Contractor Guidance for Division of HIV/STD/HCV Prevention Program Models

AI Contractor Webinar for New AI Contract Work Plans
October 14, 2014

Division of HIV/STD/HCV Prevention
HIV Prevention in the US:

National Priorities:

• Intensify HIV prevention in communities where HIV is most heavily concentrated

• Expand targeted use of effective combinations of evidence-based HIV prevention approaches

• Educate all Americans about the threat of HIV and how to prevent it
Expanding the Impact of HIV Prevention: CDC’s Approach

High Impact Prevention:
Guided by five major considerations

• Effectiveness and cost
• Feasibility of full-scale implementation
• Coverage in the target populations
• Interaction & targeting
• Prioritization
It is within our reach to end the AIDS epidemic in New York State.
Bending the Curve

Reduction in new HIV infections

• Reduce from 3,000 to 750 new HIV infections by 2020;
• Decrease the number of New Yorkers living with HIV for the first time.
Bending the Curve

- Total New Yorkers living with HIV/AIDS
- New HIV infections
- HIV/AIDS deaths

Year:
- 2000
- 2014
- 2020
- 2025

Cases:
- 150,000
- 3,000
- 750
Bending the Curve 3-Point Program

• Identify all persons with HIV who remain undiagnosed and link them to health care

• Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission

• Provide Pre-Exposure Prophylaxis (PrEP) for high risk persons to keep them HIV negative
Ending the Epidemic by 2020:
Still have some work to do ...

**Diagnosis Gap:**
- 154,000 estimated HIV infected persons
- 132,000 persons diagnosed with HIV
- 22,000 undiagnosed persons need to be diagnosed and linked to care.

**Treatment Gap:**
- 132,000 estimated HIV infected persons
- 68,000 virally suppressed
- 64,000 persons currently diagnosed need therapy to achieve viral suppression

**Total Gap:**
86,000 persons needing diagnosis and treatment
Reframing HIV Prevention: Closing the Gaps

- **Implement Major Changes to Contract Work Plans**
  - Standardized
    - across most DOP contracts
  - Streamlined
    - limited to necessary information
  - Highly Focused
    - contractors choose from limited number of program options
  - Flexible
    - permit tailoring and use of locally developed interventions that are evidence based
  - Time-phased
    - will be implemented as contracts are renewed
AI Contracts will Focus on High Impact HIV Prevention Programming

- Client Recruitment, Health Promotion, Public Information
- STD Testing & HCV Screening
- Condom Promotion, Education and Distribution
- Syringe Access Services
- Evidence Based Interventions
- Community Level Interventions
- Navigation and Retention in Services
- HIV Testing and Linkage to Prevention & HIV Care Services
Focus efforts in communities where HIV is most heavily concentrated & to populations of highest risk

Educate and raise awareness about HIV related issues (e.g., prevention, transmission, health disparities, & stigma/discrimination)

Reduce new HIV & STD infections

Increase Viral Load Suppression among PLWHA
Division of Prevention Work Plans & Generic Program Models

ATTACHMENT C – WORK PLAN

PROJECT NAME: Generic Division of HIV/STD/HCV Prevention Initiative

CONTRACTOR'S PAYEE NAME: ____________________

CONTRACT PERIOD: From: ____________ To: ____________

Provide an overview of the project including goals, tasks, desired outcomes and performance measures:

This project supports a high impact approach to prevention efforts. Funded interventions and activities seek to decrease the spread of HIV/STD/HCV through the provision of interventions and services that seek to:

- Intensify high impact prevention efforts in communities where HIV is most heavily concentrated.
- Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.
- Educate and raise awareness about HIV related issues including prevention, transmission, health disparities, and stigma/discrimination.
- Integrate STD and HCV screening/testing, referrals and education within HIV program.

Funding allows for the provision of HIV counseling/testing, and referral services (anonymous or confidential), STD/HCV screening and linkage to care, prevention outreach, health education/risk reduction, comprehensive risk reduction counseling, condom distribution, harm reduction services, peer training & support, case management, transitional planning/exit services, and other support services. Prevention interventions and client services are provided in community and criminal justice settings and address the prevention and support needs of HIV positive men and women. Prevention interventions and services are also targeted to individuals at highest risk for HIV/STD/HCV including men who have sex with men, young men of color who have sex with men, substance users, high risk heterosexual men and women, and transgenders.

The expected outcomes are to reduce disease incidence, decrease the rate of HIV transmission, decrease risky sexual and drug use behaviors among HIV positive and persons at high-risk for acquiring HIV; increase the proportion of HIV/STD/HCV infected individuals who are aware of their status, and increase the proportion of infected persons who are linked to prevention, partner services and treatment/medical care.

Work Plan, Attachment C, Contract # ______ Page 1 of 14

<table>
<thead>
<tr>
<th>Contractors funded by the Division of HIV/STD/HCV Prevention Services are required to select one program model below. Listed service targets are minimum requirements for funding.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Program Model Options</strong></td>
</tr>
<tr>
<td>Program Model #1 – HIV testing and linkage to prevention and HIV care services, navigation and retention in services for HIV+ and/or high risk negatives. Linkage to STD testing &amp; HCV screening, condom distribution, and 2 evidence based interventions for HIV+ and/or high risk negatives</td>
</tr>
<tr>
<td>Program Model #2 – HIV testing and linkage to prevention and HIV care services, navigation and retention in services for HIV+ and/or high risk negatives. condom distribution, 1 evidence based intervention for HIV+ and/or high risk negatives, and STD testing 8/4 for HCV screening</td>
</tr>
<tr>
<td>Program Model #3 – Linkage to HIV/STD testing &amp; HCV Screening, navigation and retention in services for HIV+ and/or high risk negatives, condom distribution, and 3 evidence based interventions for HIV+ and/or high risk negatives (at least one HEP EBI for HIV clients)</td>
</tr>
</tbody>
</table>

**HIV Testing and Linkage to Prevention & HIV Care Services**

- Service Target: A minimum of L in HIV tests, annually
- Obtain a previously unadjusted positivity rate of 1% annually
- All Program Models require 100% of high risk clients (MSM, IDU, and/or high risk heterosexual and/or STD/HCV positive clients) who receive HIV testing be referred to prevention services (e.g., evidence based interventions/homegrown interventions, navigation and retention services, nPEP, PEP, STD testing 8/4 for HCV screening). 60% of the L in HIV clients will be linked to services.
- All Program Models require 100% of newly identified HIV-positive clients who receive their test result will receive navigation and retention in services and linked to medical care, partner services, prevention counseling, and offered testing/screening or referred for testing/screening for STDs and HCV.

- Linkage to HIV Care Services and Navigation Based Intervention
  - ARTAS is a public health strategy that can be used to fulfill all or part of the navigation and retention in services program service requirement.

For contracts not offering HIV testing: Refer high risk clients for HIV, STD testing and/or HCV screening.

**Navigation and Retention in Services for HIV+ and/or High Risk Negatives**

- Service Target: L in unduplicated clients, annually
- Contractors must provide navigation and retention services (including patients obtaining necessary information, support, and skills to access complex medical systems) for HIV-positive and high risk negative individuals at all stages of care, treatment, prevention, and essential support services.
- At least 25% of clients enrolled must be HIV-positive individuals
- 75% of clients should be MSM, IDU, high-risk heterosexuals, and/or STD/HCV positive clients
- All clients receiving navigation and retention services must have evidence of an up to date risk assessment, linkage to care, treatment adherence assessments and viral load and/or CD4 levels documented as appropriate.

- The following activities should be included:
  a) Provision of services that reduce and/or eliminate barriers to care and services, such as accompanying individuals to medical appointments, providing transportation services, etc.
  b) Navigation of essential support services that complement biomedical and behavioral change prevention services;
  c) Referrals, follow-up, and confirmation of linkages for treatment adherence support, mental health, substance use, legal services, nPEP & PEP EBI, etc.
HIP Generic Program Models

Targeted HIV/STD/HCV Prevention Services

STD Testing & HCV Screening

HIV Testing & Linkage to Prevention and Care Services

Navigation and Retention in Services

Evidence-Based Interventions

Condom Promotion, Education & Distribution

Linkage to STD Testing & HCV Screening

Program Model #1

Program Model #2

Program Model #3
## Work Plan C: HIV Testing

### ATTACHMENT C – WORK PLAN

#### SUMMARY

<table>
<thead>
<tr>
<th>Objective</th>
<th>Budget Category</th>
<th>Tasks (Activities)</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet work plan target regarding the number of projected testing events.</td>
<td>NA</td>
<td>- Conduct confidential HIV testing and linkage to services in accordance with NYS public health law, HIV testing law as well as contractual obligations.</td>
<td>At least 85% of HIV tests conducted relative to the number projected (projected vs. actual).</td>
</tr>
</tbody>
</table>
| Increase the % of persons tested in non-clinical settings who are MSM, IDUs, and/or high-risk heterosexuals. | NA | - Recruit high risk clients for HIV testing:  
  - Precisely identify target population and actual or “virtual” places to locate the population  
  - Develop and plan a recruitment strategy (where, when, how) which incorporates appropriate messaging and is responsive to the needs of your target population: Strategies can include  
    - Outreach (Street based, Venue based, Internet)  
    - Social Networking  
    - Internal referrals or External referrals  
  - Utilize social media to facilitate client recruitment for HIV testing where possible.  
  - Perform a risk assessment to determine the need for HIV testing and for any other screening/testing/referral needs (STD, HCV, harm reduction, non-HIV related services, etc.). | At least 75% of clients tested in non-clinical settings will be MSM, IDUs, and/or high-risk heterosexuals. |

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**Projection**

- **250 HIV Tests**
  - **Measure:** 85%
  - **213 Tests**
  - **Measure:** 75%

**~ 160 clients identify as MSM, IDU &/or HRH**
HIV Testing and Linkage to Prevention & HIV Care Services

• Conduct HIV targeted testing among persons at high risk for infection
  • Increase the number of targeted population members tested for HIV
  • Increase the number of targeted population aware of HIV status

• Link all HIV positive clients to:
  • Medical care
  • Partner Services
  • Prevention Interventions
  • Navigation and Retention Services
Navigation and Retention in Services for HIV+ and/or High Risk Negatives
(Promoting Access)

• Provide navigation and retention in services for HIV positive and high risk negative (HRN) individuals at all stages of care
  • Conduct an assessment:
    • Risk screening (behavioral)
    • Services

Goals are to:
• Eliminate barriers to care – sustained linkage
• Secure support services
• Facilitate risk reduction interventions
  • EBI and or public health strategy
  • Prevention counseling,
  • Partner services
  • Treatment education/adherence support
Navigation and Retention in Services for HIV+ and/or High Risk Negatives (Promoting Access)

**HIV Positive: 25% must be HIV positive**
- Ensure linkage to medical care, partner services and prevention interventions and other support services
- Discuss and document viral load and CD4 cell count

**High Risk Negatives:**
- HIV testing, linkage to needed medical, support and prevention services, including STD screening, PrEP, nPEP, EBI, public health strategy, etc
Evidence Based Interventions for HIV+ and/or High Risk Negatives:

- **Implement High Impact Prevention (HIP) Interventions and Strategies**
  - Supported EBIs, public health strategies
  - Locally developed interventions
    - Must meet 15 common factors

- **Target interventions and strategies to high risk persons (HRN and HIV positive)**
  - 75% must be MSM, IDU, HR heterosexual
  - 25% of clients must be HIV positive
Evidence Based Interventions for HIV+ and/or High Risk Negatives:
High Impact Prevention (HIP) Interventions and Strategies

<table>
<thead>
<tr>
<th></th>
<th>Single-Session</th>
<th>Multi-Session Group</th>
<th>Multi-Session Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>_____ Total # of unduplicated clients, annually</td>
<td>_____ Total # of unduplicated clients, annually</td>
<td>_____ Total # of unduplicated clients, annually</td>
</tr>
<tr>
<td># _____ Personalized Cognitive Counseling (PCC)*§</td>
<td># _____ WiLLOW †</td>
<td># _____ ARTAS †</td>
<td></td>
</tr>
<tr>
<td># _____ RESPECT §</td>
<td># _____ Healthy Relationships†</td>
<td># _____ CRCS †§</td>
<td></td>
</tr>
<tr>
<td># _____ VOICES/VOCES*§</td>
<td># _____ CONNECT †§</td>
<td># _____ Project START †§</td>
<td></td>
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<tr>
<td># _____ Safe in the City §</td>
<td># _____ d-up*§</td>
<td># _____ CLEAR †</td>
<td></td>
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<tr>
<td># _____ Partnership for Health †</td>
<td># _____ PROMISE*†</td>
<td># _____ Locally Developed Intervention</td>
<td></td>
</tr>
<tr>
<td># _____ Sister to Sister §</td>
<td># _____ POL for MSM*§</td>
<td></td>
<td></td>
</tr>
<tr>
<td># _____ Locally Developed Intervention</td>
<td># _____ Mpowerment*§</td>
<td># _____ Many Men Many Voices (3MV)*§</td>
<td></td>
</tr>
<tr>
<td></td>
<td># _____ Locally Developed Intervention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*EBIs that are appropriate for adaption for the Transgender population
† Prevention with HIV Positive Person
§ Prevention with High Risk Negatives
Condom Promotion, Education and Distribution for HIV+ and/or High Risk Negatives

*Engage all HIV positive and high risk negative persons in a discussion about condoms*

- *Document at the individual client service level*
- *Classify by: HIV positive or High risk negative*

| Condom Promotion, Education and Distribution for HIV+ and/or High Risk Negatives |
|---|---|
| HIV Positive | High Risk Negatives |
| _____ # of Condoms Distributed | _____ # of Condoms Distributed |
STD Testing & HCV Screening

• Incorporate information about STD testing and HCV screening in your HIV prevention program
• Link (or provide*) all high risk persons to STD testing and HCV screening –
  • Based on a behavioral risk assessment
  • Connect to medical care as appropriate

*Requires Division approval
Data Collection and Reporting Requirements:
Reporting Services in AIRS

Sample for Program Model #3

• Navigation and retention in services
• Condom distribution
• 3 evidence based interventions
  (Everyone is familiar with EBI models)
Service Mapping for

**Navigation and retention in services**

<table>
<thead>
<tr>
<th>Model: Navigation and SS</th>
<th>Navigation and retention in services</th>
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</thead>
<tbody>
<tr>
<td>Intervention: Promoting Access to Care</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Cat: 00045</th>
<th>Promoting Access to Care</th>
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<tbody>
<tr>
<td>Encounter: 156</td>
<td>Promoting Access</td>
</tr>
<tr>
<td>Service: 238</td>
<td>Escort</td>
</tr>
<tr>
<td>Service: 346</td>
<td>Health Education - Individual</td>
</tr>
<tr>
<td>Service: 439</td>
<td>Intake/Assessment</td>
</tr>
<tr>
<td>Service: 702</td>
<td>Reassessment</td>
</tr>
<tr>
<td>Service: 712</td>
<td>Referral for Care</td>
</tr>
<tr>
<td>Service: 713</td>
<td>Referral for Testing</td>
</tr>
<tr>
<td>Service: 1055</td>
<td>Referral for Case Management</td>
</tr>
<tr>
<td>Service: 1120</td>
<td>Referral for Supportive Services</td>
</tr>
<tr>
<td>Service: 1121</td>
<td>Referrals for STI Screening</td>
</tr>
<tr>
<td>Service: 1123</td>
<td>Return to Care Escort</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>7/1/2014</td>
<td>6/30/2015</td>
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Illustrated Encounter Screen

Linkage to care service and referral

Actual Date: 10/02/2014
Program: FWABR
Contract: PREV2012

Service Category: 00045 Promoting Access to Care
Model: 36224 Navigation and SS
Intervention: 3669 Promoting Access to Care
Encounter: 156 Promoting Access

Staff: FWAAM Bob, Bob
Site: FWAAB SITE One

Prevention Related Information:
Session Number: 0
Incentive Provided: 
# Male Condoms: 10
# Female Condoms: 4

Services Provided: Referral for Care

Referrals Provided: Medical/Health - Primary Care - Clinic
Reporting Referrals for

**Navigation and retention in services**

Reported with each encounter
## Reporting Condoms Distributed

Reported with the individual client encounter

<table>
<thead>
<tr>
<th>Prevention Related Information</th>
<th>Next Scheduled Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Number: 0</td>
<td>Date: //</td>
</tr>
<tr>
<td># Male Condoms: 10</td>
<td>Location: //</td>
</tr>
<tr>
<td># Female Condoms: 5</td>
<td></td>
</tr>
</tbody>
</table>

Services Provided: Referral for Supportive Services