," it should be understood that not every category of prevention standards described herein will be applicable to all agencies. For example, an agency that provides HIV testing only, will not be expected to provide adherence services for clients who are accessing PrEP.

DEFINITION OF HIV PREVENTION SERVICES: HIV Prevention Services are those services and/or treatments used alone or in combination to prevent the transmission of HIV. *Biomedical* HIV prevention refers to HIV prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission by reducing the viral load of people living with HIV (PLWH) and/or by reducing the susceptibility of HIV infection among high-risk HIV-negative individuals.

DRAFT

GOALS OF HIV PREVENTION EFFORTS IN LOS ANGELES COUNTY: Aligned with the Los Angeles County Comprehensive HIV Plan (2017-2021)[1] and the National HIV/AIDS Strategy (NHAS)[2], the overarching goals of HIV prevention efforts in Los Angeles County are to:

1. Reduce new HIV infections, and
2. Reduce HIV-related disparities and health inequities.

METHOD/HIGH IMPACT PREVENTION: In order to achieve our goals, we must implement a *High-Impact Prevention*[3] approach that utilizes combinations of scientifically proven, cost-effective, and scalable interventions targeted to the populations most disproportionately impacted by HIV in Los Angeles County, as indicated by those populations with the highest HIV incidence rates. The Los Angeles County Comprehensive HIV Plan (2017-2021), based on the most recent surveillance data, identifies the following populations that experience the highest HIV incidence rates in Los Angeles County:

- Men who have Sex with Men (MSM)
- Black/African American MSM, Transwomen, and Cisgender Women
- Transwomen
- Young Men (18-29) who have Sex with Men (YMSM)
- Persons living in the Metro, South, and South Bay Service Planning Areas (SPAs)

DRAFT

[1] Los Angeles County Commission on HIV and the Los Angeles County Department of Public Health Division of HIV and STD Programs. Los Angeles County Comprehensive HIV Plan (2017-2021), September 2016.
[2] The National HIV/AIDS Strategy for the United States: Updated to 2020. https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf
[3] High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. https://www.cdc.gov/hiv/policies/hip/hip.html

In addition, there are many other populations and sub-populations highly impacted by HIV, including, but not limited to:

- American Indians/Native Americans
- Latino MSM
- Asian/Pacific Islander MSM
- Latina Cisgender women
- People between the ages of 13-17
- People over the age of 50
- People who inject drugs
- Incarcerated populations
- Stimulant users
- Commercial Sex Workers
- Sex and needle-sharing partners of all above populations

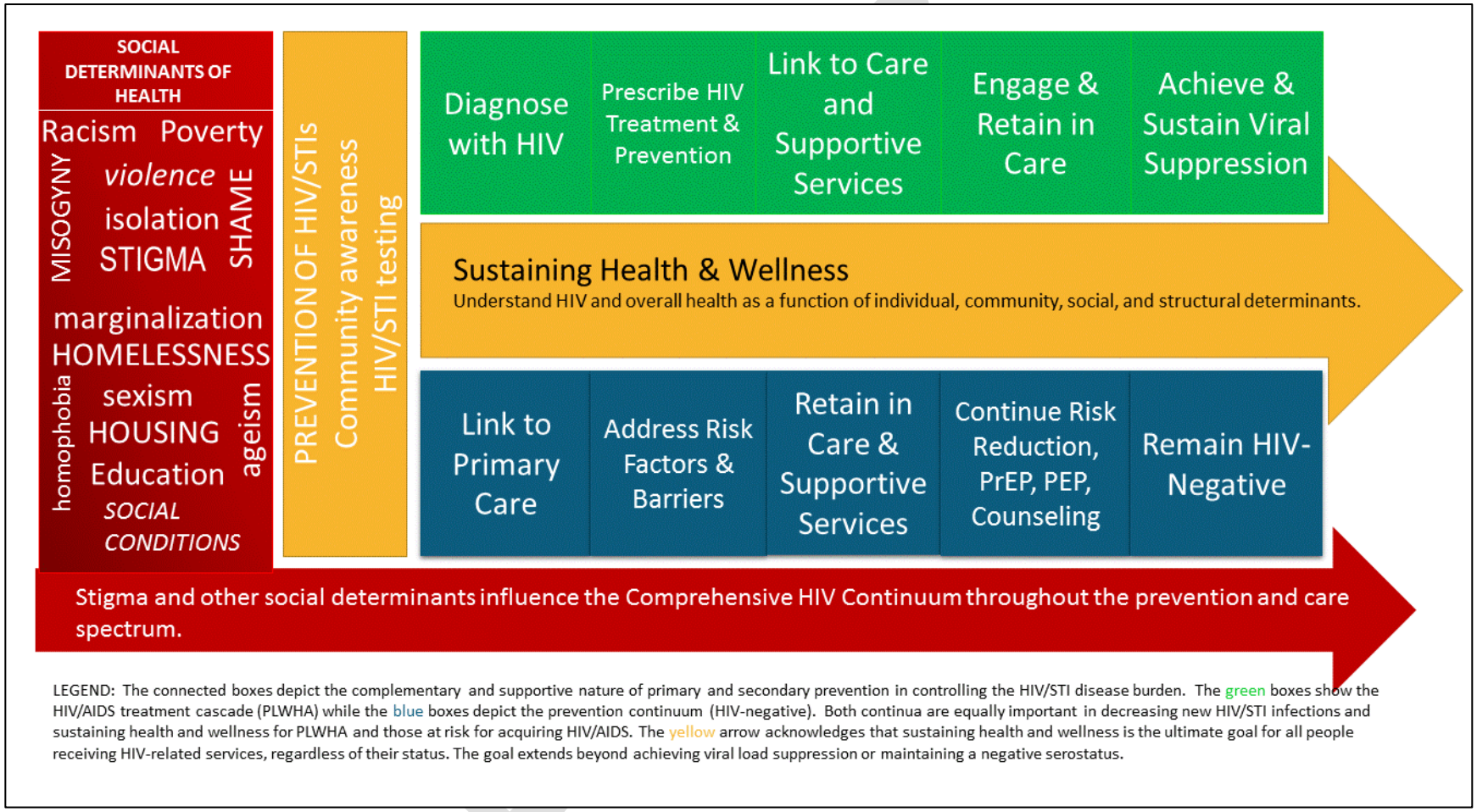
FOUNDATION FOR DEVELOPMENT OF STANDARDS: Comprehensive HIV Continuum Framework

The Los Angeles County Commission on HIV's *Comprehensive HIV Continuum Framework,* depicted in Figure 1, below, was used to guide the development of the HIV Prevention Service Standards. The *Comprehensive HIV Continuum* is an aspirational framework that builds upon the social ecological model to underscore the importance of addressing HIV care and prevention across several dimensions. In the social ecological model, health is viewed as a function of individuals and of the environments in which individuals live, including family, social networks, organizations, communities and societies.[4] The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STD disease burden. The green boxes depict the HIV/AIDS treatment cascade (focused on people living with HIV), while the blue boxes depict the prevention continuum (focused on HIV-negative individuals). Both continua are equally important in decreasing new HIV/STD infections. The Los Angeles County Commission on HIV *Standards of Care* address the services that target HIV-positive individuals (i.e. the services relevant to the green boxes). **The HIV Prevention Service Standards, described herein, address the services that target HIV-negative individuals** (i.e. the services relevant to the blue boxes).

DRAFT

[4] Eldredge, L. K. B., Markham, C. M., Kok, G., Ruiter, R. A., & Parcel, G. S. (2016). *Planning health promotion programs: an intervention mapping approach*. John Wiley & Sons.

Figure 1: The Los Angeles County Commission on HIV *Comprehensive HIV Continuum Framework*



LEGEND: The connected boxes depict the complementary and supportive nature of primary and secondary prevention in controlling the HIV/STI disease burden. The green boxes show the HIV/AIDS treatment cascade (PLWHA) while the blue boxes depict the prevention continuum (HIV-negative). Both continua are equally important in decreasing new HIV/STI infections and sustaining health and wellness for PLWHA and those at risk for acquiring HIV/AIDS. The yellow arrow acknowledges that sustaining health and wellness is the ultimate goal for all people receiving HIV-related services, regardless of their status. The goal extends beyond achieving viral load suppression or maintaining a negative serostatus.

Standards Development Process

The development of the HIV Prevention Service Standards included the input and feedback of service providers, consumers, members of the Standards and Best Practices Committee (SBP), and the Los Angeles County Department of Public Health, Division of HIV and STD Programs. In addition, four Expert Review Panels (ERPs) composed of subject matter experts were convened to provide extensive critique on proposed standards. Moreover, two community meetings were convened on May 19, 2017, to further vet the proposed standards. All comments were thoroughly reviewed by the SBP Committee resulting in some recommended revisions.

In order to guide the development of the HIV Prevention Service Standards, SBP Committee members, ERPs, and community stakeholders considered the following questions:

1. Are the standards up-to-date and consistent with national standards of high quality HIV and STD[5] prevention services?
2. Are the standards reasonable and achievable for providers?
3. Will the services meet consumer needs? (In this context, "consumers" are defined as those at risk for contracting HIV and STDs.)
4. Are proposed standards client-centered?
5. What are the important outcomes we expect for people receiving these services? How can we measure whether or not the service is working for them?

[5] Although debatable, for the purposes of this document, we chose to use the term STD (Sexually Transmitted Disease), rather than STI (Sexually Transmitted Infection). Factors that we weighted in making this decision included: perceived stigma; literal meaning of *disease* versus *infection*; and alignment with county, state, and national departmental names. For a great article on the subject, see Dr. H. Hunter Handsfield's article, "Sexually Transmitted Diseases, Infections, and Disorders: What's in a Name?" (http://www.ncsddc.org/blog/sexually-transmitted-diseases-infections-and-disorders-what's-name).

DRAFT

HIV PREVENTION SERVICE STANDARDS

UNIVERSAL HIV PREVENTION SERVICE STANDARDS: In order to achieve our goals, HIV prevention services in Los Angeles County must be:

Holistic: Preventing HIV is typically one priority among many in the lives of people accessing our services. Therefore, HIV prevention services are most effective when they are delivered with the *whole person* in mind. Whenever possible, programs and services should attend to clients' overall physical health, mental health, and spiritual health, as guided by each individual client.

Responsive to the needs and strengths of the populations served: Responsive services are services that are designed and/or delivered with continuous feedback from the populations served. Feedback should help to ensure that the services are culturally appropriate, effective in preventing HIV, respectful of clients, strength-based, sex-positive and destigmatizing, and easily accessed. Feedback methods should include client satisfaction surveys, and other means to continuously assess quality of services (e.g. secret shoppers).

Designed to address or mitigate social determinants of health: Social determinants of health are the economic and social conditions that influence the health of individuals and communities.[6] Social determinants shape the contexts that either increases or decreases an individual's risk of exposure to HIV. Because HIV disparities are inextricably linked to social determinants, interventions or services that focus on social determinants (e.g. housing, education, employment, healthcare, etc.) are necessary to reduce these disparities. The implementation of such social and structural interventions typically requires a great deal of time and effort on behalf of multiple stakeholders, given that social determinants are typically deeply entrenched and institutionalized in our society. For this reason, many HIV prevention agencies may not have the capacity to implement structural or social interventions. However, HIV prevention services should minimally reflect an understanding of the role of social determinants in their design (e.g. consider a client's competing priorities related to housing and employment). HIV prevention agencies, no matter how small, should strive to

[6] World Health Organization, Commission on Social Determinants of Health. Geneva: WHO; 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health

complement traditional HIV prevention services (e.g. HIV testing), with services that help to mitigate social determinants (e.g. free resume writing workshops).

Strength-Based: A strength-based approach to service design and provision seeks to understand and develop clients' strengths and capabilities that can lead to improved health and quality of life. Services that focus solely on individuals' deficits, needs, problems, or pathologies tend to focus only on what a client needs to "fix" about themselves, thus emphasizing negative behaviors rather than on the potential resiliency and protective factors. Furthermore, when we emphasize what a client is lacking, a dependency is created on the provider and a process of disempowerment occurs. A strength-based approach assumes that individuals have strengths, resources and the ability to recover from adversity; thus allowing a client to see opportunities and solutions rather than just problems and hopelessness. A strength-based approach results in different questions being asked (see Assessment section below) and facilitates an openness and exploration.

Sex-Positive: When services are delivered from a "sex-positive" framework or attitude, they are free from judgment about clients' sexual behaviors, including the behavior itself (as long as it is consensual); the number and type of sexual partners they may have; and the frequency of sexual behaviors they may engage in. A sex-positive attitude also serves to destigmatize sex, and may also serve to destigmatize being gay, being transgender, living with, or being at risk for HIV, etc. Being sex-positive does not mean that you ignore behaviors or circumstances that may increase someone's risk of acquiring HIV or STDs. On the contrary, when clients know that they will not be shamed or judged for the behaviors they engage in, they then will be more likely to disclose important facts and likely will be receptive to information from providers that helps them reduce their risk and/or build upon protective factors.

Culturally Responsive: All HIV prevention organizations should strive to deliver culturally responsive services. Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities.[7] Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual. Culturally-responsive services acknowledge that power imbalances exist between groups of people and cultures based on historical and institutional oppression and privilege; that we are not simply "different" from one another. Culturally responsive agencies also create a physical environment that is welcoming, warm, and that communicates a sense of safety for clients.

[7] Adapted from: Curry-Stevens, A., Reyes, M.-E. & Coalition of Communities of Color (2014). *Protocol for culturally responsive organizations.* Portland, OR: Center to Advance Racial Equity, Portland State University.

To practice cultural humility is to maintain a willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. Cultural competency implies that one can function with a thorough knowledge of the mores and beliefs of another culture; cultural humility acknowledges that it is impossible to be adequately knowledgeable about cultures other than one's own. What you learn about your clients' culture stems from being open to what they themselves have determined is their personal expression of their culture.[8] Tenets of cultural humility include:

1) Lifelong learning & critical self-reflection
2) Recognizing and challenging power imbalances for respectful partnerships, and
3) Institutional accountability

Summary of Core Prevention Service Categories, Data Indicators, Documentation Needs, and Population-based Outcomes

The HIV Prevention Service Standards detailed in this document seek to ensure the provision of a core set of integrated HIV prevention services aimed at preventing the acquisition of HIV and STDs. The Core Prevention Service Categories are: Assessment, HIV/STD Testing and Retesting, Linkage to Biomedical Prevention Services, Referral and Linkage to Non-Biomedical Prevention Services, and Retention and Adherence to Prevention Services. These categories, in addition to their corresponding data indicators, documentation needs, and population-based outcomes, are outlined in Table 1.

DRAFT

[8] Adapted from: "Cultural Humility: People, Principles and Practices," https://www.youtube.com/watch?v=_Mbu8bvKb_U

Table 1: Summary of Core Prevention Service Categories

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***
Assessment	• Number of program participants who complete assessments • Percentage of participants screened for: connection to a medical home; primary care engagement; insurance coverage; STDs; immunizations; pregnancy and family planning; mental health; substance abuse; experiences of trauma and violence; housing and employment status; and sexual health; and sexual and needle-sharing behaviors that may increase their risk of HIV acquisition.	• Completed assessments indicating specific areas or topics assessed and type of assessments used	• Decrease the number of new HIV infections, especially among the following groups: YMSM, Blacks/African Americans, Latino MSM, and Transwomen. • Increase the number of high-risk HIV negative individuals accessing pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP), as needed
HIV/STD Testing and Retesting	• Number of persons tested/screened for HIV and STDs • Number of persons tested/screened for HIV and STDs who have never tested/screened before • Number of testing sites providing integrated testing • Percentage of high-risk negative clients having documentation of HIV/STD testing every 3 months • Type and number of outreach and recruitment methods	• Documentation of HIV/STD testing in client files and data management system • Documentation of type and frequency of outreach and recruitment methods	

DRAFT

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***
Linkage to Biomedical Prevention Services	• Percentage of high-risk HIV-negative clients receiving education on PrEP • Percentage of high-risk HIV-negative clients who are interested in PrEP • Percentage of high-risk HIV-negative clients interested in PrEP that are linked to a PrEP Navigator. • Percentage of high-risk HIV-negative clients who received a PrEP prescription • Percentage of high-risk HIV-negative clients receiving education on PEP • Percentage of high-risk HIV-negative clients who received PEP within 72 hours of exposure • Percentage of high-risk HIV-negative clients who accessed PEP and transitioned to PrEP • Percentage of PrEP and PEP clients referred to medication adherence interventions or support services. • Percentage of PrEP and PEP clients who access medication adherence interventions or support services.	• Documentation of PrEP and PEP education • Documentation of client interest in learning more about PrEP (i.e. responded affirmatively to the question, "Would you like to learn more about PrEP or PEP?") • Documentation of linkage to a PrEP Navigator (may be internal or external linkage) • If available, documentation of PrEP or PEP prescription (may be client self-report) • Documentation of former PEP clients who currently access PrEP • Documentation of PrEP and PEP clients who are referred to medication adherence services • Documentation of PrEP and PEP clients who access medication adherence services	• Increase the percent of persons with known HIV status • Decrease the number of sexually transmitted infections (STDs)

DRAFT

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***

Referral and Linkage to Non-Biomedical Prevention Services	• Percent of high-risk HIV-negative clients that are referred to needed non-biomedical prevention services, as indicated via the assessment process. This may include referrals to:
	  • behavioral interventions
	  • risk-reduction education
	  • syringe exchange
	  • housing services
	  • mental health services
	  • substance abuse services
	  • food pantries
	  • employment services
	  • health insurance navigation
	  • etc.
	• Percentage of high-risk HIV-negative clients who have not accessed primary care in over one year linked to primary care medical visit within 90 days of assessment.[9]
	• Percentage of HIV prevention agencies that make external and internal[10] condoms available free of charge
		• Documentation of referrals in client files and data management system
		• Documentation of linkage to primary care (may be client self-report)
		• Documentation of condom availability
			Same as above

[9] Assuming that primary care is available to the client, which may not always be the case (i.e. for undocumented individuals, individuals who speak a language other than English, transgender individuals, etc., affordable and accessible primary care may not always be available).

[10] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

DRAFT

Core Prevention Service Categories	***Data Indicators***	***Documentation Needs***	***Population-Based Outcomes (from CHP)***
Retention and Adherence to Prevention Services	• Number of clients who remained engaged in prevention service as needed • Number of clients who adhered to PrEP medication per adherence plan determined with PrEP provider • Number of clients who adhered to PEP for 28-day course	• Documentation of provision of service(s) • Documentation of client engagement in service(s) • Documentation of adherence to PrEP or PEP medication	Same as above

*Note: The viral suppression of HIV-positive individuals is a core prevention strategy in Los Angeles County, however it is not described in these HIV Prevention Service Standards because it is highlighted in the Los Angeles County Commission on HIV *Standards of Care*.

DRAFT

ASSESSMENT

Client assessments are often the first in-depth interaction a client has with a provider agency, and thus can foster a lasting positive relationship built on trust and respect, if conducted correctly. Conversely, an assessment that a client perceives to be judgmental or disrespectful in any way can impede the client's willingness or ability to secure necessary prevention services. For this reason, the assessment process should be conducted by trained personnel. The training should include basic client-centered counseling techniques (e.g. how to communicate in a non-judgmental manner, the use of appropriate body language, etc.), and should also include elements that are specific/relevant to the type of assessment(s) conducted. For example, providers should be trained in how to utilize specific mental health and/or substance abuse screening tools (e.g. Patient Health Questionnaire (PHQ-2)), if the assessment utilizes such tools.

The assessment process should include the following activities and or elements (not necessarily in this order):

1. Explain the purpose of the assessment and obtain verbal consent to continue
2. Conduct the assessment in private, with no other clients, and preferably no other staff members able to hear the conversation
3. Gather relevant information to determine the client's needs, risks, and strengths, when appropriate
4. Inform the client of the services available (internally and externally) and what the client can expect if they were to enroll
5. Establish the client's eligibility for services, including HIV status, if relevant, and other criteria
6. Inform the client of any documentation requirements for the assessment (e.g. income verification for insurance purposes)
7. Collect required county, state, federal client data for reporting purposes
8. Collect basic client information to facilitate client identification and client follow-up
9. Begin to establish a trusting client relationship.

The assessment process is a cooperative and interactive endeavor between the staff and the client, and should be conducted in a strength-based manner, meaning the assessment should highlight clients' skills, competencies and resilience in addition to their challenges and needs. Included below are some examples of strength-based questions[11] that may be asked during an assessment, or over the course of multiple assessments, as appropriate:

[11] Adapted from "50 First Strength-Based Questions" (http://www.changedlivesnewjourneys.com/50-first-strength-based-questions).

1. What is working well (either in general, or with respect to a certain subject – adherence, overall health, etc.)?
2. Can you think of things you have done in the past that have helped with ___?
3. What small thing could you do that would make ____ better?
4. Tell me about what a good day looks like for you? What makes it a good day?
5. On a scale of 1 to 10 how would you say ___ is? What might make that score a little better?
6. What are you most proud of in your life?
7. What achievements have you have made? How did you make them happen?
8. What inspires you?
9. What do you like doing? What makes this enjoyable?
10. What do you find comes easily to you?
11. What do you want to achieve in your life?
12. When things are going well in your life – tell me what is happening?
13. What are the things in your life that help you keep strong?
14. What do you value about yourself?
15. What would other people who know you say you were good at doing?
16. You are resilient, what do you think helps you bounce back?
17. What is one thing you could do to have better health, and feeling of wellbeing?
18. How have you faced / overcome the challenges you have had?
19. How have people around you helped you overcome challenges?
20. What are three things that have helped you overcome obstacles?
21. If you had the opportunity what would you like to teach others?
22. Without being modest, what do you value about yourself, what are your greatest strengths?
23. How could/do your strengths help you to be a part of your community?
24. Who is in your life?
25. Who is important in your life?
26. How would you describe the strengths, skills, and resources you have in your life?
27. What could you ask others to do, that would help create a better picture for you?
28. What are the positive factors in your life at present?
29. What are three (or five or ten) things that are going well in your life right now?
30. What gives you energy?

DRAFT

31. What is the most rewarding part of your life?
32. Tell me about a time when you responded to a challenge in a way that made you feel really on top of things?
33. How have you been able to develop your skills?
34. How have you been able to meet your needs?
35. What kind of supports have you used that have been helpful to you? How did the supports improve things for you?
36. Tell me about any creative, different solutions you have tried. How did this work out?

The client should be the primary source of information during an assessment. However, if appropriate and with client consent, assessments may include additional information from case manager(s), medical or psychosocial providers, caregivers, family members, and other sources of information.

The assessment should be conducted in a client-centered manner that accommodates clients who are unable or otherwise hesitant to attend the appointment at the provider agency. Diverse methods of interaction (e.g., text-based, via social apps, in-person) should be supported, given that confidentiality policies are adhered to.

The assessments or screenings that are conducted should align with the client's reason(s) for accessing services and point of entry. For example, a client who is interested in accessing HIV/STD testing, PEP, or PrEP should not have to endure a lengthy assessment before accessing these services. Clients should be able to access services as expeditiously as possible. However, in some situations, or at a different point in time, a longer assessment may be appropriate.

Whenever possible, collect demographic information in a manner that is affirming of various identities and of intersecting identities. For example, allow for clients to identify their race or ethnicity using whatever categories best fit for them. When asking questions related to gender identify, consider using the two-step question that captures a transgender person's current gender identity as well as their assigned sex at birth: 1. What is your current gender identity? 2. What sex were you assigned at birth, meaning on your original birth certificate? Also, obtain the client's preferred pronoun (he, she, they, etc.).

If appropriate, assess for barriers to accessing services and remaining engaged in services. If barriers are identified, assist the client in identifying potential solutions.

Specific topics or areas should be assessed only if the provider is prepared to manage the possible responses. For example, if questions are asked pertaining to a client's history of trauma, the provider should be prepared to handle a client's potential

DRAFT

range of emotions.

Specific topics or areas should be assessed only if the provider can offer resources, referrals, and /or services in response. Given that providers/agencies have resources, referrals, and/or services at hand, consider including the following topics in client assessments:

- ✓ Connection to spirituality
- ✓ Intimate Partner Violence
- ✓ Trauma
- ✓ Sex-trafficking

The assessment process should utilize a health promotion approach. This includes using information collected during the assessment/ screening to identify appropriate messages that promote health-seeking behavior and minimize risk-behaviors or circumstances. The intention is to offer information, and suggest services and interventions that are tailored to the specific person (and their partners, if relevant) and to highlight current health promoting behaviors and overall strengths of the client.

Health promotion includes:

- ✓ Provision of information or resources related to health in general (may include overall physical health, nutrition, oral health, spiritual health, etc.), behavioral interventions (e.g., brief or intensive risk reduction strategies that encourage safer sex and use of sterile drug-injection equipment, substance use treatment) and/or biomedical interventions (e.g., PrEP, STD services, special reproductive and pregnancy services)
- ✓ Clarifying concepts and misinformation about HIV transmission, acquisition, or prevention methods
- ✓ Provision of information or resources related to specialized counseling and support to members of HIV-serodiscordant relationships
- ✓ Offering a variety of condoms (e.g. external, internal[12], non-latex, etc.) and lubrication options
- ✓ Provision of information or resources related to new, sterile syringes through syringe services programs, pharmacists, physicians, or other legal methods to persons who lack consistent access to sterile drug-injection equipment

[12] "External" and "internal" condoms are also known as "male" and "female" condoms, respectively, but are not referred to as such in this document since their use is not necessarily aligned with one's gender identity.

The assessment process should include assessing for medical and social factors that impact HIV acquisition.
Individuals at high risk for HIV acquisition can experience significant personal, social, and structural challenges, such as poverty, mental illness, substance use, unstable housing, and lack of regular medical care. Assessments should include questions pertaining to these medical and social factors that influence HIV acquisition.

HIV/STD TESTING AND RETESTING

HIV and STD testing often serve as the first point of entry in the HIV prevention continuum and for many, the key opportunity to facilitate linkage to a comprehensive array of services. Individuals at high risk for HIV should get tested every 1-3 months, regularly assessed for risks and needs, and linked or re-linked to other HIV prevention services, depending on their needs.

The following are standards that apply to HIV testing[13]:

1. HIV testing must be voluntary and free from coercion. Patients/clients must not be tested without their knowledge.
2. Opt-out HIV screening (notifying the patient/client that an HIV test will be performed, unless the patient/client declines) is recommended in all settings.
3. Specific signed consent for HIV testing should not be required.
4. Use of Ag/Ab combination tests is encouraged unless persons are unlikely to receive their HIV test results.
5. Preliminary positive screening tests for HIV infection must be followed by additional testing to definitively establish the diagnosis.
6. Providers should be alert to the possibility of acute HIV infection and perform an antigen/antibody immunoassay or HIV RNA in conjunction with an antibody test. Persons suspected of recently acquired HIV infection should be referred immediately to an HIV clinical-care provider.
7. Agencies should adhere to local and state public health policies and laws to ensure they deliver high-quality HIV testing services that are culturally competent and linguistically appropriate.
8. HIV testing should be simple, accessible, and straightforward. Minimize client barriers and focus on delivering HIV test results and on supporting clients to access follow-up HIV care, treatment, and prevention services as indicated.

[13] Adapted from *Implementing HIV TeSTDng in Nonclinical Settings: A Guide for HIV TeSTDng Providers*. https://www.cdc.gov/hiv/pdf/teSTDng/cdc_hiv_implementing_hiv_teSTDng_in_nonclinical_settings.pdf

9. To reach populations at high risk for HIV infection, sites should employ strategic targeting and recruitment efforts, establish program goals and monitor service delivery to ensure targeted testing is achieving program goals.
10. To provide the most accurate results to clients, sites should use HIV testing technologies that are the most sensitive, cost-effective, and feasible for use at their agency. Establishing relationships with facilities offering laboratory-based HIV testing is important for referring clients who may have acute HIV infection.
11. Agencies should implement a streamlined model of HIV testing that includes delivering key information, conducting the HIV test, completing brief risk screening, providing test results, providing referrals and/or ensuring linkages to services tailored to the client's specific risk.
12. Sites should consider offering HIV testing services for couples or partnered relationships to (a) attract high-risk clients who are not otherwise testing and (b) identify HIV-discordant couples and previously undiagnosed HIV-positive clients.
13. Diagnostic HIV testing and opt-out HIV screening should be a part of routine care in all health-care settings while also preserving the client's option to decline HIV testing and ensuring a provider-client relationship conducive to optimal clinical and preventive care.
14. Inform clients at high-risk for HIV/STDs about 1) methods to reduce the risk of HIV/STD acquisition; 2) STDs that can facilitate HIV acquisition; 3) the benefits of screening for STDs (that are often asymptomatic) and STD treatment
15. Assess these risk factors for HIV/STD transmission:
    - ✓ Sexual, alcohol, and drug-use triggers (boredom, depression, incarceration, sexual violence, sex work, abuse) and behaviors that may lead to HIV/STD transmission
    - ✓ Recent sex and/or needle-sharing partners who were treated for HIV/STDs, and/or other behaviors they may have that contribute to possible HIV acquisition
    - ✓ Past and recent HIV/STD diagnosis, screening, and symptoms
    - ✓ Survival sex work
    - ✓ Sense of self-worth
    - ✓ Lack of basic health information and/or information pertaining to HIV/STD risk
16. Report cases of HIV/STDs according to jurisdiction requirements and inform clients diagnosed with HIV and/or STDs that case reporting may prompt health departments to offer voluntary, confidential partner services
17. Offer external and internal condoms, and lubrication options

HIV and STD Testing services must follow these guidelines, adapted from the CDC:

- All adults and adolescents ages 13 and older should be tested at least once for HIV.

DRAFT

- Annual chlamydia screening of all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection
- Annual gonorrhea screening for all sexually active cisgender women younger than 25 years, as well as older cisgender women with risk factors such as a sex partner who has a sexually transmitted infection.
- Syphilis, HIV, and hepatitis B screening for all pregnant women, and chlamydia and gonorrhea screening for at-risk pregnant women starting early in pregnancy, with repeat testing as needed, to protect the health of mothers and their infants.
- Screening at least once a year for syphilis, chlamydia, and gonorrhea for all sexually active gay, bisexual, and other men who have sex with men (MSM), as well as sexual active transgender women who have sex with men. MSM or transgender women who have sex with men, who have unprotected sex should be screened more frequently for STDs (e.g., at 3-to-6 month intervals).
- Sexually active gay and bisexual men and sexually active transgender women who have sex with men may benefit from more frequent HIV testing (e.g., every 3 to 6 months).
- Anyone who has unprotected sex or shares injection drug equipment should get tested for HIV at least once a year.

In addition, current recommendations for meningococcal vaccines in Los Angeles County include:

- Vaccinate all MSM patients with Quadrivalent meningococcal conjugate (MCV4) vaccine during current outbreak.
- Routinely vaccinate HIV-infected patients with MCV4 vaccine as per the U.S. Advisory Committee on Immunization Practices (ACIP) recommendations.
- Offer HIV testing along with vaccination to all MSM patients who are not known to be HIV-infected and have not been tested for HIV within the last year.
- Refer MSM patients for free MCV4 vaccine if vaccination is not feasible at their primary care provider.
- Report all suspect cases of IMD immediately to LAC DPH.
- MSM who are not HIV-infected should receive 1 dose of MCV4 vaccine (Menveo® or Menactra®). Because meningococcal vaccine induced immunity wanes, a booster dose can be considered for those whose last dose of MCV4 vaccine was >5 years ago.
- HIV-infected persons should receive 2 doses of MCV4 vaccine (Menveo® or Menactra®), 8-12 weeks apart, as their primary series. Previously vaccinated HIV- infected persons who received only 1 dose of vaccine should receive a second dose at the earliest opportunity, as long as it has been at least 8 weeks from first dose. A booster dose should be given every 5 years if the primary series was administered at >7 years of age.
- Although Menactra® and Menveo® are licensed for persons through 55 years of age, they may be administered to persons 56 years of age and older.

DRAFT

{INSERT LINK TO RECOMMENDED VACCINES FOR PEOPLE AT RISK OF HIV HERE}

LINKAGE TO BIOMEDICAL PREVENTION SERVICES

Once the needs of HIV-negative clients are identified via the assessment and/or screening process, they should be connected to appropriate services to address those needs in the most expeditious manner possible. For this reason, agencies should allow clients to self-refer and or to walk-in and access services on their own.

Linkage to prevention services is a critical component of the Comprehensive HIV Continuum. For high-risk HIV-negative individuals who have recently been tested for HIV and STDs, linkage to biomedical interventions (i.e. PrEP and PEP) is often a priority.

The standards for linkage to biomedical prevention services include:

1. If agencies do not provide PrEP services, they must develop written protocols/MOUs with agencies/clinics that do provide PrEP, outlining the referral and linkage process
2. Inform clients about the benefits of biomedical interventions to prevent the acquisition of HIV
3. Ask all high-risk HIV-negative clients if they are interested in learning more about PrEP or PEP
4. Connect all high-risk HIV-negative clients to a PrEP Navigator (in-house or external) within 24 hours (or 2 business days)
5. Provide immediate, active, and, if necessary, repeated, linkage services to clients with an expressed interest in PrEP, and the immediate need for PEP
6. Provide follow-up assistance to clients who are not able to link to a PrEP Navigator
7. If your agency provides PrEP, assess the client's readiness to engage in PrEP services and barriers and facilitators to starting services
8. Help schedule appointments to see a PrEP Navigator or PrEP provider (in-house or external)
9. Offer convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
10. Maintain a client-friendly environment that welcomes and respects new clients
11. Provide reminder (and accompaniment, if possible) for first appointment, using the client's preferred contact method(s)
12. Offer client navigation assistance and support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
13. Identify and utilize specific strategies designed to overcome barriers to successful linkage. Such strategies may include:

DRAFT

- ✓ Co-locating HIV testing and biomedical interventions
- ✓ Client accompaniment to access services
- ✓ Multiple case management sessions
- ✓ Motivational counseling
- ✓ Providing trauma-informed care
- ✓ Providing crisis intervention counseling
- ✓ PrEP navigation

14. Offer guidance and assistance on how to obtain financial assistance for PrEP through private- or public-sector sources
15. Assist with health insurance and other benefits, including linkage to health insurance navigators, case management and client navigation, and intervention-specific programs (e.g. PrEP medication and co-pay assistance programs)

REFERRALS AND LINKAGES TO NON-BIOMEDICAL PREVENTION SERVICES:

Although numerous HIV prevention related services exist throughout Los Angeles County, clients in need of services may not be willing or able to access them. For example, an undocumented transgender woman may want to access regular primary care, but may not feel comfortable doing so if she fears transphobia or legal implications. For this reason, while the ultimate goal is *linkage* to a needed service, oftentimes *referrals* are all an agency can be held accountable for.

Standards related to referring clients to non-biomedical services focus on *active referrals* rather than *passive referrals*. The latter defined as telling a client about a service and or giving them a phone number and leaving it up to them to initiate contact. Conversely, active referrals address barriers to accessing services by helping the client make contact with a service provider or agency. This may include scheduling the appointment with the client and/or accompanying them to their first appointment.

Based on information obtained via the assessment process, clients may be in need of any number of prevention services; specialty services that address medical needs (e.g. primary care); and/or social needs (e.g. needs related to housing, employment etc.). Whenever possible, agencies should strive to provide specialty services onsite. If this is not feasible, providers need to ensure that clients are referred to external specialty services. How these services are prioritized depends upon the need of each particular client.

DRAFT

The standards for actively referring clients to non-biomedical prevention services include:

1. Developing written protocols/MOUs with other HIV/STD prevention and primary care providers and social service agencies to ensure linkage to appropriate prevention services
2. Assisting clients with enrolling in health insurance by referring them to a benefits counselor
3. Actively referring clients who are not accessing regular care to a medical home or primary care provider
4. Assessing possible facilitators and barriers to accessing services
5. Tracking outcomes of referral services (i.e. track linkages) and providing follow-up assistance to clients who have not been linked to prevention services
6. Helping schedule the first prevention-related service appointment
7. Actively referring to mental health services, substance use services, behavioral interventions and other psychosocial and ancillary services (e.g. housing, employment, nutritional and social support)
8. Providing transportation assistance to the first visit, when possible
9. Offering convenient scheduling whenever possible (e.g., same-day or priority appointments, extended hours)
10. Maintaining a client-friendly environment that welcomes and respects new clients
11. Providing reminders for first appointment, using the client's preferred contact method
12. Offering client navigation assistance and support to encourage attendance (e.g., directions, transportation resources, such as Metro tokens or ride shares)
13. Identifying and utilizing specific strategies designed to overcome barriers to successful linkage. Such strategies may include:
    - ✓ Co-locating HIV testing and prevention services
    - ✓ Multiple case management sessions
    - ✓ Motivational counseling
    - ✓ Trauma-informed care
    - ✓ Crisis intervention counseling
    - ✓ Navigation assistance, specifically assigning one navigator for each client (i.e. vertical navigation)
14. Maintaining a relationship with a consistent prevention team
15. Offering assistance with health insurance and other benefits, including active referrals to health insurance navigators
16. Make available online directories of providers, agencies, telemedicine agencies, and professional advice hotlines that

DRAFT

offer specialty services. Ensure that these resources are gay- and trans-affirming and otherwise culturally appropriate.

17. Develop and participate in provider networks that offer specialty services for persons with HIV, especially persons who are uninsured or underinsured or who live in underserved areas
18. Develop written protocols, memoranda of understanding, contracts, or other agreements that define financial arrangements, staff and agency responsibilities for providing linkages, making referrals, and the tracking of referral completion and satisfaction
19. Establish policies and procedures to safeguard the confidentiality of personal and health information exchanged during the linkage/referral process
20. Train staff and any specialty service providers in the following topics:
    - Staff roles and responsibilities within the agency
    - Issues such as sex trafficking, substance use, etc. that can provide a better understanding of their clients' needs
    - Identifying specialty service providers who serve the community
    - Tailoring of services to personal characteristics (e.g., language, location, and insurance status)
    - Inter- and intra-agency referral procedures
    - Maintaining confidentiality of collected personal information
    - Advocating for persons who need specialty services
    - Minor consent for HIV/STD testing (consent from youth aged 13 and older)
21. Engage case managers, navigation assistants, or other staff to provide service coordination for persons living with or at risk for HIV who have complex needs
22. Routinely provide print or audiovisual materials that describe specialty services provided onsite or through referrals
23. Monitor the quality of referrals for specialty services to inform quality improvement strategies (e.g., proportion of referred persons who obtained specialty services), client satisfaction, and barriers and facilitators
24. Routinely assess agency staff regarding knowledge and comfort to offer the prevention services the agency is providing, with language that is appropriate for the staff level (plain language for non-medical staff, etc.)
25. Include services related to economic empowerment and job-readiness

DRAFT

RETENTION AND ADHERENCE TO PREVENTION SERVICES

A key component of the Comprehensive HIV Continuum is retention and adherence to prevention services to facilitate ongoing access to the full array of services, including biomedical interventions, behavioral interventions, psycho-social services, etc.

Standards for Retention to all Prevention Services must include:

1. Assisting clients with scheduling follow-up visits
2. De-stigmatizing HIV - people living with HIV, stigma of getting HIV if prevention fails, etc.
3. Providing reminders for all visits, using the client's preferred method of contact
4. Offering or referring to navigation assistance, when possible
5. Reinforcing the benefits of prevention services
6. Regularly assess facilitators and barriers to retention, and supporting clients to overcome identified barriers
7. Regularly assessing clients' need for prevention services: *Have their needs changed? Do they no longer need services? Do they need different services?*

Standards for Adherence to Biomedical Prevention Services must include:

1. Inform clients about the benefits of sustained adherence to PrEP and PEP
2. Provide adherence support tailored to each client's needs and characteristics, and/or connect clients to medication adherence interventions
3. Work with client to develop a plan for stopping PrEP, when appropriate (e.g. temporarily, long-term, or quitting use) and transitioning to other prevention options, including addressing relationship issues and health issues that increase HIV/STD risk
4. Provide or make referrals for services to address factors that may impair adherence (e.g., comorbidity, financial, psychosocial, and structural issues)
5. Offer advice on how to maintain financial assistance for PrEP through private- or public-sector sources
6. Advise clients to take PrEP medications as prescribed; provide information about the regimen, and check for understanding in the following areas:

DRAFT

- ✓ Details of the regimen, including dosing method and schedule, dietary restrictions, and what to do when drinking alcohol or when missing doses
- ✓ Consequences of missing doses
- ✓ Potential side effects
- ✓ Potential interactions with other prescription, nonprescription, and recreational drugs, alcohol, and dietary supplements that may impair PrEP medication effectiveness or cause toxicity that could impair adherence
- ✓ Advising the client that PrEP does not protect them from other STDs and pregnancy

7. Routinely assess the client's questions, concerns, or challenges regarding PrEP use to identify potential problems
8. Assess self-reported adherence at each visit using a nonjudgmental manner
9. Assess and manage side effects at each visit
10. Consider assessing PrEP prescription refills or pill counts, if feasible, when needed to supplement routine assessment of self-reported adherence
11. Address misinformation, misconceptions, negative beliefs, or other concerns about PrEP regimen or adherence
12. Acknowledge the challenges of maintaining high adherence over a time and offer long-term adherence support, especially when health coverage, insurance, or other life circumstances change
13. Promote disclosure of challenges to adherence, and when disclosures occur, address them in a nonjudgmental manner
14. Apply motivational interviewing techniques during routine adherence assessments. These include:
    a. asking about the methods clients have successfully used or could use to increase adherence
    b. asking about recent challenges to adherence and how they could be overcome
15. Offer advice, tools, and training tailored to individual strengths, challenges, and circumstances to support adherence. Examples of advice include:
    a. linking taking PrEP to daily events, such as meals or brushing teeth
    b. using pill boxes, dose-reminder alarms, or diaries as reminders
    c. carrying extra pills when away from home
    d. actions to take if pill supply is depleted or nearly depleted
    e. avoiding treatment interruptions when changing routines (e.g., travel, erratic housing, or legal detention)
    f. consulting HIV care providers before surgery or when experiencing a new health condition or a change in life circumstance that might impair PrEP use (e.g., change in prescription, nonprescription, and other drug use)
16. Encourage persons to seek adherence support from family members, partners, or friends, if appropriate

DRAFT

Key Documents Used:

Ryan Service Standards Guide http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf. Accessed March 31, 2017.

Journal of the International AIDS Society: "Towards an integrated primary and secondary HIV Prevention continuum for the United States: a cyclical process model; Published November 17th, 2016

Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings Recommendations for Adults and Adolescents

SPECIAL ACKNOWLEDGEMENTS

We would like to thank the following individual for serving as expert reviewers and providing feedback on the development of the prevention service standards.

Stacy Alford	Children's Hospital Los Angeles
Alonso Bautista, MA, MFT	Alta Med Health Services
Joseph Cadden, MD	Los Angeles Commission Standards and Best Practices Committee
Danielle Campbell	University of California Los Angeles (UCLA) and Charles Drew University
Peter Cruz	Asian Pacific AIDS Intervention Team
Jamie Deville, MD	UCLA-Care Families Program (HIV+ Adolescents and Families)
Tom Donahoe	Los Angeles Area AIDS Education and Training Center
Matthew Emons, MD, MBA	Los Angeles Commission Standards and Best Practices Committee
John Carlos Fabian	Center for Health Justice
Dahlia Ferlito	AIDS Coordinator Office, Los Angeles
Nourbese Flint, MA	Black Women for Wellness
Thelma Garcia	East Los Angeles Women's Center
Wendy Garland, MPH	Los Angeles Commission Standards and Best Practices Committee
Gerald Garth	Black AIDS Institute

DRAFT

Grissel Granados	Los Angeles Commission Standards and Best Practices Committee
Michael Green, PhD, MHSA	Division of HIV and STD Programs
Nina Harawa, PhD	University of California Los Angeles (UCLA)
Kathleen Jacobson, MD	Keck School of Medicine, University of Southern California
Marcus Jordan	Community Member
Kim Kisler, PhD	Friends Research Institute
Roxanne Lewis	JWCH Institute
Miguel Martinez	Children's Hospital Los Angeles
riKu Matsuda	Los Angeles County Human Relations Commission
Donta Morrison	AIDS project Los Angeles – Youth Programs
Katja Nelson, MPP	AIDS Project Los Angeles
Brendan O'Connell	Bienestar
Diana Oliva, MSW	St. John's Well Child and Family Center
Angelica Palmeros, MSW	Los Angeles Commission on HIV Standards and Best Practices Committee
Thomas Puckett, Jr.	Los Angeles Commission on HIV Standards and Best Practices Committee
Craig Pulsipher, MPP, MSW	AIDS Project Los Angeles
Raul Quintero	JWCH Institute
Maria Rangel, MPA	UCLA-FAN
Terri Reynolds	Asian American Drug Abuse Program
Ace Robinson, MPH	Los Angeles Commission on HIV Standards and Best Practices Committee
Jenice Ryu, MD	LAC/USC Rand-Schrader Clinic
Stewart Slechta	Tarzana Treatment Centers
Milton Smith	Connect to Project Los Angeles
Terry Smith, MPA	Los Angeles Commission on HIV Standards and Best Practices Committee
Martha Tadesse, MSN, MPH, MPA, CCHP, RN	Los Angeles County Sheriff's Department
Octavio Vallejo, MD, MPH	Los Angeles Commission on HIV Standards and Best Practices Committee
Alberto Vasquez	Bienestar – Hollywood Center
Arlene Vasquez	Southern California Alcohol & Drug Program, Inc.
Joseph Wing, LMFT	Department of Mental health

DRAFT