Colorado Department of
Public Health & Environment

HIV Prevention Guidelines

Effective Date: January 1, 2007

Colorado Department of Public Health and Environment (CDPHE)

Definitions for HIV Prevention Interventions and Standards of Practice

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Section I: Characteristics of Successful HIV Prevention Programs and Theoretical Considerations

General Characteristics

1) They are based in behavioral and social science theory and research. Widely recognized theories include: Health Belief Model, Social Cognitive Theory, Theory of Reasoned Action, Transtheoretical (Stages of Change) Model, Diffusion of Innovation, Empowerment Theory, AIDS Risk Reduction Model, and Theory of Gender and Power.
2) They have clearly defined target groups, objectives, and interventions.
3) They have their basis in real, expressed needs of the community and individuals, and are designed according to the results of a comprehensive assessment of those expressed needs as well as an assessment of the level of motivation of the target population to change risk behaviors.
4) They are easy to access by the target populations.
5) They are culturally competent and their prevention messages are linguistically appropriate and tailored to the audience members in terms of culture, gender, age, sexual orientation, and educational level, with accommodations made for disabled participants.
6) They address the social and community norms of the target population so that program participants receive consistent messages and reinforcement for the prescribed behavior change.
7) They are offered to the target group as part of a continuum of health care (e.g. substance abuse treatment, STD testing and treatment, family planning, other physical and mental health services, etc.).
8) They address other basic needs of the targeted population (e.g. housing, food, etc.) in order for HIV prevention to be considered a priority.
9) They provide appropriate referrals that may include, but are not limited to: substance abuse treatment, HIV counseling and testing, family planning services, STD testing and treatment, hepatitis-related services, risk-reduction or relapse prevention counseling, mental health counseling, tuberculosis testing, women's health services, and HIV early intervention services.
10) They focus on behavioral skills that include how to carry out safer behaviors as well as how to avoid and cope with high-risk situations.
11) They do not provide messages that are judgmental, moralistic, or that attempt to instill fear.
12) They have ample duration and intensity to achieve lasting behavior change, and provide the support and skills necessary to maintain behavior change.
13) They incorporate quality assurance measures and adherence to plans.
14) They use evaluation findings to make timely adjustments to the programs, in order to better meet the needs of the target population.
15) They have realistic financial, human, and material resources to carry out the program.
16) They have a plan on how services will be accessible and appropriate to people who are deaf, hard-of-hearing, visually impaired, developmentally disabled, mentally disabled, or physically disabled.
17) They have protocols in regard to the safety of staff, volunteers, and clients.

Theoretical Considerations

HIV prevention programs that are most likely to succeed are based on a clear understanding of the targeted health behaviors of a well-defined target population as well as their environmental context. Theories of behavior change can and should be used to understand the "prerequisites" or necessary components for change within a target population. They can be used to help planners and educators better understand the influences upon human behavior that need to be addressed in HIV prevention interventions. They can guide the development and management of strategic planning models by providing planning groups with a checklist of factors to consider in assessing needs and in designing an intervention. They can also guide the appropriate evaluation of an intervention as they suggest what to monitor and how to measure effectiveness.

Theory and Its Importance to Health Programs

A theory is a set of interrelated concepts, definitions, and propositions that present a systematic view or explanation of behaviors, events, or situations by specifying relations among multiple variables or factors. Theories are "abstractions," which mean they are not meant to explain specific and concrete content or topic areas such as specific behaviors of particular individuals. Instead they provide the shape and the boundaries for explaining a wide range of phenomena such as behavior patterns seen within groups of individuals. Theories are also generalizable, which means they can be used to explain a variety of similar situations among different populations and predict outcomes. Formal theories are those that are developed and tested within a scientific framework.

Theories can help us understand the nature of targeted health behaviors and suggest ways to achieve positive behavior change. They can explain the dynamics of the behavior, the processes for changing the behavior, and the effects of external influences on the behavior. Theories can also help, but should not be the only determinant, that health providers use to identify the most appropriate target populations for programs, the most effective methods for accomplishing positive behavior change, and the outcomes for evaluation. Some theories focus on individuals as the unit of change, while others focus on change in groups, communities, or organizations.

Theories and Approaches Relevant to HIV Prevention

Because the HIV epidemic is driven by behavior, psychological and social theories of human behavior and behavior change have made significant contributions to the design, development, and evaluation of HIV prevention interventions. Programs that are most likely to be effective are guided by an ecological perspective, based not only on a clear understanding of targeted health behaviors, but also on their environmental context. Therefore one must approach HIV prevention, as well as other public health issues, at multiple levels of influence, stressing the interaction and integration of factors within and across levels. Key to this is the recognition that human behavior is affected by and is affecting these multiple levels of influence that are occurring within personal, social, and cultural environments. Therefore programs should combine behavioral and environmental components and be based on research and formative evaluation that assesses needs and influences at multiple levels. Below is a list of some of the principle theories that have been used to guide HIV prevention interventions at individual and

group levels and at the level of the target population or community. Brief summaries of these theories can be found in Appendix A.

- Health Belief Model
- Theory of Reasoned Action
- Social (Cognitive) Learning Theory
- Transtheoretical Model (Stages of Change)
- Diffusion of Innovation
- Empowerment Theory
- AIDS Risk Reduction Model
- Theory of Gender and Power

Discussion

One of the greatest challenges is to learn to analyze the "fit" of a theory or model for issues one is working with, especially since the various theories used within the arena of HIV prevention share many elements. For instance, the four most prominent individually-based theories (the Health Belief Model, the Theory of Reasoned Action, Social Learning Theory, and the Transtheoretical Model) have the following in common: 1) perceptions of threat and susceptibility; 2) attitudes toward performing risk-reduction behaviors; 3) normative beliefs about one's peers and community members; 4) beliefs and attitudes about one's own ability to carry out preventive actions; 5) the acquisition of social and behavioral skills that result in risk reduction; and 6) motivational factors that bring a person to a state of readiness to act. What distinguishes these is what they emphasize. In designing a behavioral intervention, depending on the needs of the target population, one might use a combination of theories as the best fit to guide design, implementation, and evaluation.

The theories described above are not without their critics. The models of behavior change that focus on individuals are commonly critiqued for their lack of emphasis on context and the powerful influences on human behavior that are drawn from the sociocultural environment. Those that emphasize populations and communities are, in turn, critiqued, for their inability to accommodate the needs of individuals who may be disenfranchised from communities and/or who have special needs different from those of the general population. Others see a major limitation in the lack of specificity in all of these theories concerning sexual desire, pleasure, affection, and sexual self-esteem. Relationships are at the core of HIV transmission, but the unique features of these relationships (love, affection, self-esteem, power, survival, intimacy, coercion, lust, and trust) are not directly addressed by existing models of behavior change.

Sources

- Calichman, Seth C., 1998, *Preventing AIDS: A Source Book for Behavioral Interventions*. Lawrence Erlbaum Associates, Inc.
- California STD/HIV Prevention Training Center, 1998, *Participant Manual: Bridging Theory and Practice*.
- National Cancer Institute, 1999, *Theory at a Glance: A Guide for Health Promotion Practice*. National Institutes of Health.
- Wingood, Gina M. and Ralph J. DiClemente, 2000, Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risks Factors, and Effective Interventions for Women. *Health Education and Behavior*. (October).

Other Resources
Compendium of HIV Prevention Interventions With Evidence of Effectiveness. Available on the Centers for Disease Control and Prevention (CDC) web site:
http://www.cdc.gov/hiv/pubs/HIVcompendium.pdf

Denver STD/HIV Prevention Training Center, Denver Public Health

Other Considerations

Competence Regarding Culture, Disability, and Other Diversity

1) Cultural Competence/Proficiency
Organizations must adhere to and demonstrate a philosophy of cultural competence and proficiency as characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and adaptations of service models in order to better meet the needs of communities of color. These agencies provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, are committed to policies that enhance services to diverse clientele and to move the agency to a position of cultural proficiency.

Culturally proficient agencies are characterized by holding culture in high esteem and seek to add to the knowledge base of culturally-competent practice by including but not limited to such areas as research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects. Attitudes, policies, and practices are the three major areas wherein development can and must occur if agencies are to move toward cultural proficiency.

As agencies gain more experience in the delivery of culturally competent services, they will acknowledge that many of the communities that are greatly impacted by HIV are disenfranchised with limited access to social, economic and political power. It is not unreasonable to expect that HIV prevention providers will develop linkages with grass root initiatives that address these broader health and social issues. In addition to the immediate goal of preventing further spread of HIV in such communities, organizations involved in prevention work are encouraged to align their programs with community efforts for self-determination and self-development. Through support of such community efforts, individuals and communities may use "their culture as an empowering tool for the achievement of personal and community health and well-being."[1] By reinforcing group identity, a sense of belonging, political advocacy and activism, community members are enlisted to develop effective responses to the conditions that contribute to high rates of HIV/AIDS among people of color.

[1] Singer, Merrill, "Confronting the AIDS Epidemic Among IV Drug Users: Does Ethnic Culture Matter," *AIDS Education and Prevention*, 1991, 3 (3): 258-283.

2) People with Disabilities, Including Those Who are Deaf, or Hard-of-Hearing

All CDPHE funded HIV prevention contractors should adhere to the following:

a) Each funded organization should develop a written access plan for people with disabilities (other than AIDS-defined disabilities) based on the services they will be providing. For example an agency would have a reasonable plan for accommodating people who use wheelchairs, or qualified interpreters would be provided upon request, etc.
b) The organization should collaborate with other agencies whose primary mission is to serve people with disabilities (other than AIDS-defined disabilities), which might include obtaining necessary training/technical assistance/consultation.
c) Agencies are encouraged to recruit and hire a culturally diverse workforce including people with disabilities.

3) Diversity

Providing competent/proficient services to communities of color and assuring access to and respectful services to the deaf/hard-of-hearing and disabled communities are issues essential for effective HIV prevention programs. It is incumbent upon organizations providing HIV prevention service to demonstrate this competency/proficiency in addressing the diverse needs of the populations they serve in terms of age, gender, substance use, socioeconomic status, sexual orientation, linguistics, disabilities, and geographic settings including migrant, seasonal or resort workers. These agencies acknowledge that such a philosophy will be evident in their attitudes, policies, and practices, and that such competency/proficiency is necessary to provide effective, respectful/service to their clientele.

4) Assessment of Competence Regarding Culture and Other Diversity

To make meaningful progress in achieving the types of competence and proficiency, providers of HIV prevention service will be systematically assessed. Through the assessment, providers will become more aware of the strengths of their current programs and areas in need of strengthening. Capacity building activities will be directed to building on these strengths and making progress in areas needing attention. Key areas to be assessed are:

a) Client demographics
b) Background of agency staff and management
c) Involvement of target populations in developing and implementing policies and procedures
d) HIV program language capacity
e) Training and other capacity building activities
f) Efforts to assess and improve programs
g) Challenges faced in doing HIV prevention work.

Code of Ethics for HIV Prevention Providers

This Code of Ethics is intended to set a standard for exemplary conduct for paid staff and volunteers providing HIV prevention services, hereafter referred to as "HIV prevention practitioners." This Code is intended to outline the responsibilities of HIV prevention practitioners to the public at large, to their clients, and to their colleagues. This code is guided by core values and a commitment to honor, even at the sacrifice of personal

advantage. It is divided into five key principles: non-discrimination, competence, integrity, relationships with clients, and confidentiality.

1) Non-Discrimination

An HIV prevention practitioner shall not discriminate against clients or colleagues based on HIV serostatus, race, ethnicity, country of origin, age, gender, substance use, socioeconomic status, sexual orientation, linguistics, disabilities, or geographic settings (including migrant, seasonal or resort workers). An HIV prevention practitioner should strive toward proficiency in regard to culture and other aspects of diversity.

2) Competence

An HIV prevention practitioner shall adhere to approved standards of practice when implementing HIV prevention interventions and shall strive continually to improve personal competence and quality of service delivery. Competence is derived from a synthesis of training and experience. It begins with a mastery of knowledge and skill competencies. The maintenance of competence requires a commitment to learning and professional improvement and must be ongoing.

a) An HIV prevention practitioner should be diligent and practice due care in providing HIV prevention services. Diligence involves rendering services in a careful and prompt manner, observing applicable technical and ethical standards. Due care involves adequate planning and supervision of any activity for which they are responsible.
b) An HIV prevention practitioner should recognize the limitations and boundaries of their competence and refrain from using techniques or offering services beyond their competence. Each practitioner is responsible for assessing his/her competence for the responsibilities assumed.
c) When an HIV prevention practitioner is aware of unethical conduct or practice on the part of an agency or another practitioner, they have an ethical duty to report the conduct or practices to appropriate authorities.

3) Integrity

To maintain and broaden public confidence, an HIV prevention practitioner should perform all responsibilities with the highest sense of integrity. Integrity can accommodate the inadvertent error and honest difference of opinion; it cannot accommodate deceit or subordination of principle.

a) Personal gain and advantage should not subordinate service and public trust.
b) An HIV prevention practitioner should conduct prevention activities fairly and accurately, resisting pressures to unduly censor or mislead.
c) HIV prevention practitioners in positions of authority should exercise compassion and wisdom to prevent harm to those whom we are pledged to serve: people affected by, infected with, or at risk of being infected with HIV.
d) An HIV prevention practitioner should not misrepresent, directly or by implication, professional qualifications or affiliations.
e) An HIV prevention practitioner should not be associated directly or indirectly with services or products in a way that is misleading or incorrect.

4) Relationships with Clients

Above all, HIV prevention practitioners should do no harm. Practices must be respectful and non-exploitative.

a) An HIV prevention practitioner does not engage in sexual acts with current clients.
b) If an HIV prevention practitioner engages in sexual acts with a former client, they must demonstrate that there has been no exploitation, in light of all relevant factors, including a) the amount of time that has passed since HIV prevention services were last rendered to the former client; b) the nature and duration of the HIV prevention service; and c) the likelihood of adverse impact on the client and others.
c) An HIV prevention practitioner does not engage in business relationships with clients that present the potential for conflict of interest.
d) An HIV prevention practitioner does not exploit relationships with clients in regard to drug taking behavior or the sharing of needles or other injection paraphernalia.

5) Confidentiality

a) HIV-related confidential information (including HIV serostatus and other potentially sensitive information, etc.) that is acquired while rendering HIV prevention service must be safeguarded against disclosure, including - but not limited to - verbal or written disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases or consent. Statute and regulations explicitly govern circumstances under which HIV-related information may be disclosed. Professional ethics or personal commitment to the preservation of trust may impose even stricter confidentiality guidelines than those reflected in the law.
b) Where there is evidence of child or other abuse, an HIV prevention practitioner is expected to comply with statutory reporting requirements, which is governed by their professional affiliations.
c) HIV prevention practitioners should develop and implement methods by which client confidentiality protections and rights are communicated and consent for the service is obtained. Such methods must be appropriate to the intervention type.

6) Other Professional Standards of Practice

In some cases, HIV prevention practitioners have other professional affiliations (nursing, social work, psychology, etc.) that require adherence to a separate code of professional conduct. The five principles listed above are not intended to override such codes of professional conduct, but to augment them and provide insight into areas that are unique to the field of HIV prevention.

Client Feedback

Each HIV prevention program must implement a procedure that allows a client to file compliments, complaints, or grievances (hereafter called "feedback) regarding the HIV prevention services they receive.

As it relates to services provided by Section staff, feedback procedures are prescribed by the Disease Control and Environmental Epidemiology Division and CDPHE policy.

As it relates to services provided by contractors funded by the STD/HIV Section, the client feedback procedures implemented for clients must include the following minimal features:

1) Rights and processes regarding complaints should be readily available to all clients and posted in a prominent location in the agency.
2) If so requested by the client, the findings of an investigation regarding the complaint and subsequent actions should be communicated to the client within a reasonable timeframe.
3) Clients should have the right to appeal to the agency Director and ultimately to the governing board of the agency.
4) Clients should have the right to appeal to the STD/HIV Section at CDPHE.
5) Clients filing complaints or appeals must not suffer loss of services or other retribution.

If a complaint is received at CDPHE regarding services or other actions performed by a contractor, the CDPHE staff member receiving the complaint will follow the following procedures:

1) If the complainant is willing and available to be interviewed, determine the nature of the concern/complaint and collect sufficient detail from the complainant to allow for an investigation to proceed, including the remedy and follow up that the complainant prefers. This information should be documented in writing, in an email or written memo.
2) Within 24 hours, the documentation should be forwarded to the Contract Monitoring Supervisor and Technical Assistance and Training Program Manager, who will make assignments for further investigation, including timeframes.
3) The investigator (typically a contract monitor) will contact the contractor and conduct an investigation in collaboration with the Contract Monitoring Supervisor. When the investigation is complete, the investigator and Contract Monitoring Supervisor will develop a report on the findings and recommendations for further actions, if any, and submit the report to the Technical Assistance and Training Program Manager.
4) The Technical Assistance and Training Program Manager will approve or disapprove the report and will communicate the findings and recommendations to the contractor. The Manager will also inform the contractor of their right to appeal to the STD/HIV Section Chief.
5) If so requested by the complainant, the disposition of the complaint will be communicated to the complainant by the investigator.

Harm Reduction Principles Applied to Drug Use and Sexual Behaviors

Note: The following principles are not necessarily listed in order of importance.

1) Harm Reduction maintains the dignity and rights of the individual, by respecting the individual's right to self-determination. Emphasis is placed on personal choice, responsibility and on effective self-management.

2) Individuals are the best source for the description of their problem, and they should be empowered to work with service providers to determine the best interventions for those problems. The individual is the primary agent in reducing the harm from there at-risk

behaviors. In the counselor-participant relationship, power is returned to and remains with the participant.

3) Effective interventions begin "where the person is," and identify a hierarchy of goals, the immediate focus is on addressing the most pressing needs. Intervening at an early stage of a problem is preferable to waiting until the individual has hit "bottom."

4) Agencies should seek to remove programmatic and individual barriers that limit individuals' access to needed services, this includes making accommodations for a person within the agency and advocating for appropriate services with other agencies.

5) Movement toward reduced harm occurs in small and realistic steps, both for substance use and sexual behaviors. Interventions can take place without the participant being completely abstinent for a defined period of time. Slow incremental change is more effective and long lasting.

6) The quality of individual and community life, health, and well-being, not simply the cessation of high-risk behaviors, is the criteria for successful interventions. Each participant is considered to be the best judge of the success of interventions for their problems.

7) Educational services and treatment interventions should be provided to people who engage in high-risk drug use and sexual behaviors and the communities in which they live in a non-judgmental and non-coercive manner as a way to reduce the attendant harm of drug use and risky sexual behaviors. Education is the key to the prevention and minimization of harms related to high-risk drug use and sexual behaviors. Educational programs must include input from participants in program design, implementation, and evaluation, encouraging active discussion throughout.

8) Harm reduction tactics include enhancing awareness of high-risk behaviors and their consequences, training in coping skills to deal effectively with high-risk situations involving drugs or sex, positive peer support, and facilitating health-promoting and risk-reducing behaviors.

9) The realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, other social inequalities, and the real or perceived legal implications or consequences affect both people's vulnerability to, and capacity for, effectively dealing with drug-related harm and sexual risk behaviors.

Program Review

As a condition for receiving federal HIV prevention funds from the Centers for Disease Control and Prevention (CDC), CDPHE and its funded contractors must demonstrate adherence to federal guidelines concerning program review. Consistent with these guidelines, CDPHE has instituted the following procedures.

As required under federal law and CDC guidelines, all materials and program content must be submitted to an independent "Program Review Panel" prior to implementation or use. This panel will evaluate the materials and program content in a timely manner to determine if the materials and program content meet all of the following five criteria:

1) The materials or program content use terms, descriptors, or displays that are necessary for the target audience to understand dangerous behaviors and to explain less risky practices to that target audience concerning HIV transmission.
2) The materials or program content include information about the harmful effects of unsafe sexual activity and/or intravenous substance use and the benefits of abstaining from unsafe sexual activity and/or intravenous substance use.
3) The materials or program content do not directly encourage homosexual or heterosexual activity or intravenous substance use.
4) The materials or program content are not deemed "obscene" according to applicable community standards.
5) If the materials or program content target youth, then those materials or program content adhere to the CDC's current edition of "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988; 37 [suppl. No. S-2]).

If, in the good faith opinion of the panel, some or all of the proposed materials or program content fail to comply with the applicable federal criteria, the reasons and rationale for the disapproval will be conveyed to the submitting party. If revisions could be made to bring the item into compliance, a description of these revisions will also be conveyed to the submitting party.

If an item fails to be approved, the submitting party has the following options:

1) Withdraw the item from further review; this could be followed by submission of an alternative item that accomplishes the same programmatic objectives;
2) Resubmit a revised item that is more clearly in compliance with the federally mandated criteria;
3) Resubmit the original item as-is, with a written statement addressed to the Program Review Panel explaining why the item is consistent with the federally mandated criteria, particularly for the intended target audience.

Evaluation

Evaluation is a key component in designing and delivering effective HIV prevention programs, services, and interventions. Properly conducted evaluations provide a wide range of stakeholders (e.g., funders, policymakers, program planners, program staff, CPG members, communities, and individuals accessing HIV programs) with information about the impacts and merits of HIV prevention programming. Depending upon the area of investigation and evaluation design, results of evaluation activities can help to answer the following questions:

- What are the prevention needs of populations at increased HIV risk and how should interventions be designed in order to best meet those needs?
- What are the characteristics of populations that are being served by existing prevention interventions? What services were delivered as a result of an intervention? What resources were used to deliver such services?
- How many people were reached by a prevention intervention? How do the characteristics of populations receiving prevention services compare to the target populations that these interventions were intended to reach?
- What referrals were given to persons receiving prevention services? How often did individuals that received a referral follow through with the referral?
- What types of agencies are delivering prevention services?
- Were services delivered in a manner that was consistent with an agreed-upon service delivery plan or curriculum?
- How accessible are existing services for their intended audience?
- What outcomes (e.g., changes in knowledge, behaviors, attitudes, skills, intention) occurred after implementing an intervention?

This section provides a framework for developing evaluation plans to address the above and other questions. Evaluation plans should include descriptions of formative, process, and outcome monitoring activities as these are described below. Staff from the R&E Unit and TATP is available to assist prevention providers in developing their evaluation plans.

<u>Formative Evaluation</u>

Formative evaluation methods are used in the planning and development phase of an intervention, as well as throughout its implementation, to gain a more in-depth understanding of the target population, their risk behaviors, the context of those behaviors, and the best ways to help people lower risk. It is also used to learn more about how best to access and influence community members, as well as to "test out" an intervention, its components, or materials, before full implementation or revision. Examples of formative evaluation methods include conducting interviews and focus groups with members of target populations to better understand risk behaviors and how best to help them to lower risk, conducting pilot tests (rehearsals of workshop activities like role plays, mock interviews, etc.), pre-testing materials (letting people review drafts of scripts, pamphlets, overheads, or other intervention materials before finalizing them), and conducting focus groups to discuss the best ways to recruit participants and present information.

Formative Evaluation Standards

1) All contractors are expected to utilize formative evaluation methods when developing and revising their interventions.
2) Formative evaluation methods used in intervention development and revision should be listed and briefly described in intervention plans and applicable progress reports submitted to CDPHE.

Process Monitoring and Process Evaluation

Process monitoring involves the collection of data used to describe the population receiving services, the number and types of services provided, and resources used to deliver such services. Process evaluation involves the collection of data used to describe how an intervention was delivered, the degree to which the population served matched the intended target population, and the degree to which an intervention was accessible to the target audience. Examples of the types of information used to conduct process monitoring and process evaluation activities can be found for all interventions and program models in respective "Data Collection and Reporting Requirements" subsections.

Process Monitoring and Process Evaluation Standards

CDPHE and its contracted agencies must collect process evaluation information documenting their activities as well as demographic information on the clients they serve. This information must be gathered in a way that is consistent with current CDC and CDPHE guidelines. Updated guidelines will be made available to contractors by CDPHE staff.

Outcome Monitoring

Outcome monitoring is the ongoing measurement of the effects of an intervention on client outcomes such as changes in behavior, knowledge, attitudes, and beliefs. Examples of the types of information used to conduct outcome monitoring activities can be found for all interventions and program models in respective "Data Collection and Reporting Requirements" subsections.

Outcome Monitoring Standards

Key elements that must be addressed in performing outcome monitoring include the following:

1) The development of outcome objectives that are specific, measurable, achievable, realistic, and time-phased. Such objectives should have a sound basis in evidence or theory and be clearly related to risk-reduction goals.
2) The establishment of baseline data against which change can be measured.
3) The development of tools and procedures for measuring outcomes stated in the objectives.

Based on these standards, CDPHE will work with providers to establish plans for monitoring intervention outcomes.

Public Health Orders

All Health Departments, which issue Public Health Orders, should issue them in accordance with Colorado Revised Statutes (CRS) 25-4-1401 et seq., that states:

1) Public Health Orders shall be used as a last resort when other measures to protect the public health have failed, including all reasonable efforts, which shall be documented, to obtain the voluntary cooperation of the individual who may be subject to such an order; and
2) Public Health Orders and measures shall be applied serially, with the least intrusive measures used first; and
3) The burden of proof shall be on state or local health department to show that specified grounds exist for the issuance of the orders or restrictive measures and that the terms imposed are no more restrictive than necessary to protect the public health.

If a public health order is challenged in court, the health department (state or local) who issued this public health order must demonstrate to the court that they have complied with the statute and its due process provisions. Courts shall then issue appropriate orders affirming, modifying, or dismissing the order. Therefore, policies and procedures of health departments should allow them to describe, to the satisfaction of the court, the methods for applying and documenting the due process standards required by the statute, the department's criteria for determining when to issue each type of order, and the department's rationale for requesting court intervention. Local health departments may either develop their own policies and procedures in this regard or may adopt the model developed by CDPHE.

Toward the core value of cultural competence and proficiency, public health orders must be issued on the basis of HIV transmission behavior, and not on demographic characteristics (e.g., race/ethnicity, sexual orientation).

Section II: Interventions

Community Level Intervention

Definition
A community level intervention (CLI) identifies and changes the norms, values, and social and environmental factors that facilitate or inhibit risk behaviors within an entire group or community, not simply individual members of the community. The intervention changes the norms, values, etc incrementally, one step at a time, closer to healthier sexual and substance use behaviors.

CLI is based on the concept that certain norms, values, beliefs, and social and environmental factors influence how members of a particular community act. A community is defined as any well-defined or delineated group that distinguishes itself by ethnicity, sexual orientation, gender, age, behavior, geography, or some other self-defining criteria.

Excludes
A community level intervention is not general public information or health communication.

Content and Methods
There are five phases to a community level intervention:

1) Definition of the community
2) Community identification phase
3) Message development phase
4) Message dissemination or saturation phase
5) Reevaluation of the norms, values, beliefs, etc. and repeat phases 3, 4, and 5 until the desired state is achieved.

The community identification is done within the specific designated community or group to identify the specific norms, values, social and environmental factors that must be changed to promote healthier behavior and to suggest the best methods by which to disseminate and saturate the community with a "healthier." The community identification will identify the social or environmental factors that must be changed. The research incorporates both qualitative and quantitative methods with community members and persons who work with or relate to the community. The content of the message and the methods used to disseminate them within the group are based on the findings of the community identification process.

Based on the research findings, messages are developed, and a selection of activities and materials are designed to disseminate and saturate the community with the messages. Activities may include one-on-one discussions through identified peer networks, advocacy or community organizing to change laws or rules that influence risk behavior, electronic or print media to disseminate the selected messages, participation in community-wide events, etc. The messages seek to move the members of the community, incrementally, one step at a time, closer to healthier sexual and needle use behaviors. The messages do this by changing the specific norms, values, beliefs, and social and environmental factors within the community that promote the risky behaviors, and/or by reinforcing norms, values, beliefs and environmental factors that

promote healthier behaviors. It is necessary to saturate the environment on a consistent and ongoing basis with prevention messages.

For example, if your research shows that community members seldom talk with casual sex partners about condom use, you would attempt to shape a new community norm by involving community members in promoting the message that negotiating condom use with casual sex partners is the expected behavior among members of this particular community. Community members come to view this healthier behavior as the "expected behavior" and incorporate it into their actions.

A community level intervention (CLI) influences and saturates the whole community (not simply individuals or groups) with prevention messages and materials, on a consistent and ongoing basis, to support healthier behavior among the people in that community.

Quality Assurance Process

Providers of CLI must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:

1) Identification of person(s) responsible for coordination and management of QA;
2) Protocol and procedures for CLI;
3) Training for staff delivering CLI;
4) Periodic observation by a trained supervisor;
5) Post-exposure prophylaxis protocol for on-the-job exposures (such as needle stick injuries);
6) Occupational health and safety issues;
7) Record keeping/confidentiality;
8) Client feedback and satisfaction.

To assure quality of services, CDPHE will perform monitoring duties, including:

1) Review of CLI data submitted to CDPHE, as compared to planned performance.
2) A minimum of one on-site observation conducted annually. On-site observation will include observation of staff or volunteers performing CLI.
3) Review of a sample of CLI forms for completion and accuracy.

Data Collection and Reporting Requirements

Providers of CLI must collect and report data on clients impacted or served, consistent with the type and intensity of the client encounter.

For clients who receive CLI messages through a social event, distribution of print materials, or electronic media, the health communication/public information data set should be collected and reported, including: event dates; delivery method; type of printed material; content/topics; number of people reached (number of attendees, number of items distributed, web hits, audience size, callers, etc.).

For clients who receive CLI messages through staff or volunteer outreach activities, the outreach data set should be collected, including: race; ethnicity; age range; gender; and primary risk either

from self-report or observation. Such data may be collected in aggregate, i.e., based on estimations and encounters versus individual-level data collected from each client.

For clients who receive CLI messages through participation in a formal group session, the group level data set should be collected. This data will be collected through unique identifiers and will not include personally identifying information. At intake, demographic and risk information should be collected on an individual client basis, including: gender, ethnicity, race, year of birth, risk behaviors, pregnancy and prenatal care status. Information should also be collected for each GLI session, including: site, session number, date, unit of delivery, delivery methods, activities conducted, materials distributed, referrals data, and a sign-in sheet with the unique identifiers from each GLI session participant.

For clients who receive CLI messages through an intensive one-on-one encounter, the individual level data set should be collected: Client Unique Identifier; birth year; county of residence; client demographics; client risk assessment data; self-reported HIV status and testing history; housing situation; pregnancy and prenatal care; incarceration history; recent diagnosis with another STD; injection drug use behavior; sexual behaviors; partner information; nonbehavioral risks; referrals made. Information should also be collected and reported for each one-on-one session, including: site, session number, date, unit of delivery, delivery methods, activities conducted, materials distributed, referrals data, and Client Unique Identifier.

Relevant Guidelines, Laws, and Regulations
CLI is a component of a "HIV education risk-reduction program" as defined in CRS 25-4-1405, subsection 3(e).

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
CLI has been shown to affect behaviors of injection drug users[2], men who have sex with men[3], and heterosexuals[4].

This intervention is a component of the following program models:
The following DEBI program models recognized by CDPHE involve CLI–

1) Mpowerment
2) Community PROMISE
3) Popular Opinion Leader

[2] Centers for Disease Control and Prevention (1999) *AIDS Community Demonstration Projects.*
[3] Centers for Disease Control and Prevention (1999) *AIDS Community Demonstration Projects.* Kegeles, SM, Hay, RB, & Coates, TJ The Mpowerment Project: A community-level prevention intervention for young gay men. *American Journal of Public Health*, 86(8), 1129-1136, 1996.
[4] Lauby, J, Smith, PJ, Stark, M, Person, B, and Adams, J. (2000) A community-level HIV prevention intervention for inner city women: Results of the women and infants demonstration trial. *American Journal of Public Health*, 90 (2), 216-222.

Group Level Intervention

Definition
Interactive health education and risk reduction education delivered to 2–20 simultaneous participants.

Excludes
Health communication/public information campaigns and any other interventions delivered to groups larger than 20. Also excludes interventions that are not based on written curricula or lack the other minimal group level intervention components, listed below.

Content and Methods
Group level interventions (GLI) funded by CDPHE must adhere to written, evidence-based curricula. Such curricula may be developed nationally (i.e., group curricula contained in a CDC-recognized Effective Behavioral Intervention program model) or the curricula may be locally developed, adapted, or tailored. These GLI curricula must be recognized or approved by CDPHE.

At a minimum, GLI curricula must include:
1) Scientifically accurate information about HIV and transmission risks.
2) Skills-building activities (e.g., communication, negotiation, coping).
3) Opportunities for active participation.
4) Content concerning the interconnections among substance use, mental illness, and HIV risk.

When warranted, GLI facilitators should meet individually with participants to briefly assess risk, screen for risk-related issues (such as addiction or mental illness), and make appropriate referrals.

Quality Assurance Process
Providers of GLI must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:
1) Identification of person(s) responsible for coordination and management of QA;
2) Protocol and procedures for updating the GLI curriculum;
3) Training for staff delivering GLI;
4) Periodic observation by a trained supervisor;
5) Post-exposure prophylaxis protocol for on-the-job exposures (such as needle stick injuries);
6) Occupational health and safety issues;
7) Record keeping/confidentiality;
8) Client feedback and satisfaction.

To assure quality of services, CDPHE will perform monitoring duties, including:
1) Review of GLI data submitted to CDPHE, as compared to planned performance.
2) A minimum of one on-site observation conducted annually. On-site observation will include observation of staff or volunteers performing GLI.

3) Review of a sample of GLI forms for completeness and accuracy.

Data Collection and Reporting Requirements
Providers of GLI must collect and report the full GLI data set as defined by CDPHE. This data will be collected through unique identifiers and will not include personally identifying information. At intake, demographic and risk information should be collected on an individual client basis, including: gender, ethnicity, race, year of birth, risk behaviors, pregnancy and prenatal care status. Information should also be collected for each GLI session, including: site, session number, date, unit of delivery, delivery methods, activities conducted, materials distributed, referrals data, and a sign-in sheet with the unique identifiers from each GLI session participant.

Relevant Guidelines, Laws, and Regulations
GLI is a component of a "HIV education risk-reduction program" as defined in CRS 25-4-1405, subsection 3(e).

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
GLI has been shown to be effective in changing risk behaviors among heterosexual men[5], HIV-infected youth[6] and adults[7], women[8], men who have sex with men[9], and injection drug users[10].

This intervention is a component of the following program models:
GLI is an explicit component of the following DEBI program models recognized by CDPHE –

1) Mpowerment
2) Healthy Relationships
3) Many Men, Many Voices
4) Popular Opinion Leader
5) The SISTA Project
6) Safety Counts

[5] Boyer CB, Shafer MB, Shaffer RA, Brodine SK, Ito SI, Ynigez DL, Benas DM, Schachter J. Prevention of Sexually Transmitted Diseases and HIV in Young Military Men: Evaluation of a Cognitive-Behavioral Skills-Building Intervention. *Sexually Transmitted Diseases*, 28(6), 349-55, 2001
[6] Brown LK, Schultz JR, Parsons JT, Butler RB, Forsberg AD, Kocik SM, King G, Manco-Johnson M, Aledort L. Sexual behavior change among human-immunodeficiency virus-infected adolescents with hemophilia. *Pediatrics*, 2000, 106(2) E22.
[7] Kalichman SC, Rompa D, Cage M, DiFonzo K, Simpson D, Austin J, Luke W, Kyomugisha F, Benotsch E, Pinkerton S, Graham J. Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-Positive People. *American Journal of Preventive Medicine*, 21(2) 85-93, 2001
[8] Dancy BL, Marcantonio R, Norr K. The Long-Term Effectiveness of an HIV Prevention Intervention for Low-Income African American Women. *AIDS Education and Prevention*, 12(2) 113-125, 2000.
[9] Kegeles, SM, Hay, RB, & Coates, TJ The Mpowerment Project: A community-level prevention intervention for young gay men. *American Journal of Public Health*, 86(8), 1129-1136, 1996.
[10] Rhodes, F. & Wood, MM A cognitive-behavioral intervention to reduce HIV risks among active drug users: Efficacy Study. *Staying Negative in A Positive World: HIV Prevention Strategies that Work*, Sacramento: California Dept of Health Services, Office of AIDS, 1998.

Health Communication/Public Information

Definition

The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services.

Excludes

Group interventions with a skills-building component, which constitutes a separate intervention category.

Content and Methods

HC/PI Delivery methods include:

1) Radio/television: Broadcasts of public service announcements, commercial air time, and the inclusion of HC/PI messages in radio or television programs.
2) Print Media: Publication and distribution of HC/PI messages through magazines, newspapers, pamphlets, brochures, flyers, posters, or billboards.
3) Telephone: Offering up-to-date information and referral to local services (e.g., counseling/testing and support groups) through "hotlines" or other telephone services.
4) Internet: The use of email, chat rooms, or web sites to deliver information electronically;
5) In Person: Delivery of HC/PI messages in the physical presence of the client(s), including lectures and presentations.
6) Risk Reduction Material Distribution: the creation and distribution of risk reduction materials (such as condoms, safer sex kits, and safer injection kits), including material "drop off" activities.

Regardless of delivery method, HC/PI should be designed to achieve one or more of the following outcomes:

1) Dispelling myths about HIV transmission;
2) Supporting volunteerism for HIV prevention programs;
3) Reducing discrimination toward persons with HIV/AIDS or persons perceived to be at risk for HIV infection;
4) Promoting support for strategies and interventions that contribute to HIV prevention in the community;
5) Increasing access to available services.

HC/PI programs must also support other components of health education and risk reduction activities.

Messages and materials must be sensitive and appropriate to the target audience's values, needs, and interests and must be pre-tested to assure understanding by and relevance to the target audience. This includes alternative formats for the disabled.

Quality Assurance Process

Providers of HC/PI must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:

1) Identification of person(s) responsible for coordination and management of QA;
2) Protocol and procedures for HC/PI;
3) Training for staff delivering HC/PI;
4) Periodic observation and review of HC/PI materials by a trained supervisor;
5) Record keeping/confidentiality;
6) Client feedback and satisfaction.

To assure quality of services, CDPHE will perform monitoring duties, including:
1) Review of HC/PI data submitted to CDPHE, as compared to planned performance.
2) A minimum of one on-site observation conducted annually. On-site observation will include observation of staff or volunteers performing HC/PI.
3) Review of a sample of HC/PI forms for completion and accuracy.

Data Collection and Reporting Requirements
The HC/PI data set should be collected and reported, including: event dates; delivery method; type of printed material; content/topics; number of people reached (number of attendees, number of items distributed, web hits, audience size, callers, etc.).

Relevant Guidelines, Laws, and Regulations
CRS 25-4-1405, subsection 2.

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
HC/PI has been shown to alter knowledge, attitudes, and beliefs about HIV among youth.[11] It has also been shown to change attitudes among men who have sex with men.[12] HC/PI is often used as a recruitment strategy for other programs and interventions which have been shown to be effective, but the effect of HC/PI cannot be isolated from the other program components.

This intervention is a component of the following programs:
HC/PI is part of the Community PROMISE program model.

[11] Markham, C., Baumler, E, Richesson, R., et al. (2000) Impact of HIV-positive speakers in a multi-component, school-based HIV/STD prevention program for inner-city adolescents. *AIDS Eduction and Prevention,* 12(5), 442-54.
[12] Pele, G., Menard, C, Ramon, A, et al (1996) Impact of prevention advertising campaigns targeting homosexualmen, initiated by the French ministry of health: Global evaluation and perception among the general public and homosexual men. Presented at the XI International Conference on AIDS, Vancouver, BC, Canada.

Individual Level Intervention

Definition
Health education and risk-reduction counseling provided to one individual at a time.

Excludes
Outreach, Comprehensive Risk Counseling and Services, and counseling delivered in the context of HIV testing.

Content and Methods
Individual level interventions (ILI) funded by CDPHE must adhere to written, evidence-based protocols. Such protocols may be developed nationally (i.e., ILI protocols contained in a CDC-recognized Effective Behavioral Intervention program model), or the protocols may be locally developed, adapted, or tailored. These ILI protocols must be recognized or approved by CDPHE.

At a minimum, an ILI protocol must include:
1) Introduction and orientation, including an explanation of confidentiality;
2) Risk assessment;
3) Based on the risk assessment, screenings for substance abuse, mental illness, and CRCS. If the client is living with HIV, there must be additional screening for priority services;
4) Assessment of the client's motivation to reduce risk;
5) Assisting the client in developing a risk reduction plan;
6) Skills-building;
7) Making referrals, as needed.

The number and length of ILI sessions is prescribed by the counseling protocol. Generally, ILI is a short-term intervention, but it often consists of more than one session.

Quality Assurance Process
Providers of ILI must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:
1) Identification of person(s) responsible for coordination and management of QA;
2) Protocol and procedures for ILI;
3) Training for staff delivering ILI;
4) Periodic observation by a trained supervisor;
5) Post-exposure prophylaxis protocol for on-the-job exposures (such as needle stick injuries);
6) Occupational health and safety issues;
7) Record keeping/confidentiality;
8) Client feedback and satisfaction.

To assure quality of services, CDPHE will perform monitoring duties, including:
1) Review of ILI data submitted to CDPHE, as compared to planned performance.
2) A minimum of one on-site observation conducted annually. On-site observation will include observation of staff or volunteers performing ILI.

3) Review of a sample of ILI forms for completeness and accuracy.

Data Collection and Reporting Requirements
Providers of ILI must collect and report the full ILI client data set as defined by CDPHE, including: Client Unique Identifier; birth year; county of residence; client demographics; client risk assessment data; self-reported HIV status and testing history; housing situation; pregnancy and prenatal care; incarceration history; recent diagnosis with another STD; injection drug use behavior; sexual behaviors; partner information; nonbehavioral risks; referrals made. Information should also be collected and reported for each ILI session, including: site, session number, date, unit of delivery, delivery methods, activities conducted, materials distributed, referrals data, and Client Unique Identifier.

Relevant Guidelines, Laws, and Regulations
ILI is a component of a "HIV education risk-reduction program" as defined in CRS 25-4-1405, subsection 3(e).

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
ILI has been demonstrated to be effective for heterosexual adults[13], people living with HIV[14], men who have sex with men[15], and injection drug users[16].

This intervention is a component of the following programs:
ILI is an explicit component of the Safety Counts DEBI program models recognized by CDPHE. It is often a component of other program models when participants require screening, individualized referrals, or other services not readily delivered in a group setting.

[13] Boyer, CB, Barrett, DC, Peterman, TA, Bolan, G (1997) Sexually transmitted disease and HIV risk in heterosexual adults attending an STD clinic: evaluation of a randomized controlled behavioral risk-reduction intervention trial. *AIDS* 11(3): 359-367; Kamb, ML, Fishbein, M, Douglas, JM, et al. (1998) Efficacy of risk-reduction counseling to prevent HIV and STDs: A randomized control trial. *JAMA*, 280 (13): 1161-1167.
[14] Fogarty LA, Heilig CM, Armstrong K, Cabral R, et al. (2001) Long-term effectiveness of a peer-based intervention to promote condom and contraceptive use among HIV-positive and at-risk women. *Public Health Reports*, 116 Suppl 1, 103-119.
[15] EXPLORE Study Team. (2004) Effects of a behavioural intervention to reduce acquisition of HIV infection among men who have sex with men: the EXPLORE randomised controlled study. *Lancet* 364:41–50.
[16] Weibel, W, Jimenez, A, Johnson, W, et al (1996) Risk behavior and HIV seroincidence among out-of-treatment injection drug users: A four-year prospective study. Journal of AIDS and Retrovirology 12(3); 282-289.

Outreach

Definition
An HIV educational intervention designed to reach at-risk populations where they live, work, socialize, or congregate.

Excludes
Interventions that require populations to present themselves at an agency's office or clinic in order to receive services. Also excludes condom drop offs, materials distribution, and other public information activities that lack one-on-one contact with a client.

Content and Methods

Outreach involves one-on-one contact with at-risk individuals in community settings such as parks, bars, public sex environments, neighborhood events, and interactive web-based environments (including dating web sites, chat rooms, etc.). Outreach particularly targets people who do not normally seek health care and other services through traditional means.

At a minimum, outreach involves presenting an HIV prevention message and promoting further services (including HIV testing). Expanded outreach may include distribution of health education/risk reduction materials, risk assessment, identifying client needs, risk reduction education, and active referrals to additional HIV prevention or other services.

Outreach is typically a part of a larger program model, linking clients to more intensive services as needed.

Quality Assurance Process
Providers of Outreach must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:
1) Identification of person(s) responsible for coordination and management of QA;
2) Protocol and procedures for Outreach;
3) Training for staff delivering Outreach;
4) Periodic observation by a trained supervisor;
5) Post-exposure prophylaxis protocol for on-the-job exposures (such as needle stick injuries);
6) Occupational health and safety issues;
7) Record keeping/confidentiality;
8) Client feedback and satisfaction.

To assure quality of services, CDPHE will perform monitoring duties, including:
1) Review of Outreach data submitted to CDPHE, as compared to planned performance.
2) A minimum of one on-site observation conducted annually. On-site observation will include observation of staff or volunteers performing Outreach.
3) Review of a sample of Outreach forms for completion and accuracy.

Data Collection and Reporting Requirements

Providers of Outreach must collect and report the full Outreach data set as defined by CDPHE, including: race; ethnicity; age range; gender; and primary risk either from self-report or observation. Such data may be collected in aggregate, i.e., based on estimations and encounters versus individual-level data collected from each client.

Relevant Guidelines, Laws, and Regulations
Outreach is a component of a "HIV education risk-reduction program" as defined in CRS 25-4-1405, subsection 3(e).

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
Outreach (as part of a larger community level program model) has been shown to affect behaviors of injection drug users[17], men who have sex with men[18], and heterosexuals[19].

This intervention is a component of the following programs:
Outreach is an explicit component of the following DEBI program models recognized by CDPHE–
1) Mpowerment
2) Community PROMISE
3) Popular Opinion Leader
Outreach is often used as a recruitment and dissemination strategy for other program models.

[17] World Health Organization (2004) *Evidence for Action: Effectiveness of Community-Based Outreach in Prevention HIV/AIDS among Injecting Drug Users*, page 21.
[18] Centers for Disease Control and Prevention (1999) *AIDS Community Demonstration Projects.*
[19] Corby, NH and Wolitski, RJ (1996) Condom use with main and other sex partners among high risk women: Intervention outcomes and correlates of reduced risk. *Drugs and Society*, 9, 75-96. Lauby, J, Smith, PJ, Stark, M, Person, B, and Adams, J. (2000) A community-level HIV prevention intervention for inner city women: Results of the women and infants demonstration trial. *American Journal of Public Health*, 90 (2), 216-222.

HIV Counseling, Testing, and Referral – Public Health

Definition
An individualized intervention, delivered by designated public health agencies, by which clients learn their HIV serostatus, develop a risk reduction plan to protect themselves and their partners, and receive referrals for additional services, as needed.

Excludes
HIV Testing and Counseling in Health Care Settings, which has separate standards.

Content and Methods
HIV Counseling, Testing, and Referral – Public Health (CTR/PH) funded by CDPHE must include the following core elements:
1) Introduction and orientation, including an explanation of consent and confidentiality.
2) Risk assessment
3) Based on the risk assessment, screenings for substance abuse, mental illness, and CRCS.
4) Assessment of the client's motivation to reduce risk.
5) Assisting the client in developing a risk reduction plan.
6) Assessment of the client's readiness to learn her/his HIV serostatus.
7) Administering the test and interpreting the results.
8) Renegotiating or reinforcing the risk reduction plan, in light of the test results.
9) If the client tests positive, screening for priority services.
10) Making referrals, as needed.

A CTR/PH risk assessment must include thorough history-taking, including: other STD diagnoses; incarceration; sexual activity with male, female, and transgender partners; commercial sex work; sex while intoxicated; sex with partners known to be living with HIV; sex with partners of unknown HIV serostatus; injection drug use; sex with anonymous partners; other transmission risks; pregnancy and prenatal care (for female clients).

For clients who <u>test positive</u> for HIV, the following screenings are required:
1) CRCS screening, if they report partners who were anonymous or HIV serostatus unknown;
2) Substance abuse and mental health screening, if they report injection drug use or sex while intoxicated;
3) Screening for priority services, including linkage to early care, support services, case management, client advocacy, partner notification, disclosure assistance, and counseling.

For clients who <u>test negative</u> for HIV, the following screenings are required:
1) Substance abuse and mental health screening, if they report injection drug use or sex while intoxicated;
2) CRCS screening, if they report high-risk sexual partners or practices (MSM, IDU, PLWH, commercial sex work).

Screening tools and methods must be approved by CDPHE. When warranted by the screening, active referrals should be provided to the client.

Consistent with Colorado statute (CRS 25-4-1405.5), confidential testing is the preferred method for the detection of HIV infection at CDPHE-funded CTR/PH. The statute also allows for the availability of an anonymous testing option if approved through a public hearing held by the local board of health.

Only those individuals testing confidentially may receive their results in writing. With confidential testing, if the results are positive and the client seems ready to seek further social and/or medical services, the counselor should offer the client the test results in writing. In addition, if a client tests anonymously, the test results are positive, and the client seems ready to seek further social and/or medical services, the client should be counseled and given the option of changing the test from anonymous to confidential and receive the test results in writing upon the client's request. To get written results the client must present valid identification.

No one determined by the counselor to be under the age of 12 may elect to be tested anonymously.

Written consent is required for individuals testing through a contracted agency. Consent forms should be signed prior to the beginning of the counseling session. Consent forms should inform the client about grievance procedures. A consent form specified by the CDPHE or an approved equivalent must be used for CTR/PH.

Providers offering rapid testing technology must utilize devices approved by the U.S. Food and Drug Administration and must adhere to applicable manufacturer, legal, and regulatory guidelines.

Quality Assurance Process

Providers of CTR/PH must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:
1) Identification of person(s) responsible for coordination and management of QA;
2) Protocol and procedures for HIV counseling;
3) Training for staff delivering CTR/PH;
4) Periodic observation by a trained supervisor;
5) Post-exposure prophylaxis protocol for on-the-job exposures;
6) Occupational health and safety issues;
7) Record keeping/confidentiality.

In addition, when rapid testing technology is utilized, the written QA plan must address:
1) Specimen collection methods;
2) Management/disposal of bio-hazardous waste;
3) Storage and transportation of tests;
4) Supplemental or confirmatory testing;
5) Maintenance of laboratory equipment;
6) Required logs;
7) Schedule of direct observation of all staff responsible for performing and interpreting HIV rapid tests;
8) Access to clinical experts.

To assure quality of services, CDPHE will perform monitoring duties as prescribed by Colorado Board of Health Regulations:
1) A semi-annual analysis of the number of persons receiving HIV antibody testing and the proportion of persons testing receiving results per contracted agency.
2) A minimum of one on-site observation conducted annually. This on-site observation will include observation of counselors performing HIV pre and posttest prevention and risk-reduction counseling.
3) A semi-annual analysis of testing trends (anonymous vs. confidential).
4) A semi-annual review of counseling and partner notification forms for completion and accuracy.
4) A minimum of one annual audit of charts for all contracting agencies.
5) Accuracy and completion of the posttest counseling reimbursement form submitted to the CDPHE.

Data Collection and Reporting Requirements
Providers of CTR/PH must collect and report the full CTR/PH data set as defined by CDPHE, including: client demographics; locating information (for those testing confidentially); client risk assessment data; HIV testing history; specimen type; test technology utilized; test results; screenings performed; referrals made; and delivery of results to the client.

As defined in Colorado regulation (6 CCR-1009-9, Regulation 1), diagnosed cases of AIDS, HIV-related illness, and HIV infection, regardless of whether confirmed by laboratory tests, shall be reported to CDPHE within seven days of diagnosis. Contractual providers of CTR/PH must also report the data associated with persons testing HIV negative within seven days.

Relevant Guidelines, Laws, and Regulations
CRS 25-4-1401 et seq
6 CCR-1009-9
Revised Guidelines for HIV Counseling, Testing, and Referral (CDC, 2001)

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
Client centered counseling associated with HIV testing has been shown to be effective with heterosexual adults[20]. Across risk groups, finding out that one is living with HIV has been shown to change behavior.[21]

[20] Kamb ML, Fishbein M, Douglas JM Jr, Rhodes F, et al. (1998). Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. Project RESPECT Study Group. *JAMA* 280(13):1161-7.
[21] Marks G, Crepaz N, Senterfitt JW, Janssen RS. (2005) Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. *J Acquir Immune Defic Syndr* 39:446-53.

HIV Testing and Counseling in Health Care Settings

Definition
An individualized intervention, delivered in a health care setting, by which clients learn their HIV serostatus and, when testing positive, receive risk reduction counseling and referral to additional services.

Excludes
HIV Counseling, Testing, and Referral–Public Health, which has separate standards.

Content and Methods
As specified in Colorado statute (CRS 25-4-1405.5), HIV Testing and Counseling in Health Care Settings (TC/HC) cannot be provided anonymously.

TC/HC funded by CDPHE should be offered on an opt-out basis. This means that TC/HC should be voluntary and undertaken only with the patient's knowledge and understanding that testing is planned. Patients should be informed verbally or in writing that HIV testing will be performed unless they decline. Patients should be given verbal or written information, including the meanings of positive and negative test results, and should be offered an opportunity to ask questions and to decline testing. If a patient declines an HIV test, this decision should be documented in the patient record.

TC/HC providers offering HIV rapid testing must utilize devices approved by the U.S. Food and Drug Administration and must adhere to applicable manufacturer, legal, and regulatory guidelines.

For TC/HC patients who test HIV-negative, results may be communicated without direct personal contact between the patient and providers (for example, by telephone). Patients at high risk for HIV infection should be advised of the need for periodic retesting and should be referred to prevention counseling.

For TC/HC patients who test HIV-positive, results should be communicated through direct personal contact and all of the following should be addressed: active linkage to HIV partner counseling and referral services; brief risk assessment and counseling; collection of accurate locating information; screening for mental health, substance abuse, and comprehensive risk counseling and services (CRCS); active linkage to early care, mental health, substance abuse and CRCS services, as appropriate.

There are two types of TC/HC, based on the setting in which the service is offered: 1) TC/HC in prenatal, labor and delivery, or postpartum settings and 2) TC/HC in other healthcare settings. Each type of TC/HC has its own set of guidelines.

The following guidelines apply to TC/HC in prenatal, labor and delivery, or postpartum settings:
1) HIV testing should be part of the routine panel of prenatal blood tests recommended for all pregnant women.
2) Screening should occur after the patient is notified that HIV testing is recommended for all

pregnant patients and that she will receive an HIV test unless she actively declines.
3) Pregnant women who decline TC/HC should not be pressured or coerced to reconsider. However, providers should discuss and address reasons for declining an HIV test (such as logistical problems, lack of perceived risk, concerns about partner violence, and stigma) and the importance of retesting if a prior negative HIV test preceded the pregnancy. If initially declined, TC/HC should be re-offered at a later point in the pregnancy and at labor and delivery.
4) The HIV test should be performed as early as possible during every pregnancy. A second HIV test during the third trimester (preferably before 36 weeks of gestation) is recommended for women known to be at high risk for acquiring HIV, such as: injection drug users and their sex partners, commercial sex workers, sex partners of people living with HIV, women with a new or more than one sex partner during the pregnancy, or women with signs and symptoms of HIV infection. Retesting may be omitted in the third trimester if a woman was tested for HIV within the last six weeks.
5) Any woman with undocumented HIV status at the time of delivery should be screened with a rapid HIV test unless she declines. Appropriate antiretroviral prophylaxis should be recommended to women on the basis of a reactive test result without waiting for the result of a confirmatory test.
6) When a woman's HIV status is still unknown at the time of delivery, she should be tested immediately postpartum unless she declines. If she declines an HIV test, she should be informed that the newborn will be tested for HIV unless she declines. She should be informed that identifying HIV antibodies in her infant indicates HIV infection of herself.
7) For infants whose HIV exposure is unknown and who are in foster care, the person legally authorized to provide consent should be informed that HIV testing is recommended for infants whose biological mothers have not been tested.
8) The benefits of antiretroviral prophylaxis are best realized if initiated within the first 12 hours after birth.
9) Whenever possible, uncertainties about laboratory test results indicating confirmed HIV infection status should be resolved before final decisions are made regarding reproductive options, antiretroviral therapy, cesarean delivery, or other interventions. However, if confirmatory testing is not possible before delivery, antiretroviral prophylaxis should be recommended to any pregnant patient with a reactive HIV screening test result.

The following guidelines apply to TC/HC in healthcare settings <u>other than</u> prenatal, labor and delivery, or postpartum:
1) TC/HC should be routinely performed for all patients age 13–64 unless or until the prevalence of undiagnosed HIV infection in the patient population of the health care provider is found to be less than 0.1%.
2) All patients seeking treatment for sexually transmitted diseases (STDs) should receive TC/HC during each visit for a new complaint. This includes patients seeking care in STD clinics.
3) TC/HC should be offered annually to: men who have sex with men; injection drug users; persons who exchange sex for money or drugs; sex partners of people living with HIV; heterosexual persons who themselves or whose sex partners have had a new or more than one sex partner in the previous three months.
4) Providers should encourage TC/HC for patients and their prospective partners before they initiate a new sexual relationship.

Quality Assurance Process
Providers of TC/HC must demonstrate that quality assurance procedures are equally applied to TC/HC and to testing for other health conditions performed in the health care setting.

In addition, when rapid testing technology is utilized, an appropriate CLIA certification must be in effect for the clinic providing TC/HC.

To assure quality of services, CDPHE will perform monitoring duties as prescribed by Colorado Board of Health Regulations:
1) A semi-annual analysis of the number of persons receiving HIV antibody testing and the proportion of persons testing receiving results per contracted agency.
2) A minimum of one on-site observation conducted annually.
4) A semi-annual review of counseling and partner notification forms for completion and accuracy.
4) A minimum of one annual audit of charts for all contracting agencies.
5) Accuracy and completion of the reimbursement form submitted to the CDPHE.

Data Collection and Reporting Requirements
Providers of TC/HC must collect and report the full TC/HC data set as defined by CDPHE, including: test/client identification number; date of testing; site identification number; age; sex; race; ethnicity; self-reported HIV testing history; specimen type; test type (conventional vs. rapid); test results; receipt of test results. When feasible, HIV risk behavior should also be collected and reported. Although client name does not need to be reported to CDPHE on people testing negative, it must be collected and maintained as part of the patient record.

For all TC/HC clients who test HIV positive, the following additional data elements must be collected and reported to CDPHE: name; address; date of birth; county of residence; housing situation; pregnancy and prenatal care; incarceration history; recent diagnosis with another STD; injection drug use behavior; sexual behaviors; partner information; nonbehavioral risks; and referrals made.

As defined in Colorado regulation (6 CCR-1009-9, Regulation 1), diagnosed cases of AIDS, HIV-related illness, and HIV infection, regardless of whether confirmed by laboratory tests, shall be reported to CDPHE within seven days of diagnosis.

Relevant Guidelines, Laws, and Regulations
CRS 25-4-1401 et seq
6 CCR-1009-9
Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings (CDC, 2006)

Published research has demonstrated that this has been an effective intervention in the following populations and settings:

Across risk groups, finding out that one is living with HIV has been shown to change behavior.[22]

[22] Marks G, Crepaz N, Senterfitt JW, Janssen RS. (2005) Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. *J Acquir Immune Defic Syndr* 39:446--53.

Partner Counseling and Referral Services

Definition

The goal of Partner Counseling and Referral Services (PCRS) is to stop the unintentional spread of HIV by notifying persons of possible exposure to HIV and other STDs (e.g., gonorrhea, chlamydia, or syphilis), by facilitating testing and treatment, and by promoting status disclosure and risk reduction. PCRS is a service offered to people infected with HIV, their sex and needle-sharing partners, parents or guardians of perinatally exposed children and other individuals at increased risk of acquiring HIV infection. These services help individuals and their partners gain earlier access to individualized counseling, HIV testing, STD testing, medical evaluation, treatment, and other prevention and support services. PCRS is a service that combines multiple interventions and prevention strategies, including Counseling, Testing and Referral; Individual Level Intervention; and Disclosure Assistance, as well as disease investigation, analysis and control strategies.

Excludes

PCRS excludes interventions where partner counseling is not the focus of the service. Only state and local health departments offer PCRS.

Content

PCRS includes a confidential interview and discussion between the index client and a trained health professional about the client's risk, measures to reduce the risk, and sexual and needle-sharing partners who may be infected or who are at risk for becoming infected.

PCRS includes a confidential interview and discussion between the partners of the index client and a trained health professional about the partner's exposure, risk, testing options and measures to reduce the risk. If the partner's tests are positive services are offered for his or her sexual and needle-sharing partners who may be infected or who are at risk for becoming infected.

The client/partner interview and counseling session may include:

1) Information regarding confidentiality
2) Risk assessment
3) Assessment of course of infection
4) Discussion of options for health care follow up and referral
5) Discussion of risk reduction including disclosure assistance and referral for support
6) Eliciting and notifying partners
7) HIV testing and referral for care and support, delivered according to CTR standards
8) STD testing and referral for treatment and support
9) Clustering
10) Spousal notification

PCRS includes offering referrals for medical, emotional, social and other support services not offered by the health professional.

The process for making referrals includes:

1) Helping the client and partner/s define their priorities

2) Discussing and offering options, offering referrals
3) Making referrals to known and trusted services
4) Assessing whether the suggested referral works for the client and partner
5) Facilitating an active referral
6) Developing a follow up plan after giving the referral.

PCRS includes field investigation for client locating, contact tracing and disease control activities.

PCRS is linked to Comprehensive Risk and Counseling Service (formerly prevention case management) as the highest risk clients are identified.

PCRS is linked to Public Health Orders. Individuals who continue to engage in high-risk behavior after testing positive for HIV may meet criteria for a public health order in accordance with state statute.

Methods

PCRS is conducted according to CDC-approved procedures in compliance with Colorado State law. All providers must complete the following courses or its equivalent:

1) Employee Development Guide
2) Introduction to Sexually Transmitted Disease Intervention
3) HIV Prevention Counseling and Referral Services
4) 1:1 Client-Centered Counseling
5) Test Decision Counseling
6) Cultural competence
7) Mental Health and Substance Use

PCRS is provided when a need is identified by surveillance or PCRS staff; upon client request; as indicated by health care providers, citizens, and medical information; and as determined by epidemiological evidence.

PCRS is delivered as an urgent service. The index client, and sexual and needle-sharing partners is located and interviewed at the earliest possible opportunity. PCRS is a field-based service that is delivered in a variety of settings appropriate to client needs.

PCRS is voluntary. The client may decline to be interviewed or to name partners. The client may choose to notify his or her partners of an unsafe exposure without health department assistance (client referral) or elect health department assistance in notifying partners.

PCRS is typically conducted in one to three sessions, with each session not lasting more than one hour.

PCRS is delivered in a client-centered manner, that is, tailored to the behavior, circumstances, and special needs of a person.

Data Collection
PCRS providers will collect and record all data required by STD*MIS and other standard documentation practices as prescribed by approved procedures.

Quality Assurance
A minimum of 80 percent of those assigned for PCRS will be offered PCRS. Agencies providing PCRS will have a partner index (defined as the number of unsafe partners identified for whom identifying information was sufficient to initiate counseling and referral, divided by the number of interviewed HIV positive persons with unsafe behavior in the last year) of 1.0.

A partner is defined as a person named by an infected person as having been an unsafe sexual needle-sharing partner of that infected person. If sufficient locating information is obtained to conduct an investigation, such partner is defined as an initiated partner.

Of all in-state initiated partners investigated by a PCRS provider, 75 percent must be located and offered HIV prevention counseling and testing as documented by the results of the investigation.

Disclosure Counseling and Serostatus Negotiation

Definition

A skill building, coaching, problem solving and counseling intervention primarily for HIV infected persons that focuses on increasing disclosure of serostatus to sex and needle sharing partners to reduce uninformed exposures associated with nondisclosure. Assists HIV infected persons to adaptively respond to and cope with the disclosure experience.

Excludes

HCPI initiatives aimed at addressing normative expectations related to serostatus disclosure, reducing stigma associated with disclosure and increasing the sensitivity of persons in responding to persons who disclose their status.

Content and Methods

Disclosure counseling involves engaging HIV infected persons in an exploration of their perceptions, skills, beliefs and patterns of telling at risk past, present and future sex and needle share partner of their HIV status. Disclosure counseling is most effective when messages are provided in each encounter and across intervention and care venues.

Disclosure counseling should include the following core elements:

1) Assessment of disclosure patterns
2) Exploration of perceptions, feelings and beliefs about disclosure/nondisclosure
3) Training or practice on communication skills needed for disclosure
4) Identification of disclosure and non-disclosure circumstances/triggers
5) Problem solving and skill building to facilitate disclosure
6) Motivation and encouragement for disclosure
7) Referral is provided to partner counseling and referral services

Quality Assurance Process

1) Disclosure counseling and serostatus negotiation protocol
2) Training on communication skills and motivational interviewing
3) Periodic observation by and feedback from a trained supervisor

To assure quality of services, CDPHE will perform monitoring duties, including:

1) Review of intervention data submitted to CDPHE, as compared to planned performance
2) A minimum of one on-site observation conducted annually

Data Collection and Reporting Requirements

Providers of disclosure counseling and serostatus negotiation services must collect individual-level from each client and report the full intervention data set as defined by CDPHE including: race; ethnicity; age range; gender; and primary risk.

Comprehensive Risk Counseling and Services

Definition

Comprehensive Risk Counseling and Services (CRCS) is a client-centered HIV prevention activity for increasing behaviors that reduce risk of transmitting or acquiring HIV by clients with multiple or complex problems such as mental health or substance abuse issues. CRCS provides long term, individualized prevention counseling, support, and service brokerage.

Excludes

CRCS excludes one-to-one counseling that lacks multiple sessions conducted over a 3 to12 month period.

Content

The goal of CRCS is to promote the adoption and maintenance of HIV risk-reduction behaviors and to improve skills in accessing community resources that support behavior change for clients who have multiple, complex risk-reduction needs. CRCS is a one-to-one, multi-session, intensive intervention that is intended for clients who would otherwise have a poor prognosis for changing behaviors.

CRCS is a voluntary and confidential, is flexible as to time and setting based on client needs, and may be delivered to person living with HIV or at highest risk of becoming infected.

CRCS is delivered in conjunction with Ryan White CARE Act case management services to the extent that these services are available. CRCS must compliment, coordinate with and fill the gaps in the services provided by Ryan White, chief of which is risk reduction counseling.

The role of the CRCS provider is to help the client reduce the risk of transmitting or acquiring HIV by providing education, counseling, risk reduction planning, capacity building, opportunities for skills practice and support.

The following characteristics are primary indicators of a need for CRCS, especially if the client is HIV positive. Any one of these characteristics, plus evidence of high-risk behaviors, identifies appropriateness for CRCS. High-risk behavior is defined as unprotected anal or vaginal intercourse or sharing needles or other injection equipment without using condoms for sexual contacts and without cleaning needles for needle sharing and failure to disclose HIV positive status prior to engaging in behavior.

The primary characteristics are:

1) Failure to respond to other, less-intensive interventions as indicated by continued exposure, i.e. acquiring an STDs or being named by an infected individual as an unsafe sex partner who fails to disclose HIV status;
2) High likelihood of having transmitted HIV to others;
3) Indifference to risks posed to sexual and needle-sharing partners;
4) Severe and persistent mental illness, particularly bipolar disorder or sexual addiction;
5) Substance misuse.

The following are secondary factors, which may be considered in determining the need for CRCS. These additional factors are supporting criteria to the 5 primary characteristics listed above. Determination of appropriateness for CRCS should not be based solely upon any single secondary factor.

1) Inability or difficulty understanding HIV risk and the reality of HIV infection or habitually retesting for with an HIV positive status;
2) High risk behaviors with anonymous, Internet, bathhouse or bookstore partners;
3) Exchange of sex for something of value with low self-efficacy or chaotic life situations which increases willingness to take HIV risk;
4) Lack of adequate support for HIV risk reduction from partners, peers or others.

Method

The recommended case size for one full time CRCS provider is 20 active cases.

The following are essential components of CRCS:

1) Recruitment and Engagement

The purpose of this component is to bring clients into CRCS. Recruitment includes creating incoming referral mechanisms by building relationships and partnerships with agencies that will refer clients for consideration in the CRCS program. Engagement involves informing clients as to the nature of CRCS and its potential benefit, and to enroll clients into CRCS. The engagement process is concluded when the client signs a consent to treatment form agreeing to accept CRCS or declines participation in the CRCS program.

2) Client Assessment

The intent of this component is to determine the client needs, strengths, and weaknesses in ten key areas: HIV risk; mental health; injection and non-injection drug, and alcohol use: personalization of HIV risk; connectedness; self-efficacy; trauma and abuse; ability to cope with HIV+ status; socioeconomic factors; and degree to which medical care and HIV treatment have been accessed. All clients must be assessed regarding HIV risk, mental health and substance use. Not all other key areas apply to the immediate needs of all clients. A client-centered approach must be used. An assessment tool provided by CDPHE, or an equivalent approved by CDPHE, must be utilized and included in every client record. The CDQ is required for assessing mental health and substance abuse. As part of the assessment process CRCS providers may review other client records such as records from hospital, mental health providers, substance abuse treatment centers, and jails by obtaining a signed release of information form from the client.

The assessment process must be ongoing after initial or baseline assessment. The CDPHE assessment tool (or approved equivalent) must be used to document change vis-à-vis baseline.

Addressing client needs in the areas of finance, legal issues, and housing must be coordinated with Ryan White case management providers.

3) Development of a Client-Centered Prevention Plan

The intent of this component is to provide an HIV risk reduction focus to future

interactions with the client and to map the future direction of CRCS sessions. A prevention plan should be in writing, in a form and format approved by CDPHE. The prevention plan must be collaboratively developed with the client and must include three to 10 objectives based on the findings from the assessment. The objectives must be clearly focused to direct the client toward reducing HIV-related harm or risk of HIV transmission. The objectives must be specific, measurable, achievable, realistic, and time phased. The client's readiness to address each objective must be determined and documented as a baseline for progress. As objectives are completed, new objectives can be added. A written prevention plan must be included in every client record. A prevention-planning tool is available through CDPHE.

4) HIV Risk-Reduction Counseling Sessions

CRCS is delivered in multiple sessions conducted over a 3 to 12 month period from date of engagement (date of signed consent to treatment). CRCS providers must make every effort to complete casework e.g. prevention plan objectives within 6 months. Within the context of client needs, the CRCS provider must address critical issues such as the pros and cons of disclosure, partner care, condom use and HIV and STD testing and screening where appropriate. Each session is typically 40-50 minutes long. Interactions of less than 40 minutes are considered a client contact, not a session. Both contacts and sessions must be documented. Written documentation in every client record must include: progress made toward the completion of the objectives including progression in readiness for change; major HIV-related changes; incidents arising in each session or reported as occurring between sessions; results of previous referrals and referral to new services; and other information deemed relevant by the prevention case manager. Session documentation forms are available through CDPHE.

5) Referral

The intent of this component is to ensure that the client is supported and connected to services not provided by the CRCS provider. Referral mechanisms must be established by building relationships and partnerships with agencies that will provide clients with other services, primary of which are HIV medical care and treatment, Ryan White case management, mental health therapy and substance use treatment. The client must be involved in the referral process. CRCS providers must make active referrals that include determining and encouraging client buy-in and priorities; assisting the client in setting and keeping referral appointments; and following up with client and provider (when necessary, appropriate and permitted) to assure effectiveness of referral. Client records must include written notes regarding coordination of services and active follow up. Referral and referral tracking forms are available through CDPHE.

6) Discharge from CRCS and Maintenance of Risk-Reduction Goals

The intent of this component of CRCS is to ensure that clients eventually becomes self-sufficient in implementing his or her personalized strategies for HIV risk reduction or becomes as self-sufficient in this area as possible as evidenced by completion of prevention plan objectives. Discharge criteria must be discussed with the client at the time of engagement and periodically throughout the CRCS process. Client records must include written notes regarding progress leading to CRCS discharge, a follow up plan for each client, and client perceptions of future needs as he or she maintains lower HIV risk behavior.

The following are criteria for client discharge or case closure:

1) The client successfully meets the objectives of her or his prevention plan and has supports in place to maintain behavior change or has made sufficient progress toward her or his objectives within six months.
2) The client has made negligible progress during the 6-month period in meeting the objectives in his or her prevention plan and continued CRCS is unlikely to yield greater progress.
3) The client verbally refuses services.
4) The client is lost to the intervention when she or he has moved without providing locating information or have moved out of state. The client is categorized as "unable to locate" after one month. During the one-month period, the CRCS provider must document his or her effort to locate the client, including the following searches: Post Office, homeless shelters, jails, Department of Motor Vehicles, Internet phone record searches, and medical records.
5) The client dies.
6) The client's situation or environment is dangerous to the prevention case manager.

Quality Assurance Process

Providers of CRCS must have a written Quality Assurance (QA) plan that is consistent with these *Definitions and Standards*. At a minimum, the QA Plan must address:

1) Identification of person(s) responsible for coordination and management of QA;
2) A CRCS implementation manual, tailored for the agency and its target population, including written standards for all the essential components of CRCS (recruitment and engagement; client assessment; development of a client-centered prevention plan; HIV risk reduction counseling sessions; referral; and discharge) as well as linkages to partner counseling and referral services;
3) Training for staff delivering CRCS;
4) Periodic observation by a trained supervisor;
5) Chart reviews;
6) Case conferencing and presentations;
7) Post-exposure prophylaxis protocol for on-the-job exposures (such as needle stick injuries);
6) Occupational health and safety issues;
7) Record keeping/confidentiality;
8) Client feedback and satisfaction.

To assure quality of services, CDPHE will perform monitoring duties, including:

1) Review of CRCS data submitted to CDPHE, as compared to planned performance.
2) A minimum of one on-site observation conducted annually. On-site observation will include observation of staff performing CRCS.
3) Review of a sample of CRCS forms and files for completeness and accuracy.

Data Collection and Reporting Requirements

Providers of CRCS must collect and report the full CRCS client data set as defined by CDPHE, including: Client Unique Identifier; birth year; county of residence; client demographics; client risk assessment data; self-reported HIV status and testing history; housing situation; pregnancy and prenatal care; incarceration history; recent diagnosis with another STD; injection drug use behavior; sexual behaviors; partner information; nonbehavioral risks; referrals made. Information

should also be collected and reported for each CRCS session, including: site, session number, date, unit of delivery, delivery methods, activities conducted, materials distributed, referrals data, and Client Unique Identifier.

Relevant Guidelines, Laws, and Regulations
CRCS is a component of a "HIV education risk-reduction program" as defined in CRS 25-4-1405, subsection 3(e).

Published research has demonstrated that this has been an effective intervention in the following populations and settings:
HIV prevention case management (the predecessor to CRCS, with similar features) has been shown to be effective in changing risk behaviors among HIV positive heterosexual adults, men who have sex with men, and injection drug users.[23]

This intervention is a component of the following program models:
CRCS is considered to be a separate program model in the CDC Diffusion of Effective Behavioral Interventions (DEBI) framework.

[23] Gasiorowicz, M, Llanas, M., DiFrancesco, W, et al (2005) Reductions in transmission risk behaviors in HIV-positive clients receiving prevention case management: Findings from a community demonstration project. *AIDS Eduction and Prevention*, 17, Supplement A, 40-52.

Section III – Program Models Recognized by the Centers for Disease Control and Prevention (CDC) and CDPHE

As stated in Section I of this document, successful HIV prevention interventions are "based in behavioral and social science theory and research." To promote further implementation of research-based approaches, CDC developed the Compendium of HIV Prevention Interventions with Evidence of Effectiveness, followed by the Diffusion of Effective Behavioral Interventions (DEBI) project. As a CDC-funded project area, and with a shared concern about translation of research and theory into practice, CDPHE also recognizes and promotes evidence-based program models .

To receive recognition by DEBI and CDPHE, claims of effectiveness must be substantiated by research studies showing positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections). Such studies must employ rigorous research designs, with both intervention and control groups, so that the positive outcomes could be attributed to the interventions.

In the DEBI framework, program models are distinguished from interventions. As defined by CDC, a program model is "the scientific or operational rationale that serves as the foundation for the development of an intervention." The underlying program model is the foundation on which an HIV prevention program is built. Under a program model, an agency provides some combination of group, individual, and outreach interventions; the program model ties these interventions together, supplying the participants with a consistent experience and a coordinate set of intended outcomes.

Program Models Recognized By CDPHE

The CDPHE currently recognizes seven DEBI program models, as show in the table below. Each of these program models employs one or more interventions.

	Outreach	ILI	GLI	CLI	HC/PI
Community PROMISE	X			X	X
Healthy Relationships			X		
Many Men, Many Voices			X		
Mpowerment	X		X	X	
Popular Opinion Leader	X			X	
Safety Counts		X	X		
SISTA Project			X		

Note that this table shows only those interventions that are <u>required components</u> of the program models.[24]

[24] In some cases, providers may include optional interventions not explicitly required by the program model. For instance, a SISTA project may choose to conduct an HC/PI campaign to publicize their services although it is not explicitly required under the SISTA program model.

The following are classified as “stand alone” interventions. Per CDC guidelines, they should not be classified as a component of any other program model.

1. HIV Counseling, Testing, and Referral
2. Comprehensive Risk Counseling and Services
3. Partner Counseling and Referral Services

In addition, CDPHE currently recognizes one adapted program model. The “ManREACH” program model is a rural adaptation of the Mpowerment Program Model.

Fact sheets on each of these program models may be found in Appendix C. Additional information on the DEBI program models may be found at www.effectiveinterventions.org

APPENDIX A

Theories and Models

Health Belief Model

The Health Belief Model is based on the premise that perceptions of personal threats are a necessary precursor to taking preventive action. The major factors that influence whether or not a person will adopt new behaviors to lower risk include: 1) characteristics of the individual that influence behavior; 2) perceived susceptibility on the part of the individual (i.e., to what extent do they think they can get HIV) and perceived severity of the health problem; 3) expectancies for taking action and making a particular behavior change (i.e., perceived benefits, barriers, and costs for taking action); and 4) cues in the environment that promote taking action. Recently added to this model is the concept of self-efficacy, or one's confidence in the ability to successfully perform an action. Overall, one must believe that the benefits of performing a behavior outweigh the consequences of not performing it before behavior change will occur.

Theory of Reasoned Action

The Theory of Reasoned Action is based on the premise that attitudes about behaviors and perceived norms for practicing behaviors lead to intentions that are then a step away from engaging in a specific behavior. Behavioral intentions are determined by attitudes, beliefs, and perceptions that are all influenced by social contexts and individual experiences. Community attitudes and beliefs and norms are social forces that influence individuals' intentions and behavior. Behavior is a function of the processing of information available to a person in a given context at a given time. Behavior is therefore determined by intentions, attitudes, perceived normative pressures, beliefs about consequences, values placed on perceived norms, and values placed on potential outcomes. The Theory of Reasoned Action is also based on the premise that behaviors are under the direct control of individuals. However, there are many instances when individuals lack direct control over their actions, and the theory is limited in explaining behaviors under these circumstances.

Social (Cognitive) Learning Theory

The Social Learning Theory is also based on the premise that behaviors, environmental influences, and personal factors such as attitudes and beliefs are highly interactive and interdependent, meaning that they each influence the others. The environment shapes, maintains, and constrains behavior, but people are not passive in the process as they can create and change their environments. This theory emphasizes the roles of outcome expectancies (beliefs about positive or negative consequences) and reinforcement for adopting behavior changes. Central to the theory are self-efficacy beliefs that are tied to the ability to perform specific actions under specific circumstances. Acquisition of new skills is often required that are obtained through direct experience or by modeling others.

The Social Learning Theory assumes that individuals exist within environments where other people's thoughts, advice, examples, assistance, and emotional support affect their own feelings, behaviors, and health. Some of these influential people might include family members, co-workers, peers, health professionals, and others who are similar to them.

Transtheoretical Model (Stages of Change)
The Transtheoretical Model proposes that behavior change is a process and not an event. People are at varying levels of motivation or readiness to change. The theory proposes that people move through a sequence of change processes that are ordered by degrees of motivation and behavior. These vary for different individuals and groups and for different behavioral changes. The theory emphasizes the primacy of cognitive processes (e.g., attitudes and beliefs). The change process includes the following stages: 1) precontemplation; 2) contemplation; 3) preparation: 4) action; and 5) maintenance. The process is not linear and often involves relapse as a normal part of one's attempt to change behaviors. A provider must determine people's status in the change process when designing an intervention. People at different points in the process of change can benefit from different interventions, matched to their stage at that time.

Diffusion of Innovation
The Diffusion of Innovation Theory addresses how new ideas, products, and social practices spread within a social group or between social groups. It is based on the process through which any new idea is communicated to members of a group or population and the stages or intervals over time in which people respond to and accept those messages. The theory's key components include: 1) the communication channels through which innovations or new messages are dispersed; 2) the opinion leaders who are respected community members who can assist in dispersing the innovation or message; and 3) the time and process required for the innovation to reach community or group members and for people to receive and accept the messages. Social networks aid the diffusion process.

Empowerment Theory
The Empowerment Theory is a community-level model that embodies an ecological perspective and provides a basis for pursuing goals of better health for individuals, groups, and communities. It is based on the premise that groups of people change through a process of coming together to share experiences, understand social influences, and collectively develop solutions to problems. Its key components include participatory research and education, which means that community people are involved in developing the knowledge necessary to build an intervention, and they are instrumental in implementing and evaluating the intervention as well. Through an empowerment model, community groups are helped to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching their goals. Therefore it stimulates problem solving and activates community members. A community's own concerns and desires are essential to the planning process. Prevention plans must emerge from the community for which it is being developed. Community-level theories such as this complement individually oriented behavior change models by emphasizing changing the social or cultural environment and by including broad aims such as advocacy and policy development.

AIDS Risk Reduction Model
Using constructs derived from the Health Belief Model, the Social Cognitive Theory, the Diffusion of Innovation Theory, and the Transtheoretical and other models, the AIDS Risk Reduction Model is crafted specifically for HIV prevention. It is also a stage model in which an individual must first recognize and label their vulnerability for HIV infection, make a commitment to changing their behavior (which involves changing attitudes and gaining self-

efficacy), and, finally, enacting the change. This final stage includes “help seeking” which involves gaining support for changing behaviors, communicating with sex partners, and initiating change.

Theory of Gender and Power

The Theory of Gender and Power grew from a realization that most of the theoretical models driving the field of HIV prevention had an individualistic orientation and did not consider the broader context of women’s lives. It is a social structural theory based on premises of sexual inequality and gender and power imbalance. According to the theory, there are three major social structures that characterize the relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis (including social norms and affective attachments). These three structures exist at two different levels: the societal and the institutional. They are rooted in society through numerous abstract, historical, and sociopolitical forces that consistently segregate power and ascribe social norms on the basis of gender-determined roles. They are evident in social institutions such as schools, work sites, families, religious institutions, and through images of women in the media. The presence of these and other social mechanisms constrains women’s behaviors by producing gender-based inequities in women’s economic potential and control over resources as well as the expectations of women’s roles in society. Such inequities and disparities in expectations generate exposures and risk factors that adversely influence women’s risks for HIV.

APPENDIX B

Guidelines for Legal and Operational Protection of Confidential HIV and Communicable Disease Public Health Reports and Records

Background

It is the duty of state and local health officers to investigate and control HIV and communicable diseases. Colorado Board of Health Rules and Regulations require that information about communicable disease be shared between the state and local health departments, and that this information remain confidential. CDPHE assures the CDC and all 50 states with which it has interstate reciprocal agreements, that all agencies with which it lawfully shares HIV surveillance information are bound by the same legal restrictions as CDPHE. Public health agencies and contractors must hold public health reports and records as strictly confidential and not release information upon subpoena, search warrant, or discovery proceedings except under specific circumstances permitted by law (C.R.S. § 25-4-1404(1); C.R.S. § 25-1-122(4)).

Rationale

The protection of confidentiality of reportable conditions requires a consistent, long-term, and statewide approach. The statutes (see references) that protect public health records (as defined below) apply simultaneously to both CDPHE and local health agencies. Furthermore, CDPHE may have additional requirements in its contracts with local health agencies concerning the confidentiality of records, when information is collected using the resources from the contract. Even though a local health agency may be the specific recipient of a subpoena for public health records, the actions taken by the local health agency affect not only CDPHE, but all other local health agencies in Colorado, because of the potential to set legal precedents. As a result, these guidelines have been developed to assure that a highly protective approach is administered by all public health agencies in the state and that there is close collaboration between CDPHE and the affected local health agency. These guidelines are intended to provide assistance in the practical application of state law and regulations and to provide examples pertaining to the protection of records. An additional goal is the development of a well-trained workforce who is committed to confidentiality protection.

Definitions

1) Public health reports and records: All information regarding a case of a reported disease, including lab reports, medical reports, demographics, risk factor information, follow up investigations, partner notification/contact tracing records, counseling notes, and HIV prevention case management notes and records. In other words, there is no distinction made as to where the data came from; if the information is in the file or folder of the public health agency and is not a clinic chart, it is a public health report and is subject to the confidentiality protections listed in C.R.S. § 25-1-122 (4) and C.R.S. § 25-4-1404 (1). If the information came from a clinic chart, it is nonetheless a public health report once it is placed in the file, folder, or database of the public health surveillance/ investigation/ counseling/case management worker or program. No distinction should be made between clinical information and “Epi” information; both are considered public health records if they are physically located in the public health file, folder, or database.

2) Medical records: All information in medical charts held in a clinic or office by a health care practitioner. If a local health agency has, for example, an STD clinic, then the information about

a patient in the chart located in the clinic is a medical record and is subject to the confidentiality protections afforded all medical records by C.R.S. § 18-4-412.

Comments

The same information, (e.g. positive urethral culture for N. gonorrhoeae), may appear in both a clinic chart and a public health record. Different statutes protect the confidentiality, based on the location of the information. In general, epidemiologic and prevention information collected after a case is reported, such as named partners, risk factors, and case management, should not intentionally be photocopied and placed in the medical record.

Guidelines for Local Health Agencies and Contractors

1) Review and ensure the organization's compliance with:
   a) Colorado statutes related to HIV
   b) Colorado statutes related to communicable diseases
   c) Colorado Board of Health Rules and Regulations pertaining to HIV
   d) Colorado Board of Health Rules and Regulations pertaining to Communicable Diseases
   e) Definitions for HIV Prevention Interventions and Standards of Practice as approved annually by the Core Planning Group of Coloradans Working Together: Preventing HIV/AIDS.

2) Ensure that all employees who have "need to know" status and access to confidential HIV or communicable disease information sign confidentiality agreements. A sample agreement is attached. Keep file copies of all signed Confidentiality Agreements.

3) Contact the CDPHE executive director, state epidemiologist, chief medical officer, or office of Legal and Regulatory Affairs attorney when questions arise. These CDPHE employees will be able to provide technical assistance regarding the practical interpretation of HIV and communicable disease statutes and Board of Health Rules and Regulations.

4) Prevent attempts by outside agencies to obtain unauthorized access to public health reports, records, and staff testimony.

5) Upon receipt of a subpoena for any HIV or communicable diseases record or staff testimony:
   a) Notify your agency's official legal counsel. Note: Because of client-attorney privilege and for the purpose of legal representation, you may share public health reports and records information with your agency's official legal counsel.
   b) Notify the CDPHE state epidemiologist, chief medical officer, or Office of Legal and Regulatory Affairs attorney <u>within 24 hours</u> after being served with a summons, complaint, or other pleading in a case that involves any HIV or communicable diseases related reports, records or services or records.
   c) CDPHE staff may contact the Attorney General's Office for additional legal advice, as needed.
   d) It may be helpful to provide copies of subpoenas to the CDPHE or Attorney General staff that is providing guidance. This sharing of information back and forth is most helpful when it is done collaboratively and in a timely manner.
   e) CDPHE, through the Attorney General's Office, may additionally want to prepare its own legal arguments.
   f) Do not release any records to the court until you have received legal advice by the agency's counsel and one of the CDPHE staff listed above.

g) After receiving such legal advice, respond to all subpoenas with a motion to quash, unless an exception exists in law (e.g., in the case of an STD record, if the patient who is the subject of the case agrees to the testimony), as provided under C.R.S. §25-1-122 (4) (c)), or if testimony is required under C.R.S. §18-3-415.5, or pursuant to C.R.S. §25-4-1406 or C.R.S §25-4-1407.
h) For situations in which the agency may choose to make a report of child abuse, provide only the information allowed by law (C.R.S. §25-4-1404 (1) (d) and C.R.S. §25-1-122 (4) (d)) to agencies responsible for receiving or investigating reports of child abuse or neglect. It is CDPHE's understanding of the legislative intent, that the "general nature of the child's injury" does not include disease specific information or public health reports and records.
i) If a lower court makes a decision contrary to the statutes, this decision must be appealed in a higher court. This appeal should be coordinated with CDPHE.

6) CDPHE may conduct a site visit to inspect the agency's physical and electronic security systems, and make recommendations to increase security. The electronic and physical security systems for HIV must satisfy the requirements of both CDC and CDPHE.
7) CDPHE will provide orientation and training, on request, to assist agencies in meeting these guidelines.

References
Copies may also be obtained by calling the Disease Control and Environmental Epidemiology Division at CDPHE at 303-692-2700. Some references may be obtained on the Internet; these addresses are provided below.

Colorado statutes related to HIV: C.R.S. § 25-4-1401 et seq. Internet*: http://216.250.5.221/cgi-dos/statsrcp.exe?N*

Colorado statutes related to communicable diseases: C.R.S. § 25-1-122 et seq. Internet: *http://216.250.5.221/cgi-dos/statsrcp.exe?N*

6 CCR-1009-9
effective 6/30/97
STATE OF COLORADO
COLORADO BOARD OF HEALTH
RULES AND REGULATIONS
PERTAINING TO THE REPORTING, PREVENTION, AND CONTROL OF AIDS, HIV RELATED ILLNESS, AND HIV INFECTION

Colorado has a comprehensive public health AIDS/HIV control law: Colorado Revised Statutes Title 25, Article 4, Sections 1401 et seq. These regulations are intended to provide detail and clarification for selected parts of the above-cited statute. The statute covers subject matters not included in these regulations.

C.R.S. 25-4-1405.5 (2) (a) (I) requires the Colorado Department of Public Health and Environment (CDPHE) to conduct an anonymous counseling and testing program for persons considered to be at high risk for infection with HIV. The provision of confidential counseling and testing for HIV is the preferred screening service for detection of HIV infection. Local boards of health that provide HIV counseling and testing through a contractual agreement with the CDPHE must consider the need for an anonymous HIV testing option in their jurisdiction. The consideration of this option must provide an opportunity for public comment in a public forum at a minimum of every two years. Other mechanisms for input into the need for an anonymous testing option in that jurisdiction must be available in addition to the public forum, including anonymous testimony in writing or through an organization. Local Boards of Health must document the following: notification of interested parties and the public, time allowed between notification and the public forum, accessibility in both location and time of the public forum, and the response to public comment in the decision process. Local boards of health electing to provide confidential HIV testing with an anonymous option must do so in conjunction with counseling and testing sites (CTS); i.e., CDPHE designated sites which screen individuals for HIV infection without providing on-going health care. This will be done through a contractual agreement with the CDPHE. Local boards of health may elect, at the time of contract renewal, to provide confidential testing with an anonymous option.

Per C.R.S. 25-4-1405.5 (2) (a) (II), Regulations 6-8 are the performance standards for confidential and anonymous HIV CTS and the CDPHE staff.

Regulation 1
Reporting By Physicians, Health Care Providers, Hospitals, And Others
Diagnosed cases of AIDS, HIV-related illness, and HIV infection, regardless of whether confirmed by laboratory tests, shall be reported to the state or local health department or health agency within 7 days of diagnosis by physicians, health care providers, hospitals, or any other person providing treatment to a person with HIV infection. When hospitals and laboratories transmit disease reports electronically using systems and protocols developed by the department that ensure protection of confidentiality, such reporting is acceptable and is considered good faith reporting.

All cases are to be reported with the patient's name, date of birth, sex, address (including city and county), name and address of the reporting physician or agency; and such other information as is needed to locate the patient for follow up. For cases reported from a public anonymous testing site as provided by C.R.S. 25-4-1405.5, the patient's name and address and the name and address of the reporting physician are not required. Reports on hospitalized patients may be made part of a report by the hospital as a whole.

Research activities of persons performing clinical research on persons with AIDS, HIV-related illness, or HIV infection whose research activity:
1) Involves the study of HIV treatment or vaccine effectiveness or is basic biomedical research into the cellular mechanisms causing HIV infection or HIV-related disease;
2) Meets the research exemption criteria of C.R.S. 25-4-1402.5(3); and
3) Has been approved by the Board of Health pursuant to C.R.S. 25-4-1402.5(2) shall be exempt from meeting the reporting requirements for AIDS, HIV-related illness, and HIV infection.

Regulation 2
Reporting by Laboratories
Laboratories shall report every test result that is diagnostic of or highly correlated with or indicates HIV infection. The report shall include the name, date of birth, sex and address of the individual from whom the specimen was submitted. Such test results shall be reported by all in-state laboratories and by out-of-state laboratories that maintain an office or collection facility in Colorado or arrange for collection of specimens in Colorado. The laboratory that performs the test must report results, but an in-state laboratory that sends specimens to an out-of-state referral laboratory is also responsible for reporting the results. The laboratory shall also report the name and address of the attending physician and any other person or agency referring such specimen for testing.

When associated with other clinical or laboratory evidence of HIV infection, the Board of Health defines a CD4 test result of either CD4 count <500 mm or CD4 percent <29 percent 3 as a primary immunologic measure indicating severe HIV infection and, when the count is <200 mm, as defining AIDS. Laboratories shall report CD4 counts <500 mm OR 3 3 CD4 percent <29 percent. The Department shall destroy personal identifying information on all persons with CD4 results in the reportable range if investigation subsequent to the report finds no evidence of HIV infection. Laboratories may fulfill the requirement to report CD4 counts <500 mm or CD4 percent <29 percent by allowing authorized personnel of the Department of Public Health and Environment access to such records.

Laboratories shall follow the same procedures for reporting as are required of other reporting sources in Regulation 1.

Report of test results by a laboratory does not relieve the attending physician of his/her obligation to report the case or diagnosis, nor does report by the physician relieve the laboratory of its obligation.

Regulation 3
Information Sharing

Information concerning cases of AIDS, HIV-related illness, or HIV infection shall be shared between the appropriate local health department or health agency and the state health department, as provided by C.R.S. 25-4-1404 (1)(B), and in a timely manner, usually within the timeframe for reporting in Regulation 1.

These requirements shall not apply if the state and local health agencies mutually agree not to share information on reported cases.

Regulation 4
Confidentiality
All public health reports and records held by the state or local health department in compliance with these regulations shall be confidential information subject to C.R.S. 25-4- 1404. The public health reports and records referred to in C.R.S. 25-4-1404 shall include, but not be limited to, the forms and records designated by the CDPHE for institutions and agencies which screen individuals for HIV infection without providing ongoing health care, such as a public HIV counseling and testing site.

Reasonable efforts shall be made by the department to consult with the attending physician or medical facility caring for the patient prior to any further follow up by state or local health departments or health agencies.

Regulation 5
Investigations To Confirm The Diagnosis And Source Of HIV Infection And To Prevent HIV Transmission
It is the duty of state and local health officers to conduct investigations to confirm the diagnosis and sources of HIV infection and to prevent transmission of HIV. Such investigations shall be considered official duties of the health department or health agency. Such investigations may include, but are not limited to:
1) Review of pertinent, relevant medical records by authorized personnel if necessary to confirm the diagnosis, to investigate possible sources of infection, to determine objects and materials potentially contaminated with HIV and persons potentially exposed to HIV. Such review of records may occur without patient consent and shall be conducted at reasonable times and with such notice as is reasonable under the circumstances;
2) Performing follow up interview(s) with the case or persons knowledgeable about the case to collect pertinent and relevant information about the sources of HIV infection, materials and objects potentially contaminated with HIV, and persons who may have been exposed to HIV.

Regulation 6
Objective Standards
1) Training
- a) All persons providing HIV pre and posttest prevention and risk-reduction counseling at a CTS will have completed the HIV Serologic Test Counseling course or an equivalent of not less than 16 hours of training, approved by the CDPHE STD/AIDS Program.
- b) All persons providing HIV pre and posttest prevention and risk reduction counseling at a CTS will have a minimum of 8 hours of relevant HIV/STD or allied health services continuing education annually, approved by the CDPHE STD/AIDS Program.

d) All persons performing partner notification interviews will have completed courses concerning introduction to sexually transmitted disease interviewing and partner notification, as specified by the CDPHE.

2) Notification of Results

a) Of all HIV tests performed at a CTS, 90 percent of those persons testing HIV positive will receive results and posttest risk-reduction counseling.

b) Of all HIV tests performed at a CTS, 80 percent of those persons testing HIV negative will receive results and posttest prevention and risk reduction counseling.

3) Partner Notification

If CDPHE staff provides partner notification for a CTS, then the following standards do not apply to the CTS.

a) Of the 90 percent of HIV positive individuals receiving results and posttest counseling, 100 percent will be assigned for partner notification interview. A minimum of 75 percent of those assigned for a partner notification interview will receive an interview. Agencies providing partner notification services (CDPHE and local health departments) will have a partner index (defined as the number of unsafe partners identified for whom identifying information was sufficient to initiate notification, divided by the number of interviewed HIV positive persons with unsafe behavior in the past year) of 0.8. Effective January 1, 1995, the acceptable partner index will be 1.0. Documentation of this activity will be provided to the CDPHE through use of a CDPHE specified form.

A contact is defined as a person named by an infected person as having been an unsafe sex partner/needle share partner of that infected person.

If sufficient locating information (name, age, sex, phone number, recent address, work address) is obtained to conduct an investigation, such a contact is defined as an initiated contact.

b) Of all in-state initiated contacts, 60 percent must be located and offered HIV prevention and risk-reduction counseling and/or testing as documented by the results of the investigation on the CDPHE specified form. Documentation of investigation outcomes will include disposition codes as specified by the CDPHE, dates and location of counseling, and dates and location of testing (if done).

Regulation 7
Operational Standards

1) Counseling

a) All counselors at a CTS performing HIV pretest prevention and risk reduction counseling will: a) conduct a risk assessment, b) discuss and develop a risk-reduction plan, i.e., identify with the client specific behaviors that can realistically be changed to reduce risk, c) fully and legibly complete for each person tested the HIV 1 Serology lab slip.

b) All counselors at a CTS performing HIV posttest prevention and risk reduction counseling will: a) inform clients in person of test results, b) explain the significance of both positive

and negative test results, c) discuss and/or modify the risk-reduction plan, d) refer clients who test positive for follow up medical and counseling services.

2) Consent Form
   a) A consent form specified by the CDPHE or an approved equivalent must be used at all CTS.

3) Testing Parameters
   a) CTS will not provide anonymous testing to any person 12 years of age or younger.
   b) If a counselor judges that a client is unable to understand either counseling or the testing process, e.g., because the client is under the influence of drugs or alcohol, the counselor may defer testing.

4) Written Results
   a) CTS may only provide written results to persons testing confidentially. To receive written results, the CTS must be presented with photo identification from the person requesting written results at the time of posttest.
   b) Contracting agencies may not give written results to any person testing anonymously.

5) Confidentiality and Record Maintenance
   a) Contracting agencies must have and adhere to an HIV record retention policy. The local board of health must adopt any record retention policy with the opportunity for public comment and input through an open public forum conducted at least every two years. Other mechanisms for input into the record retention policy must be available in addition to the public forum, including anonymous testimony in writing or through an organization.

Any policy must address the following areas:
   a) Linkage of personal identifiers, behavioral risk information and results; time frames, if any for delinkage, (The CDPHE encourages that any record retention policy include the delinking of identifying information from risk information 120 days from the date of testing.),
   b) The availability of anonymous testing,
   c) Time frames for destruction of records,
   d) Method and supervision for destruction of records,
   e) Approval of record retention policy by the Colorado State Archivist,
   f) Procedures for hard (paper) records and electronic (computer) records,
   g) Procedures for records of negative results and positive results,
   h) Inclusion of record retention information in the client consent form.

Per C.R.S. 25-4-1404.5 (2) (a) (II), a person may provide personal identifying information after counseling, if the person volunteers to do so. Contracting agencies must document this information when volunteered, and provide this information to the CDPHE on the posttest reimbursement form submitted to the CDPHE within 30 days of the date the blood specimen was collected.

Regulation 8
Evaluation Standards and Penalties

1) Each CTS's compliance with these standards will be evaluated by the following:

a) A semi-annual analysis by the CDPHE staff of the number of persons receiving HIV antibody testing and the proportion of persons testing receiving results per contracted agency.

b) A minimum of one on-site observation conducted annually by the CDPHE staff. This on-site observation will include observation of counselors at each CTS performing HIV pre and posttest prevention and risk-reduction counseling.

c) A semi-annual analysis of testing trends (anonymous vs. confidential) conducted by CDPHE staff.

d) A semi-annual review of counseling and partner notification forms for completion and accuracy conducted by CDPHE staff.

e) A minimum of one annual audit of charts for all contracting agencies, conducted by CDPHE staff.

f) Accuracy and completion of the posttest counseling reimbursement form submitted to the CDPHE.

2) Failure of a CTS to comply with and meet these standards may result in one or more of the following action(s):

a) The CTS may meet with the CDPHE to develop a plan for improving performance in specified areas.

b) The CTS may be given a probationary period to comply and meet the standards.

c) The CTS may be reevaluated by the end of the probationary period.

d) Failure to meet and comply with the standards may result in contract termination.

25-4-1401 - Legislative Declaration.
The general assembly hereby declares that infection with human immunodeficiency virus, the virus that causes acquired immune deficiency syndrome (AIDS), referred to in this Part 14 as "HIV", is an infectious and communicable disease that endangers the population of this state. The general assembly further declares that reporting of HIV infection to public health officials is essential to enable a better understanding of the disease, the scope of exposure, the impact on the community, and the means of control; that efforts to control the disease should include public education, counseling, and voluntary testing; that restrictive enforcement measures should be used only when necessary to protect the public health; and that having AIDS or the HIV infection, being presumed to have the HIV infection, or seeking testing for the presence of such infection should not serve as the basis for discriminatory actions or the prevention of access to services. The general assembly further declares that the purpose of this Part 14 is to protect the public health and prevent the spread of said disease.

25-4-1402 - Reports of HIV Infection.
1) Every attending physician in this state shall make a report to the state department of public health and environment or local department of health, in a form and within a time period designated by the state department of public health and environment, on every individual known by said physician to have a diagnosis of AIDS, HIV-related illness, or HIV infection, including death from HIV infection.
2) All other persons treating a case of HIV infection in hospitals, clinics, sanitariums, penal institutions, and other private or public institutions shall make a report to the state department of public health and environment or local department of health, in a form and within a time period designated by the state department of public health and environment, on every individual having a diagnosis of AIDS, HIV-related illness, or HIV infection, including death from HIV infection.
3) Repealed.
4) The reports required to be made under the provisions of subsections (1) and (2) of this section shall contain the name, date of birth, sex, and address of the individual reported on and the name and address of the physician or other person making the report.
5) Good faith reporting or disclosure pursuant to this section or section 25-4-1403 shall not constitute libel or slander or a violation of the right of privacy or privileged communication.
6) Any person who in good faith complies completely with this Part 14 shall be immune from civil and criminal liability for any action taken in compliance with the provisions of this Part 14. Compliance by a physician with the reporting requirements of this Part 14 and with any regulations promulgated by the state department of public health and environment relating thereto shall fulfill any duty of such physician to a third party.

25-4-1402.5 - Exemption From Reporting
1) The reporting of the name, address, date of birth, or sex of research subjects with AIDS, HIV-related illness, or HIV infection to the state department of public health and environment or local department of health pursuant to the provisions of sections 25-4-1402 and 25-4-1403 shall not be required of any researcher conducting a medical research study of HIV treatment or vaccine effectiveness or conducting basic biomedical research into the cellular mechanisms causing HIV infection or HIV-related disease pursuant to an approved research protocol. For the purposes of the research exemption authorized in this section "approved research protocol," means any

activity that has been reviewed and approved by the state board of health. The research exemption authorized in this section does not alter the reporting requirements of persons and researchers otherwise required to make reports when engaged in any treatment or testing outside the scope of or prior to enrollment in an approved research protocol. The research exemption authorized in this section does not alter the reporting requirement of persons otherwise required to make reports when engaged in any treatment or testing outside the scope of a research protocol and such exemption does not exempt the researcher from reporting other reportable diseases. The research exemption authorized in this section does not exempt medical researchers from meeting the requirements of section 25-4-1405 (5) to provide post-test counseling to infected enrolled research subjects and referral of such subjects to the state department of public health and environment or local department of health for partner notification services.
2) The state board of health shall approve research activities for the research reporting exemption specified in subsection (1) of this section based on evidence that the research activity for which an exemption is requested meets the eligibility requirements specified in subsection (3) of this section.
3) The state board of health shall grant the exemption specified in subsection (1) of this section, if the research activity meets all of the following criteria:

a) Is fully described by a research protocol;
b) Is subject to review by and is governed by the federal department of Health and Human Services;
c) Has as the protocol objectives either: The investigation of the effectiveness of a medical therapy or vaccine in preventing infection or the progression of HIV-related disease; or basic medical research into the cellular mechanisms causing HIV infection or HIV-related disease;
d) Is reviewed and approved by a duly constituted institutional review board in accordance with the regulations established by the secretary of the federal department of health and human services;
e) The researcher has provided information that the research activity will be facilitated by an exemption specified in subsection (1) of this section; and
f) Has been determined to have potential health benefits.

4) Repealed.

25-4-1403 - Reports of Positive HIV Tests

All laboratories or persons performing laboratory tests for HIV shall report to the state department of public health and environment or appropriate local department of health, in a form and within a time period designated by the state department of public health and environment, the name, date of birth, sex, and address of any individual whose specimen submitted for examination tests positive for HIV as defined by the state board of health. Such report shall include the test results and the name and address of the attending physician and any other person or agency referring such positive specimen for testing.

25-4-1404 - Use of Reports.

1) The public health reports required to be submitted by sections 25-4-1402 and 25-4-1403 and records resulting from compliance with section 25-4-1405 (1) and held by the state department of public health and environment, any local department of health, or any health care provider or facility, third-party payor, physician, clinic, laboratory, blood bank, or other agency shall be

strictly confidential information. Such information shall not be released, shared with any agency or institution, or made public, upon subpoena, search warrant, discovery proceedings, or otherwise, except under any of the following circumstances:

a) Release may be made of such information for statistical purposes in a manner such that no individual person can be identified.
b) Release may be made of such information to the extent necessary to enforce the provisions of this Part 14 and related rules and regulations concerning the treatment, control, and investigation of HIV infection by public health officials.
c) Release may be made of such information to medical personnel in a medical emergency to the extent necessary to protect the health or life of the named party.
d) An officer or employee of the local department of health or state department of public health and environment may make a report of child abuse to agencies responsible for receiving or investigating reports of child abuse or neglect in accordance with the applicable provisions of the "Child Protection Act of 1987" set forth in Part 3 of article 3 of title 19, C.R.S. However, in the event a report is made, only the following information shall be included in the report:
    i) The name, address, and sex of the child;
    ii) The name and address of the person responsible for the child;
    iii) The name and address of the person who is alleged to be responsible for the suspected abuse or neglect, if known; and
    iv) The general nature of the child's injury.
e) The state department of public health and environment and any local department of health, upon being contacted by a district attorney pursuant to section 18-3-415.5, C.R.S., shall provide the information specified in said section.
f) An officer or employee of the state department of public health and environment or of a local department of health, pursuant to section 18-3-415.5, C.R.S., shall provide, for purposes of a sentencing hearing, oral and documentary evidence limited to whether a person who has been bound over for trial for any sexual offense, as described in section 18-3-415.5, C.R.S., was provided notice that he or she had tested positive for the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome or had discussion concerning his or her HIV infection, and the date of such notice or discussion.

2) No officer or employee of the state department of public health and environment or local department of health shall be examined in any judicial, executive, legislative, or other proceeding as to the existence or content of any individual's report retained by such department pursuant to this Part 14 or as to the existence of the contents of reports received pursuant to sections25-4-1402 and 25-4-1403 or the results of investigations in section 25-4-1405. This provision shall not apply to administrative or judicial proceedings pursuant to section 25-4-1406 or 25-4-1407 or section 18-3-415.5, C.R.S.

3) Information regarding AIDS and HIV infection in medical records held by a facility that provides ongoing health care is considered medical information, not public health reports, and is protected from unauthorized disclosure as provided in section18-4-412, C.R.S

25-4-1405 - Disease Control by the State Department of Public Health and Environment and Local Health Departments.

1) It is the duty of state and local health officers to investigate sources of HIV infection and to use every proper means to prevent the spread of the disease.

2) It is the duty of state and local health officers, as part of disease control efforts, to provide public information, risk-reduction education, confidential voluntary testing and counseling, educational materials for use in schools, and professional education to health care providers.
3) The state department of public health and environment shall develop and implement programs under which state and local health departments may perform the following tasks:

a) Prepare and disseminate to health care providers circulars of information and presentations describing the epidemiology, testing, diagnosis, treatment, medical, counseling, and other aspects of HIV infection;
b) Provide consultation to agencies and organizations regarding appropriate policies for testing, education, confidentiality, and infection control;
c) Conduct health information programs to inform the general public of the medical and psychosocial aspects of HIV infection, including updated information on how infection is transmitted and can be prevented. The department shall prepare for free distribution among the residents of the state printed information and instructions concerning the dangers from HIV infection, its prevention, and the necessity for testing.
d) Prepare and update an educational program on HIV infection in the workplace for use by employers;
e) Develop and implement HIV education risk-reduction programs for specific populations at higher risk for infection; and
f) Develop and update a medically correct AIDS prevention curriculum for use at the discretion of secondary and middle schools.

4) School districts are urged to provide every secondary school student, with parental consent, education on HIV infection and AIDS and its prevention.
5) It is the duty of every physician who, during the course of an examination, discovers the existence of HIV infection or who treats a patient for HIV infection to inform the patient of the interpretation of laboratory results and counsel the patient on measures for preventing the infection of others, prophylaxis and treatment of opportunistic infections, treatment to prevent progression of HIV infection, and the necessity of regular medical evaluation.
6) Any local health department, state institution or facility, medical practitioner, or public or private hospital or clinic may examine and provide treatment for HIV infection for any minor if such physician or facility is qualified to provide such examination and treatment. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination and treatment. The physician in charge or other appropriate authority of the facility or the licensed physician concerned shall prescribe an appropriate course of treatment for such minor. The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any person other than the minor except for purposes of a report required under sections 25-4-1402 and 25-4-1403 and subsection (8) of this section and a report containing the name and medical information of the minor made to the appropriate authorities if required by the "Child Protection Act of 1975", Part 3 of article 3 of title 19, C.R.S. If the minor is less than sixteen years of age or not emancipated, the facility or physician of the consultation, examination, and treatment may inform the minor’s parents or legal guardian. The physician or other health care provider shall counsel the minor on the importance of bringing his parents or guardian into the minor’s confidence about the consultation, examination, or treatment.

7) a) When investigating HIV infection, state and local health departments, within their respective jurisdictions, may inspect and have access to medical and laboratory records relevant to the investigation of HIV infection.
b) Repealed.

7.5) a) When a public safety worker, emergency medical service provider, or staff member of a detention facility has been exposed to blood or other bodily fluid which there is a reason to believe may be infectious with HIV, state and local health departments within their respective jurisdictions shall assist in evaluation and treatment of any involved persons by:

i) Accessing information on the incident and any persons involved to determine whether a potential exposure to HIV occurred;
ii) Examining and testing such involved persons to determine HIV infection when the fact of an exposure has been established by the state or local health department;
iii) Communicating relevant information and laboratory test results on the involved persons to such persons' attending physicians or directly to the involved persons if the confidentiality of such information and test results is acknowledged by the recipients and adequately protected, as determined by the state or local health department; and
iv) Providing counseling to the involved persons on the potential health risks and treatment resulting from exposure.

b) The employer of an exposed person shall ensure that relevant information and laboratory test results on the involved person are kept confidential. Such information and laboratory results are considered medical information and protected from unauthorized disclosure.

c) For purposes of this subsection (7.5), "public safety worker" includes, but is not limited to, law enforcement officers, peace officers, and firefighters.

8) a) No physician, health worker, or other person and no hospital, clinic, sanitarium, laboratory, or other private or public institution shall test, or shall cause by any means to have tested, any specimen of any patient for HIV infection without the knowledge and consent of the patient; except that knowledge and consent need not be given:

i) Where a health care provider or a custodial employee of the department of corrections or the department of human services is exposed to blood or other bodily fluids that may be infectious with HIV;
ii) When a patient's medical condition is such that knowledge and consent cannot be obtained;
iii) When the testing is done as part of seroprevalence surveys if all personal identifiers are removed from the specimens prior to the laboratory testing;
iv) When the patient to be tested is sentenced to and in the custody of the department of corrections or is committed to the Colorado mental health institute at Pueblo and confined to the forensic ward or the minimum or maximum-security ward of such institute;
v) When a person is bound over for trial of a sexual offense as set forth in section 18-3-415 or 18-3-415.5, C.R.S., or subject to testing under section 18-7-201.5 or 18-7-205.5, C.R.S., and is tested by a health care provider or facility other than one that exclusively provides HIV testing and counseling.

b) Any patient tested for HIV infection pursuant to this subsection (8) without his knowledge and consent shall be given notice promptly, personally, and confidentially that a test sample was taken and that the results of such test may be obtained upon his request.

25-4-1405.5 - Extraordinary Circumstances - Procedures.
1) The general assembly hereby finds, determines, and declares that the continued risk to the public health of the citizens of this state resulting from the presence and transmission of HIV infection warrants the implementation of controlled extraordinary measures to further the containment of HIV.

2) a)

i) The provision of confidential counseling and testing services for HIV is the preferred screening service for detection of HIV infection. However, the department shall, consistent with generally accepted practices for the protection of the public health and safety, conduct an anonymous counseling and testing program for persons considered to be at high risk for infection with HIV. Such program shall be conducted at selected HIV testing sites. The department may operate sites or contract through local boards of health to conduct such testing in conjunction with counseling and testing sites, subject to maintaining standards for performance set by the state board of health.

ii) The state board of health shall adopt rules specifying the performance standards for anonymous and confidential counseling and testing sites. Standards shall include, but are not limited to, performance standards for notifying and counseling HIV-infected persons and for partner notification.

b)

i) The disclosure of an individual's name, address, phone number, or birth date shall not be required under the program as a condition of being tested to determine whether such person is infected with HIV. Any provision of this Part 14 that requires or can be construed to require a person seeking to be tested for HIV to disclose such information shall not apply to persons seeking to be tested at said test sites.

ii) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), the age and sex of a person seeking to be tested at the said test sites may be required. A person may provide personal identifying information after counseling, if the person volunteers to do so.

(c) to (e) (Deleted by amendment, L. 93, p. 539, § 1, effective July 1, 1993.)
(3) and (4) (Deleted by amendment, L. 93, p. 539, § 1, effective July 1, 1993.)

25-4-1406 - Public Health Procedures for Persons with HIV Infection.
1) Orders directed to individuals with HIV infection or restrictive measures on individuals with HIV infection, as described in this Part 14, shall be used as the last resort when other measures to protect the public health have failed, including all reasonable efforts, which shall be documented, to obtain the voluntary cooperation of the individual who may be subject to such an order. The orders and measures shall be applied serially with the least intrusive measures used first. The burden of proof shall be on the state department of public health and environment or local health department to show that specified grounds exist for the issuance of the orders or restrictive

measures and that the terms and conditions imposed are no more restrictive than necessary to protect the public health.

2) When the executive director of the state department of public health and environment or the director of the local department of health, within his respective jurisdiction, knows or has reason to believe, because of medical or epidemiological information, that a person has HIV infection and is a danger to the public health, he may issue an order to:

a) Require a person to be examined and tested to determine whether he has HIV infection;

b) Require a person with HIV infection to report to a qualified physician or health worker for counseling on the disease and for information on how to avoid infecting others;

c) Direct a person with HIV infection to cease and desist from specified conduct which endangers the health of others, but only if the executive director or local director has determined that clear and convincing evidence exists to believe that such person has been ordered to report for counseling or has received counseling by a qualified physician or health worker and continues to demonstrate behavior which endangers the health of others.

3) If a person violates a cease and desist order issued pursuant to paragraph (c) of subsection (2) of this section and it is shown that the person is a danger to others, the executive director of the state department of public health and environment or the director of the local department of health may enforce the cease and desist order by imposing such restrictions upon the person as are necessary to prevent the specific conduct which endangers the health of others. Restrictions may include required participation in evaluative, therapeutic, and counseling programs. Any restriction shall be in writing, setting forth the name of the person to be restricted and the initial period of time, not to exceed three months, during which the order shall remain effective, the terms of the restrictions, and such other conditions as may be necessary to protect the public health. Restrictions shall be imposed in the least restrictive manner necessary to protect the public health. The executive director or the director issuing an order pursuant to this subsection (3) shall review petitions for reconsideration from the person affected by the order. Restriction orders issued by directors of local departments of health shall be submitted for review and approval of the executive director of the state department of public health and environment.

4) a) Upon the issuance of any order by the state department of public health and environment or the local department of health pursuant to subsection (2) or (3) of this section, such department shall give notice promptly, personally, and confidentially to the person who is the subject of the order stating the grounds and provisions of the order and notifying the person who is the subject of the order that he has a right to refuse to comply with such order and a right to be present at a judicial hearing in the district court to review the order and that he may have an attorney appear on his behalf in said hearing. If the person who is the subject of the order refuses to comply with such order and refuses to cooperate voluntarily with the executive director of the state department of public health and environment or the director of the local department of health, the executive director or local director may petition the district court for an order of compliance with such order. The executive director or local director shall request the district attorney to file such petition in the district court, but, if the district attorney refuses to act, the executive director or local director may file such petition and be represented by the attorney general. If an order of compliance is requested, the court shall hear the matter within ten days after the request. Notice of the place, date, and time of the court hearing shall be made by personal service or, if the person is not available, shall be mailed to the

person who is the subject of the order by prepaid certified mail, return receipt requested, at his last-known address. Proof of mailing by the state department of public health and environment or local department of health shall be sufficient notice under this section. The burden of proof shall be on the state department of public health and environment or the local department of health to show by clear and convincing evidence that the specified grounds exist for the issuance of the order and for the need for compliance and that the terms and conditions imposed therein are no more restrictive than necessary to protect the public health. Upon conclusion of the hearing, the court shall issue appropriate orders affirming, modifying, or dismissing the order.

b) If the executive director or local director does not petition the district court for an order of compliance within thirty days after the person who is the subject of the order refuses to comply, such person may petition the court for dismissal of the order. If the district court dismisses the order, the fact that such order was issued shall be expunged from the records of the state department of public health and environment or local department of health.

5) Any hearing conducted pursuant to this section shall be closed and confidential, and any transcripts or records relating thereto shall also be confidential.

25-4-1407 - Emergency Public Health Procedures.

1) When the procedures of section 25-4-1406 have been exhausted or cannot be satisfied as a result of threatened criminal behavior and the executive director of the state department of public health and environment or the director of a local department of health, within his respective jurisdiction, knows or has reason to believe, because of medical information, that a person has HIV infection and that such person presents an imminent danger to the public health, the executive director or local director may bring an action in district court, pursuant to rule 65 of the Colorado rules of civil procedure, to enjoin such person from engaging in or continuing to engage in specific conduct which endangers the public health. The executive director or local director shall request the district attorney to file such action in the district court, but, if the district attorney refuses to act, the executive director or local director may file such action and be represented by the attorney general.

2) Under the circumstances outlined in subsection (1) of this section, in addition to the injunction order, the district court may issue other appropriate court orders including, but not limited to, an order to take such person into custody, for a period not to exceed seventy-two hours, and place him in a facility designated or approved by the executive director. A custody order issued for the purpose of counseling and testing to determine whether such person has HIV infection shall provide for the immediate release from custody and from the facility of any person who tests negative and may provide for counseling or other appropriate measures to be imposed on any person who tests positive. The person who is the subject of the order shall be given notice of the order promptly, personally, and confidentially stating the grounds and provisions of the order and notifying such person that he has a right to refuse to comply with such order and a right to be present at a hearing to review the order and that he may have an attorney appear on his behalf in said hearing. If such person contests testing or treatment, no invasive medical procedures shall be carried out prior to a hearing being held pursuant to subsection (3) of this section.

3) Any order issued by the district court pursuant to subsection (2) of this section shall be subject to review in a court hearing. Notice of the place, date, and time of the court hearing shall be given promptly, personally, and confidentially to the person who is the subject of the court order.

Such hearing shall be conducted by the court no later than forty-eight hours after the issuance of the order. Such person has a right to be present at the hearing and may have an attorney appear on his behalf in said hearing. Upon conclusion of the hearing, the court shall issue appropriate orders affirming, modifying, or dismissing the order.
4) The burden of proof shall be on the state or local department of health to show by clear and convincing evidence that grounds exist for the issuance of any court order pursuant to subsection (1) or (2) of this section.
5) Any hearing conducted by the district court pursuant to subsection (1) or (2) of this section shall be closed and confidential, and any transcripts or records relating thereto shall also be confidential.
6) Any order entered by the district court pursuant to subsection (1) or (2) of this section shall impose terms and conditions no more restrictive than necessary to protect the public health.

25-4-1408 - Rules and Regulations.
The state board of health may adopt such rules and regulations as are in its judgment necessary to carry out the provisions of this Part 14.

18-3-415.5 - Acquired Immune Deficiency Syndrome Testing for Persons Charged with Certain Sexual Offenses - Mandatory Sentencing.
1) For purposes of this section, "sexual offense" is limited to a sexual offense that consists of sexual penetration, as defined in section 18-3-401 (6), involving sexual intercourse or anal intercourse.
2) Any adult or juvenile who is bound over for trial subsequent to a preliminary hearing or after having waived the right to a preliminary hearing on a charge of committing a sexual offense shall be ordered by the court to submit to a diagnostic test for the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome, said diagnostic test to be ordered in conjunction with the diagnostic test ordered pursuant to section 18-3-415. The results of said diagnostic test shall be reported to the district attorney. The district attorney shall keep the results of such diagnostic test strictly confidential, except for purposes of pleading and proving the mandatory sentencing provisions specified in subsection (5) of this section.
3) a) If the person tested pursuant to subsection (2) of this section tests positive for the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome, the district attorney may contact the state department of public health and environment or any local health department to determine whether said person had been notified prior to the date of the offense for which the person has been bound over for trial that he or she tested positive for the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome.
b) If the district attorney determines that the person tested pursuant to subsection (2) of this section had notice of his or her HIV infection prior to the date the offense was committed, the district attorney may file an indictment or information alleging such knowledge and seeking the mandatory sentencing provisions authorized in subsection (5) of this section. Any such allegation shall be kept confidential from the jury and under seal of court.
c) The state department of public health and environment or any local health department shall provide documentary evidence limited to whether the person tested pursuant to subsection (2) of this section had notice of or had discussion concerning his or her HIV

infection and the date of such notice or discussion. The parties may stipulate that the person identified in said documents as having notice or discussion of his or her HIV infection is the person tested pursuant to subsection (2) of this section. Such stipulation shall constitute conclusive proof that said person had notice of his or her HIV infection prior to committing the substantive offense, and the court shall sentence said person in accordance with subsection (5) of this section.

d) If the parties do not stipulate as provided in paragraph (c) of this subsection (3), an officer or employee of the state department of public health and environment or of the local health department who has had contact with the person tested pursuant to subsection (2) of this section regarding his or her HIV infection and can identify said person shall provide, for purposes of pretrial preparation and in court proceedings, oral and documentary evidence limited to whether said person had notice of or had discussion concerning his or her HIV infection and the date of such notice or discussion. If the state department or the local health department no longer employs an officer or employee who has had contact with the person tested pursuant to subsection (2) of this section regarding the person's HIV infection, the state department or the local health department shall provide:

i) The names of and current addresses, if available, for each former officer or employee who had contact with the person tested pursuant to subsection (2) of this section regarding the person's HIV infection;

ii) Documentary evidence concerning whether the person tested pursuant to subsection (2) of this section was provided notice of or had discussion concerning his or her HIV infection and the date of such notice or discussion; and

iii) If none of said former officers or employees are available, any officer or employee who has knowledge regarding whether the person tested pursuant to subsection (2) of this section was provided notice of or had discussion concerning his or her HIV infection and the date of such notice or discussion. Said officer or employee shall provide such evidence for purposes of pretrial preparation and in court proceedings.

4) Nothing in this section shall be interpreted as abridging the confidentiality requirements imposed on the state department of public health and environment and the local health departments pursuant to Part 14 of article 4 of title 25, C.R.S., with regard to any person or entity other than as specified in this section.

5) a) If a verdict of guilty is returned on the substantive offense with which the person tested pursuant to subsection (2) of this section is charged, the court shall conduct a separate sentencing hearing as soon as practicable to determine whether said person had notice of his or her HIV infection prior to the date the offense was committed, as alleged. The sentencing hearing shall be conducted by the judge who presided at trial or before whom the guilty plea was entered or a replacement for said judge in the event he or she dies, resigns, is incapacitated, or is otherwise disqualified as provided in section16-6-201, C.R.S. At the sentencing hearing, the district attorney shall have the burden of proving beyond a reasonable doubt that said person had notice of his or her HIV infection prior to the date the offense was committed, as alleged.

b) If the court determines that the person tested pursuant to subsection (2) of this section had notice of his or her HIV infection prior to the date the offense was committed, the judge shall sentence said person to a mandatory term of incarceration of at least three

times the upper limit of the presumptive range for the level of offense committed, up to the remainder of the person's natural life, as provided in section 16-13-804, C.R.S.

APPENDIX C

HEALTHY RELATIONSHIPS

A Small-Group Intervention for Men and Women Living with HIV/AIDS
FACT SHEET

Program Overview
Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Core Elements
Core elements of Healthy Relationships are:

- Defining stress and reinforcing coping skills across three life areas—disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships.
- Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.
- Teaching decision-making skills about disclosure of HIV status.
- Providing personal feedback reports to motivate change of risky behaviors and continuance of protective behaviors.
- Using movie clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-plays.

Target Population
The Healthy Relationships intervention targets men and women living with HIV/AIDS.

Program Materials

- Intervention package

Research Results
Implementation of Healthy Relationships produced the following results:

- Participants reported greater self-efficacy for suggesting condom use with new partners.
- Participants reported intentions to consider the pros and cons of HIV status disclosure to partners.
- Participants reported intentions to engage in safer sex with partners who did not know their HIV status.
- Participants were significantly more likely to have followed through on their earlier intentions at the three-month and six-month follow-up.
- Participants reported less unprotected intercourse, more protected intercourse, and fewer sexual contacts at the six-month follow-up.
- Participants reported less sexual intercourse and less unprotected intercourse with non-HIV-positive partners at the three-month and six-month follow-up.
- Participants were significantly more likely to refuse to engage in unsafe sex at the six-month follow-up.

For More Information on Healthy Relationships
Interested CBOs and personnel will be contacted when a training date is available in your geographic area.

To place your name on a list for a future training, **please visit our website www.effectiveinterventions.org.** If you do not have access to the web, you may also call (800) 462-9521 or email interventions@aed.org

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Kalichman, S., Rompa, D., Cage, M., DiFonzo, K., Simpson, D., Austin, J., Luke, W., Buckles, J., Kyomugisha, F., Benotsch, E., Pinkerton, S., Graham, J. (2001). Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people. *American Journal of Preventive Medicine*, 21(2), 84-92.

MANY MEN, MANY VOICES

A Group-Level Intervention for Gay Men of Color
FACT SHEET

Program Overview
Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia.

3MV is designed to be facilitated by a peer in groups of 6-12 clients. The 2-3 hour sessions aim to foster positive self image; educate participants about their STD/HIV risks; and teach risk reduction and partner communication skills. The sessions are highly experiential, incorporating group exercises, behavioral skills practice, group discussions, and role play.

The sessions address specific influencing factors in a sequence including:

- **Session 1:** The Dual Identity of Gay Men of Color
- **Session 2:** STD/HIV Prevention for Gay Men of Color – Sexual Roles and Risks
- **Session 3:** STD/HIV Risk Assessment and Prevention Options
- **Session 4:** Intentions to Act and Capacity to Change
- **Session 5:** Sexual Relationship Dynamics – Partner Selection, Communication, and Negotiation
- **Session 6:** Social Support and Problem Solving to Maintain Change
- **Session 7 (optional):** Building a Healthy Community

The intervention can also be adapted to 12 sessions of 75-90 minutes each, or condensed into a weekend retreat, covering the 18-21 hours of intervention curriculum.

Core Elements
Core elements of 3MV are:

- Educate clients about HIV risk and sensitize to personal risk.
- Develop risk reduction strategies.
- Train in behavioral skills.
- Train in partner communication and negotiation.
- Provide social support and relapse prevention.

Target Population
The 3MV intervention targets gay men of color. The intervention also targets men on the 'down low' with or without female partners (i.e., men of color who have sex with other men but do not identify as gay or bisexual).

Program Materials
Educational materials for distribution which may be used to recruit persons into the group.

Research Results
After implementation of the original intervention (12 sessions of 75-90 minutes each), participants reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men who did not participate in the intervention.

For More Information on 3MV
To obtain additional information about the technical assistance system and/or to get your name on a list for a future training, **please visit our website www.effectiveinterventions.org.** If you do not have access to the web, you may also call (800) 462-9521 or email interventions@aed.org.

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Kelly, J.A., St. Lawrence, J.S., Hood, H.V., Brasfield, T.L. (1989). Behavioral intervention to reduce AIDS risk activities. *Journal of Consulting and Clinical Psychology,* 57(1):60-67.

THE MPOWERMENT PROJECT

A Community-Level HIV Prevention Intervention for Young Gay Men
FACT SHEET

Program Overview
The Mpowerment Project was developed by and for young gay man ages 18-29. The intervention is run by a core group of 10-15 young gay men from the community and paid staff. The young gay men, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours. The program relies on a set of four integrated activities:

- *Formal Outreach:* Teams of young gay men go to locations frequented by young gay men to discuss and promote safer sex, deliver appealing informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates their own social events (e.g., dances, video parties, picnics, and discussion groups) to attract young gay men and to promote safer sex.

- *M-groups:* These peer-led, 2-3 hour meetings of 8-10 young gay men discuss factors contributing to unsafe sex among the men (e.g., misconceptions about safer sex, beliefs that safer sex is not enjoyable, and poor sexual communication skills). Through skills-building exercises, the men practice safer sex negotiation and correct condom use skills. Participants receive free condoms and lubricant and are trained to conduct informal outreach.

- *Informal Outreach:* Informal outreach consists of young men discussing safer sex with their friends.

- *Ongoing Publicity Campaign:* The campaign attracts men to the project by word of mouth and through articles and advertisements in gay newspapers.

Core Elements
The core elements of Mpowerment include:
- Recruiting a core group of young gay men to design and carry out project activities
- Establishing a project space where many of the project activities can be held
- Conducting entertaining, venue-based (e.g., bars, community events) outreach by teams of young gay men
- Sponsoring social events to promote community-building among young gay men.
- Convening peer-led, one-time discussion groups.
- Conducting a publicity campaign about the project within the community.

Target Population
The Mpowerment project targets young gay and bisexual men (ages 18-29).

Program Materials
- Overview video of the program
- Program implementation manual
- M-group facilitator guide
- Facilitator training video

Research Results
The Mpowerment Project yielded the following results in the young gay men who participated:

- Participants significantly decreased their rates of unprotected anal intercourse.

For More Information on the Mpowerment Project
To obtain additional information about the technical assistance system and/or to get your name on a list for a future training, **please visit our website** **www.effectiveinterventions.org**. If you do not have access to the web, you may also call (800) 462-9521 or email interventions@aed.org.

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Kegeles, S.M., Hays, R.B., Coates, T.J. (1996). The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men. *American Journal of Public Health*, 86 (8), 1129 – 1136.

POPULAR OPINION LEADER

A Community AIDS/HIV Risk Reduction Program
FACT SHEET

Program Overview
POL is a community-level HIV prevention intervention designed to identify, enlist, and train opinion leaders to encourage safer sexual norms and behaviors within their social networks of friends and acquaintances through risk reduction conversations.

Core Elements
The core elements of POL include:

- Intervention is directed to an identifiable target population in well-defined community venues and where the population's size can be estimated.
- Ethnographic techniques are systematically used to identify segments of the target population and to identify those persons who are most popular, well-liked, and trusted by others in the each population segment.
- Over the life of the program, 15% of the target population size found in intervention venues is trained as POLs.
- The program teaches POLs skills for initiating HIV risk reduction messages to friends and acquaintances during everyday conversations.
- The training program teaches POLs characteristics of effective behavior change communication messages targeting risk reduction attitudes, norms, intentions and self efficacy. In conversations, POLs personally endorse the benefits of safer behavior and recommend practical steps needed to implement change.
- Groups of POLs meeting together weekly in sessions that use instruction, facilitator modeling, and extensive role play exercises to help POLs refine their skills and gain confidence in delivering effective HIV prevention messages to others. Groups are small enough to provide extensive practice opportunities for all POLs to shape their communication skills and create comfort in delivering conversational messages.
- POLs set goals to engage in risk reduction conversations with friends and acquaintances in the targeted population between weekly sessions.
- POLs conversational outcomes are reviewed, discussed, and reinforced at subsequent training sessions.
- Logos, symbols, or other devices are used as "conversation starters" between the POLs and others.

Target Population
POL can be used with various at-risk populations in a variety of venues. POL has been tested with gay men in bars, African American women in low-income housing settings, and male commercial sex workers.

Program Materials

- Intervention implementation manual
- Instructional video
- Materials to conduct POL trainings
- Materials to manage and evaluate the program

For More Information on Popular Opinion Leader
To obtain additional information about the technical assistance system and/or to get your name on a list for a future training, **please visit our website www.effectiveinterventions.org**. If you do not have access to the web, you may also call (800) 462-9521, or email interventions@aed.org.

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Kelly, J.A., St. Lawrence, J.S., Diaz, Y.E., Stevenson, L.Y., Et al. (1991). HIV Risk Behavior Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis, *American Journal of Public Health*, 81 (2), 168 – 171.

Kelly, J.A., (2004). Popular opinion leaders and HIV prevention peer education: Resolving discrepant findings, and implications for the development of effective community programmes. *AIDS Care*, 16(2), 139-150.

COMMUNITY PROMISE

Peers Reaching Out and Modeling Intervention Strategies
A Community-Level HIV/STD Prevention Intervention
FACT SHEET

Program Overview
Community PROMISE is an effective, community-level HIV/STD prevention intervention that relies on role model stories and peer advocates from the community. The intervention is based on behavioral theories including Stages of Change. Community PROMISE begins with a community identification process to collect and analyze information about the community, including HIV/STD risk behaviors and influencing factors, to help agencies identify target populations and appropriately tailor the intervention. Members of the target population who have made positive HIV/STD behavior change are interviewed and role models stories are written based upon the interviews. The stories are personal accounts about how and why they took steps to practice HIV/STD prevention behaviors and the resulting positive effects on their lives. Peers advocates from the target populations are recruited and trained to distribute the role model stories and prevention materials within their social networks. New role model stories are written based on continuous formative research that reflects behavior change within the target population.

Core Elements
- Community identification process to collect information about the community, including HIV/STD risk behaviors and influencing factors
- Creating role model stories based on personal accounts from individuals in the target population who have made positive behavior change
- Recruiting and training peer advocates from the target population to distribute role model stories and prevention materials
- Continuous formative evaluation to capture behavior change within the target population.

Target Populations
Community PROMISE can serve any population, since it is created anew each time it is implemented in collaboration with the community. The intervention has been tested with African American, White, and Latino communities, including intravenous drug users and their sex partners, non-gay identified men who have sex with men, high risk youth, female sex workers, and high risk heterosexuals, among others. It is also being developed for other populations and for individuals living with HIV.

Program Materials
- Implementation Manual
- Two videos: *Intervention Overview* and *How to Conduct a Role Model Story Interview*
- Technical Assistance Guide
- Canvas carrying bag

Research Results
In the original research, those exposed to the intervention moved toward consistent condom use with main and non-main partners, increased condom carrying and showed positive progression in the stages-of-behavior-change for condom and bleach use.

For More Information on Community PROMISE
To obtain additional information about the technical assistance system and/or to get more information on how to obtain training, **please visit our website www.effectiveinterventions.org**.

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CDC AIDS Community Demonstration Projects Research Group (1999). Community-level HIV Intervention in Five Cities: Final Outcome Data from the AIDS Community Demonstration Projects. *American Journal of Public Health*, 89 (3), 336 B 345.

SAFETY COUNTS

A Cognitive-Behavioral Intervention to Reduce HIV/HCV Risks Among Drug Users

FACT SHEET:

Program Overview

Safety Counts is an HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.

This intervention works well with CDC's Advancing HIV Prevention initiative as it strongly encourages HIV testing as a precursor to program enrollment, clients can be recruited from testing programs, and sessions include a discussion of the importance of testing to the client. The intervention addresses the needs of both HIV-negative and HIV-positive clients.

Core Elements

Original program developers identify the five core elements as:

- Group Session One and Group Session Two (identify client's HIV risks and current stage of change, hear risk-reduction success stories, set personal goal, identify first step to reduce HIV risk, and make referrals to C&T and medical/social services)
- One (or more) Individual Counseling Session (discuss/refine risk-reduction goal, assess client's needs, and provide needed referrals to C&T and medical/social services)
- Two (or more) Social Events (share meal and socialize, participate in a planned HIV-related risk-reduction activity, and receive reinforcement for personal risk reduction)
- Two (or more) Follow-up Contacts (review client's progress in achieving risk-reduction goal, discuss barriers encountered, identify concrete next step and discuss possible barriers/solution, and make referrals to C&T and medical/social services)
- HIV/HCV Counseling and Testing (offer the client this service either through referrals or at the implementing agency)

Target Population

Safety Counts targets individuals who are currently using drugs, including injectors and non-injectors, and are not in drug treatment programs.

Program Materials

- Program manual
- Handouts / worksheet master copies
- Program forms to track enrollment, client participation, etc.
- Evaluation tools / forms
- Sample video

Research Results

- Clients who were enrolled in *Safety Counts* were about 1.5 times more likely to reduce their drug- and sex-related risks compared with clients in the standard intervention.
- Clients who were enrolled in *Safety Counts* were more than 2.5 times more likely to self-report an increase in condom use compared with clients in the standard intervention.
- Clients who were enrolled in *Safety Counts* were significantly more likely to self-report a reduction in the number of times they inject and more likely to test negative for opiates through urinalysis.

For More Information on Safety Counts

To obtain additional information about the technical assistance system and/or to get your name on a list for a future training, **please visit our website www.effectiveinterventions.org**. If you do not have access to the web, you may also call (800) 462-9521, or email interventions@aed.org

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Rhodes, F., Wood, M.S. (1999). A cognitive-behavioral intervention to reduce HIV risks among active drug users. Paper presented at the 127th Annual Meeting of the American Public Health Association, Chicago, IL.

Rhodes, F., Humfleet, G.L. (1993). Using goal-oriented counseling and peer support to reduce HIV/AIDS risk among drug users not in treatment. *Drugs & Society* (3/4):185-204.

THE SISTA PROJECT

Sisters Informing Sisters on Topics about AIDS
A Peer-led Program to Prevent HIV Infection in African American Women
Fact Sheet

Program Overview
The SISTA project is a social-skills training intervention for African American women. It is aimed at reducing HIV sexual risk behavior. It is comprised of five 2-hour sessions, delivered by peer facilitators in a community-based setting. The sessions are gender specific and culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, prevention video viewing, and take-home exercises.

Core Elements

- Conduct small group sessions to discuss the session objectives, model skills development, role play women's skills acquisition and address the challenges and joys of being an African American woman.
- Utilize skilled facilitators to implement SISTA group sessions.
- Utilize cultural and gender appropriate materials to acknowledge pride, enhance self worth in being an African American woman (e.g., use of poetry, artwork by African American women).
- Train women in sexual assertion skills, so that they can both demonstrate care for partners and negotiate safe behaviors.
- Teach women proper condom use--SISTA is designed to foster positive attitudes and norms towards consistent condom use and provide women the appropriate instruction for placing condoms on their partner.
- Discuss cultural and gender triggers that may make it challenging for women to negotiate safer sex.
- Emphasize the importance of partner involvement in safer sex--the homework activities are designed to involve the male partner.

Target Population
The SISTA project targets heterosexually active African American women.

Program Materials

- Facilitator's manual
- Videotape (*It's Like This)*
- Five Activity Masters packets
- Evaluation materials (including evaluation assistance kit, original and process evaluation)

CDC has developed supplemental materials

- Community Facilitator Guide
- Technical Assistance Guide
- Evaluation Technical Assistance Guide
- Evaluation Plan

Evaluation
The SISTA project was first implemented in an African American community in San Francisco. The results are as follows:

- Participants in the social-skills intervention demonstrated increased consistent condom use, sexual behavior self-control, sexual communication, and sexual assertiveness skills.

- The partners of participants in the social-skills intervention were more likely to adopt and support consistent condom use.

More Information
For more information about the technical assistance system or to get your name on a list for a future training, please visit our website: www.effectiveinterventions.org. You may also call (800) 462-9521 or email us at interventions@aed.org.

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DiClemente, R.J., Wingood, G.M. (1995). A randomized controlled trial of an HIV sexual risk reduction intervention for young African American women. *The Journal of the American Medical Association*, 274 (16), 1271–1276.

Colorado ManREACH

2007 FACT SHEET

Program Model Overview

Colorado ManREACH was developed by and for Colorado men who have sex with men (MSM) who reside outside the Denver metropolitan area. It is an adaptation of the Mpowerment Program Model[1] , recognized by the Diffusion of Effective Behavioral Interventions initiative at the U.S. Centers for Disease Control and Prevention and approved by the STD/HIV Section at Colorado Department of Public Health and Environment (CDPHE).

Structurally, ManREACH targets MSM who reside in regions outside of the Denver metropolitan area. In each region, following the Mpowerment Model, ManREACH is run by a core group of 10-15 MSM from the community and paid staff. The MSM, along with other volunteers, design and carry out all project activities. Activities occur at both the regional and state wide levels; three times per year, MSM from all three regions convene for state wide gatherings.

Colorado ManREACH relies on a set of four integrated activities, based on the Mpowerment model:

- *Formal Outreach:* Teams of MSM utilize rural MSM social networks to discuss and promote safer sex, deliver appealing informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates social events or accesses social events held by other organizations (e.g., dances, video parties, picnics, potlucks, and discussion groups) to attract MSM and to promote safer sex.
- *M-groups:* These peer-led, 2-3 hour meetings of 6-10 MSM discuss factors contributing to unsafe sex among the men (e.g., unhealthy partner selection practices, emotionally unsatisfying interactions with other MSM, loneliness, depression, uncontrolled substance use). A standard M-Group curriculum is used in all regions. Through skills-building exercises, the men practice communication, safer sex, negotiation and correct condom use skills. Participants receive free condoms and lubricant and are trained to conduct informal outreach.
- *Informal Outreach*: Informal outreach consists of MSM discussing safer sex with their friends.
- *Ongoing Publicity Campaign*: The campaign attracts men to the project by word of mouth, by Internet-based strategies, and through flyers, articles and advertisements.
- *One-on-one Screening and Referral*: Some ManREACH participants express intensive needs that require screening and active referrals, particularly regarding mental health and substance abuse. Regional coordinators are responsible for providing this service as needed.

Core Elements

The table below lists the Core Elements of the underlying Mpowerment program model and summarizes how these elements are implemented at the regional and state wide levels of ManREACH.

[1] Kegeles, S.M., Hays, R.B., Coates, T.J. (1996). The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men. *American Journal of Public Health*, 86 (8), 1129 – 1136

Mpowerment Program Model Core Element	ManREACH activities to be delivered at the regional level	ManREACH activities to be delivered at the state wide level
Recruiting a core group of gay men to design and carry out project activities.	Each of the regional projects has a Core Group consisting of MSM from that region. The Core Groups design and carry out the project activities in their region.	Each of the regions is represented on the State Wide Steering Committee. This Committee sets the agendas for the state wide gatherings and advises CDPHE on matters of state wide significance (e.g., sets the standard curriculum for the M-Groups, reviews local activities for consistency across the state).
Establishing a project space where many of the project activities can be held.	Utilize local venues that are sympathetic to the intents of the project and can be "temporarily owned" by the project for the duration of the activity. Attempt to utilize a consistent venue or set of venues as much as possible.	Conduct gatherings in settings where ManREACH has exclusive use of the facility for the duration of the gathering. Attempt to utilize a consistent venue or set of venues as much as possible to build a sense of "ownership."
Conducting entertaining, venue-based (e.g., bars, community events) outreach by teams of gay men	Volunteers perform outreach at the following: • Venues frequented by MSM, such as gay bars, as they exist in the larger population centers (Fort Collins, Colorado Springs, Grand Junction); • Community events that target a gay population but are not convened by ManREACH (e.g., 4cGLAD events, GLB community center events, GLBT film festivals, informal potlucks held in local areas).	• Volunteers publicize the state wide gatherings as part of their local outreach activities in the larger population centers. • Periodic outreach and distribution of materials publicizing the state wide gatherings to areas outside the population centers, particularly those areas that do not have local events and M-Groups. • Outreach to Internet chat rooms that cater to rural Colorado MSM.
Sponsoring social events to promote community-building among gay men.	Conduct small scale (6 – 10 participants) and large scale (11 + participants) social events to attract rural MSM. Use these events to publicize other regional and state wide ManREACH events, including M-Groups and the state wide gatherings.	Conduct state wide gatherings that promote deeper, longer-lasting connections among participants.
Convening peer-led, one-time discussion groups	• Conduct an M-Group whenever 6 – 10 participants have registered, preferably at least quarterly. • Utilize the standard M-Group curriculum.	At statewide gatherings, conduct workshops that convey M-Group content, particularly safer sex, substance abuse, and skills development (negotiation, communication, decision-making).
Conducting a publicity campaign about the project within the community.	• If available, utilize media that targets rural MSM to publicize events in the region. • Publicize regional events via email lists, including those made available from organizations with similar missions (e.g., PFLAG). • Place banners and other publicity on Internet sites frequented by rural MSM in the region.	• Utilize media that targets rural MSM to publicize state wide gatherings. • Publicize state wide gatherings via email lists, including those made available from organizations with similar missions (e.g., PFLAG). • Place banner ads and other publicity on Internet sites frequented by rural Colorado MSM.